PATIENT REGISTRATION FORM
DR. KORDAS PEDIATRIC HEALTH CARE CENTER

PERSONAL DATA **DATE:**_____

Child's Name:_____ DOB:_____ Sex:_____

Child's Name:_____ DOB:_____ Sex:_____

Child's Name:_____ DOB:_____ Sex:_____

Child's Name:_____ DOB:_____ Sex:_____

Home Address:_____City:_____ State:_____Zip:_____

Billing Address:_____City:_____ State:_____Zip:_____

Home#:_____Email Address:_____May we contact you via email? Y/N

Emergency Contact:_____ Phone:_____

Parent#1 Name:_____ DOB_____ ss#_____

Employer:_____Occupation:_____Work Phone:_____

Cell Phone:_____ Driver's License Number:_____ State:_____

Parent#2 Name:_____ DOB_____ ss#_____

Employer:_____Occupation:_____Work Phone:_____

Cell Phone:_____ Driver's License Number:_____ State:_____

INSURANCE INFORMATION

Subscriber's Name:_____ Insurance Company:_____

ID#_____ Group#_____ Phone#_____

Secondary Insurance Company:_____Subscriber Name:_____

ID#_____ Group#_____ Phone#_____

PREFERRED PHARMACY NAME:_____Address:_____ Phone#:_____

Preferred Pharmacy Name:_____ **Address:**_____**Phone number**_____

Financial Agreement:

By signing below, I hereby certify the correctness of the above information and authorize the release of information to my insurance company. I assign benefits to DR KORDAS PEDIATRIC HEALTH CARE CENTER and to the attending doctor: Dr. Bernadeta Kordas, M.D., Dr. Pearl Park, D.O., or Dr. Michelle Rose, M.D. based on the appointment that I make. A photocopy of the assignment of benefits may serve as an original. I hereby agree that in consideration for services rendered by the doctor, I shall make prompt payment to my account as bills are presented. I also understand that I am ultimately responsible for my bill regardless of my insurance coverage.

Signature:_____ Date:_____

Permission to treat:

I give permission to Dr. Bernadeta Kordas M.D., Dr. Pearl Park, D.O. and Dr. Michelle Rose, M.D. to render treatment to my minor children or to myself.

Signature:_____ Relationship:_____ Date:_____

CHILD/ADOLESCENT HEALTH QUESTIONNAIRE

Name: _____ Age:_____ Date:_____

BIRTH HISTORY:

Hospital where born:_____

Birth Weight:_____ Full term or premature? _____

Method of delivery: Vaginal_____ Cesarean section_____

During pregnancy did mother smoke cigarettes, marijuana, drink alcohol or take any medications?

If Yes, please explain: _____

Any problems or health concerns during pregnancy? YES NO

If yes, please explain:_____

Any issues as a newborn? YES NO

If yes, please explain:_____

EARLY DEVELOPMENT:

Feeding history: Breast milk? _____ Until what age?_____ Formula name?_____

Age solids started?_____ Sat?_____ Walked?_____ First words?_____

MEDICAL PROBLEMS:

Any problems after birth?	YES	NO
Any reactions to vaccinations?	YES	NO
Reactions to drugs?	YES	NO
Recurring infections?	YES	NO
Multiple (>3) ear infections by age 2?	YES	NO
Bronchitis or pneumonia?	YES	NO
Kidney or bladder infections?	YES	NO

History of seizures?	YES	NO
Constipation or recurrent diarrhea?	YES	NO
Hay fever? Asthma? Eczema?	YES	NO
Allergies to foods?	YES	NO
Childhood diseases? (e.g. chickenpox?)	YES	NO

BEHAVIOR PROBLEMS:

Please circle all that apply:

Temper tantrums Sleep problems Toilet training problems Aggression

Any other concerns? _____

Accidents: (examples: broken bones, loss of consciousness or overdosing?)_____

_____

Hospitalizations? If yes, why?_____

Surgeries?_____

Family History: circle all that apply to any close relative

High blood pressure	Hives	Hay fever	Cancer
High Cholesterol	Lung disease	Foot problems	Anemia
Heart attack before age 60	Nervous disease	Kidney/bladder	Skin disorder
Diabetes	Bone disease	Mental retardation	Thyroid disease
Obesity	Breathing problems	Learning disorders	Arthritis
Deafness	Allergy	Vision problems	Muscle disease
Seizure disorder	Colitis	Migraine Headaches	Bleeding problems
Scoliosis	Alcoholism	Smoking	

Please describe if any above applies.

_____

Family History

Patient Name: _____ Date of Birth (DOB): ____ / ____ / _____

Directions:
If you answer yes to any of the following questions, please provide more details under "comments"

Have any biological family members had...?	Child being seen	Sibling(s)	Biological Father	Biological Mother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other relatives (list)	Comments
Childhood hearing loss										
Nasal allergies/ hay fever										
Asthma										
Food Allergies										
Cystic Fibrosis										
Tuberculosis/ positive PPD										
Stroke (before 55 years old)										
Heart disease (before 55 years old)										
High cholesterol/takes cholesterol medication										
Anemia										
Bleeding disorder/hemophilia										
Dental decay										
Cancer (before 55 years old)										
Liver disease										
Kidney disease										
Diabetes (before 55 years old)										
Bed wetting (after 10 years old)										
Obesity										
Epilepsy/convulsions/seizures										
Alcohol abuse										
Drug abuse										
Tobacco abuse										
ADHD										
Anxiety										
Depression										
Mental health problems										
Autism										
Developmental disability										
Birth defects/chromosomal abnormalities										
Immune problems, HIV, or AIDS										
Migraine headaches										
Lazy eye										
Vision problems										
Hip dysplasia										
Hip problems										
Any other significant problem										

DR. KORDAS PEDIATRIC HEALTH CARE CENTER LLC
3335 N. ARLINGTON HEIGHTS RD. SUITE H
ARLINGTON HEIGHTS, IL 60004
PHONE (224) 857-8000 FAX (224)857-8001

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home.

We invite you to share with us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing.

Patient Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

_____ Home Telephone: _____

_____ OK to leave message with detailed information

_____ Leave message with call-back number only

_____ Cell Phone: _____

_____ OK to leave message with detailed information

_____ Leave message with call-back number only

_____ Work Telephone: _____

_____ OK to leave message with detailed information

_____ Leave message with call-back number only

_____ Written Communication: _____

_____ OK to mail to my home address c

_____ OK to mail to my work/office address

_____ Other: _____

Preferred Contacts: We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

- Name: _____ Telephone: _____ Relationship: _____
- Name: _____ Telephone: _____ Relationship: _____
- Name: _____ Telephone: _____ Relationship: _____

Patient Signature: _____ Date: _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

DR KORDAS PEDIARTRIC HEALTH CARE CENTER LLC
Authorization To Disclose Health Information Via E-Mail
Office Emails: kids.dr@aol.com or dr.pediatric@aol.com

Patient Name: _____ DOB_____

Street: _____

City: _____ ST: _____ Zip: _____

Phone: _____ **Cell:**_____

This authorization covers protected health information (PHI) disclosed by, DR. KORDAS PEDIATRIC HEALTH CARE CENTER LLC personnel to a patient or a patient's representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

****

To be completed by patient or patient's representative:
My signature at the bottom of this form is authorization for Dr. Kordas Pediatric Health Care Center LLC to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Law may no longer protect re-disclosure.
- **I should not use e-mail for any urgent or time-sensitive medical questions or issues**
- Once transmitted, I am responsible for safeguarding the information I receive
- I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a Revocation of Release of Medical Information Form. A revocation will not apply to information that has already been released as a result of this authorization
- To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to Dr. Kordas Pediatric Health Care Center LLC party at the e-mail address below
- I am responsible for notifying Dr. Kordas Pediatric Health Care Center LLC party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- Dr. Kordas Pediatric Health Care Center LLC will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is: _____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient Date

SMS TEXT MESSAGING CONSENT FORM

DR KORDAS PEDIATRIC HEALTH CARE CENTER LLC is planning to introduce a mobile texting communication service.

This service will be used to send text reminders to patients regarding upcoming appointments.

We always strive to maintain confidentiality of your information and will continue to do so while using this system. To help us do this, it is important that you let us know if you change your mobile number in the future. We will NOT send out any texts unless you have explicitly consented.

If you give consent for us to communicate with you by mobile text messaging as outlined above please fill in your child/children details below. If you decide you no longer wish to receive messages through this service please inform us.

Patient Name(s):	
Date of Birth(s):	
Mobile Number:	
Patient Address:	

I confirm that I have read and understood the information above and ***I CONSENT*** *to receive text messages from the practice for the purpose of appointment reminders at my mobile number provided above and to any number forwarded or transferred to that number. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing and plan details)*

Signature of Parent /Guardian of Patient:	
Name (Please Print):	
Date:	

_____ I DO NOT WISH TO RECEIVE TEXT MESSAGE REMINDERS

PRACTICE USE ONLY: SMS CONSENT TEMPLATE COMPLETED: ___
SCANNED AND UPLOADED TO EMR_____ STAFF INITIALS: _____

DR. KORDAS PEDIATRIC HEALTH CARE CENTER

Patient Name:_____ Date:_____

CANCELLATION/MISSED APPOINTMENT POLICY

Your appointment has been set aside for you. This time is unavailable to other patients. For all missed or cancelled appointments with less than 24 hrs notice you will be charged a $50 cancellation fee. Appointment reminders are a courtesy. Should you not receive a reminder, it is still your responsibility to remember your appointment.

I have read and understand the cancellation/missed appointment policy.

_____

Patient signature

If patient is a minor, please provide patient or guardian's information.

Name: _____ Relationship:_____

Parent or Guardian Signature:_____

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise

Dear Parent/Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How Your HEALTH INFORMATION May be Used:

To Provide Treatment

We will use your **HEALTH INFORMATION** within our office to provide you with the best medical care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between nurses, nurse practitioners, physicians, receptions, laboratory, and business office staff. In addition, we may share your health information with specialists, clinical laboratories, pharmacies and other health care personnel providing your treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities used clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general medical health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow-up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive medical care we can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you don't not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic of the understanding of new side effects of drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information
Other than is state above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate with your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review and copy your (child's) health information, including your complete chart, x-rays and billing records. If you would like a copy of your (child's) health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was nor created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to nor more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

DR. KORDAS PEDIATRIC HEALTH CARE CENTER LLC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of DR. KORDAS PEDIATRIC HEALTH CARE CENTER LLC Notice of Privacy Practices effective March 21st,2018.

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient's name). I have received a copy of DR. KORDAS PEDIATRIC HEALTH CARE CENTER LLC Notice of Privacy Practices effective March 21st,2018.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective March 21st, 2018 given to individual on _____(date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____
Signature: _____ Date: _____

Dr. Kordas Pediatric Health Care Center LLC

3335 N. Arlington Heights Rd. Suite G-H
Arlington Heights, Illinois, 60004
Phone: (224)857-8000 Fax:(224)857-8001

Release of Medical Records To: Dr. Kordas Pediatric Health Care Center LLC

*** **Immediate: Please fax immunization records only to**_____ ***

Please mail full records to the office location and address checked above.

Notes: _____

Patient Information:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Release Records From (doctor or facility name): _____

Address: _____

City/state/Zip: _____ Phone: _____ Fax: _____

Authorization *(initial each item below)*

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____ Failure to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____ _____

Name (print) Signature Date

Relationship to Patient: ____ Self ____ Parent ____ Legal Guardian ____ Other (please specify)