Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

Name:_____ Today's Date: _____
Last First M

Address: _____
Street Address City State Zip Code

Phone #1(_____)_____-_____ □ H□C□W Phone #2(_____)_____-_____ □ H□C□W

GENDER: □MALE □FEMALE

SSN: _____DOB: _____

RACE: □African American/Black □White □American Indian/Alaska Native □Asian □Native Hawaiian or Pacific Islander □ Declined

ETHNICITY: □Hispanic □Non-Hispanic □Declined

PARENT #1 INFORMATION

Name:_____ SSN: _____DOB: _____
Last First M
Address: _____
Street Address City State Zip Code

Phone #1(_____)_____-_____ □ H□C□W Phone #2(_____)_____-_____ □ H□C□W E-mail_____

Occupation: _____Employer_____

Relationship with patient_____ Do you live with child? □NO □YES

PARENT #2 INFORMATION

Name:_____ SSN: _____DOB: _____
Last First M
Address: _____
Street Address City State Zip Code

Phone #1(_____)_____-_____ □ H□C□W Phone #2(_____)_____-_____ □ H□C□W E-mail_____

Occupation: _____ Employer_____

Relationship with patient_____ Do you live with child? □NO □YES

EMERGENCY CONTACT #1

Name:_____Relationship_____

Phone #1(_____)_____-_____ □ H□C□W Phone #2(_____)_____-_____ □ H□C□W

EMERGENCY CONTACT #2

Name:_____Relationship_____

PHONE #1(_____)_____-_____ □ H□C□W PHONE #2(_____)_____-_____ □ H□C□W

REFERRAL INFORMATION

Referring physician name: _____ Phone:(____)_____-_____ Fax:(____)_____-_____

Address:_____
Street Address City State Zip Code

PRIMARY CARE PHYSICIAN INFORMATION

PCP name: _____ Phone:(____)_____-_____ Fax:(____)_____-_____

Address:_____
Street Address City State Zip Code

INSURANCE INFORMATION

_____

PRIMARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER NAME_____RELATIONSHIP_____

_____
SUBSCRIBER SSN DOB EMPLOYER WORK #

DO YOU HAVE A SECONDARY INSURANCE? □ NO □ YES. IF SO, PROVIDE INFORMATION BELOW

_____
SECONDARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER
NAME_____RELATIONSHIP_____

_____
SUBSCRIBER SSN DOB EMPLOYER WORK #

PHARMACY INFORMATION

PREFERRED PHARMACY NAME_____

ADDRESS_____

PHONE (_____)_____-_____ FAX NUMBER (_____) _____-_____

The information I provided is correct to the best of my knowledge.

Parent/Guardian Signature_____Date_____

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CONSENT FOR TREATMENT

In presenting my child for diagnosis and treatment, I hereby voluntarily authorize Pediatric Neurology of Lehigh Valley, through its appropriate personnel, to perform or have performed upon me or my child, appropriate assessment and treatment procedures as may in the providers professional judgement be necessary. I further authorize Pediatric Neurology of Lehigh Valley, to release to appropriate agencies, any information acquired in the course of my child's examination and treatment.

I give my consent to the provider and staff of Pediatric Neurology of Lehigh Valley to perform medical services determined to be necessary or advisable for the benefit of my child's healthcare. Pediatric Neurology of Lehigh Valley is authorized to use and disclose my protected health information for treatment, payment, and operations consistent with its Notice of Privacy Practices.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

By signing below, I certify that I have read, reviewed carefully, and fully understand and accept the terms of treatment for me or my child provided by Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our treatment practices.

_____ _____
PATIENT NAME DOB

_____ _____
GUARANTOR NAME (PRINTED) DOB

_____ _____
PARENT/GUARANTOR SIGNATURE DATE

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FINANCIAL POLICY

Thank you for choosing Pediatric Neurology of Lehigh Valley to care for your child's neurological health care needs. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care. The following is a state ment of our Financial Policy. Please read prior to your appointment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Payment is due at the time of service or your child may not be seen by the physician. We accept Cash, Check, Discover, Visa and MasterCard as forms of payment. There will be a service charge of $25 for returned checks. _____(initial)

INFORMATION REGARDING INSURANCE

Contracted Insurance Plans: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays, deductibles and co-insurance percentages are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. As a courtesy, we may verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of all services. A list of visit charges for office visits are available at your request. _____(initial)

Non-Contracted Insurance Plans: We are **not** contracted with Medicare or any form of (MA) medical assistance and cannot bill MA or Medicare. You are responsible for payment of all services rendered. For non-contracted commercial insurance plans, to assist you, we will bill your commercial insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. _____(initial)

Self Pay: If your child does not have health insurance, you will be responsible for services rendered here at Pediatric Neurology of Lehigh Valley. You are responsible for prompt payment to Pediatric Neurology of Lehigh Valley of the full and entire amount of treatment provided to you or your child, at each visit. _____(initial)

Usual and Customary Charges: Pediatric Neurology of Lehigh Valley is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment in a timely manner if your insurance carrier authorizes and certifies care but fails to pay as agreed upon. _____(initial)

Minor Patients: Please note that the adult accompanying the minor child to the appointment and the parents (or guardians of the minor) are responsible for full payment at the time of the visit. We ask that minors be accompanied by a parent or guardian to each appointment, and that if the person accompanying the child is not the guarantor, payment arrangements must be made in advance, prior to our provider seeing the patient. _____(initial)

OTHER FEES
Missed Appointments: Children who are not present for their appointment will be charged a missed appointment fee and scheduled for another day. We require 24 hours notice/1 full business day for cancellations. Example: by Friday morning for a Monday morning appointment, our policy is to charge for missed appointments at the rate of $125.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments. _____ (initial)
Collections: You may be dismissed from the practice if you fail to meet your financial responsibilities within 4 months (120 days) and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. _____(initial)
Returned check fee: There will be a service charge of $25 for returned checks. _____(initial)
Forms: There may be a minimal charge of $10.00 and up to a maximum of $50.00 for completion of any forms not completed during a scheduled office visit. _____(initial)
Medical Records: There may be a charge for copying medical records. Price depending on number of pages needed to be printed. ____(initial)

Please keep this policy for your records. Sign the following acknowledgment on the next page and return to the staff of PNLV to keep on file.

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FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

By signing below you are acknowledging that you have read, reviewed carefully, and fully understand our Financial Policy and accept your financial responsibility to Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our financial practices. You understand that you are obligated to ensure payment of the fees stated in our Financial Policy, in full and in a timely manner.

Patient Name:_____ DOB:_____

Guarantor Name: _____ DOB:_____

Parent/Guarantor Signature:_____ DATE:_____

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how PNLV may use and disclose medical information about you or your child, and how you can obtain access to this information. Please review our policy carefully. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care.!

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of PNLV. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.!

ADDITIONAL USES OF INFORMATION

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. Please review those rights below.

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

PNLV DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office.

Violations: If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below you are acknowledging that you have read, reviewed carefully, and fully understand and accept the privacy practices of Pediatric Neurology of Lehigh Valley. You understand that if you at any point have questions or concerns regarding these policies, you
can refer to the Notice of Privacy Practices, or call our office.

Patient Name:_____ DOB: _____

Parent Name:_____

Parent/Guardian Signature:_____DATE:_____

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INITIAL PATIENT INFORMATION QUESTIONNAIRE

Parents/ Guardians: Please help us provide the best possible care for your child by filling out this form.

Patient Name:_____DOB:_____
Last First M

Name of person completing form:_____ Relationship to patient:_____
How did you hear about our office?_____

Primary Physician: _____ Phone: _____
Address: _____

Reason for today's consultation?

Main questions or concerns regarding your child?
1. _____
2. _____
3. _____

What are your expectations for this evaluation?_____
_____

Has your child seen another neurologist, developmental pediatrician or psychiatrist in the past for your current concern?
□No □Yes If so, please provide Name & Address.
_____
_____

Please indicate if your child is: □ Left Handed □Right Handed □Ambidextrous □No Preference

Current Medications (Feel free to attach a medication sheet if there is not enough space provided.)

Medication Name	Dose	How Often

Vitamins/ Supplements:
_____
_____

Drug Allergies/ Adverse Reactions (Please list drug and reaction):

_____

_____

Food/Seasonal Allergies

_____ _____ _____ _____

Does you child have an allergy to Latex? □No □Yes

Immunizations: □ Up to date □ Up to date but given on delayed schedule □ Not up to date/ deferred
If not up to date, please explain: _____

Past Medical History

Please list known prior medical diagnoses below.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Other:

Has your child ever had (Please check all that apply)

□ Seizures □ Meningitis/Encephalitis □ Head Injury/Concussion Explain _____

_____Has your child ever been hospitalized? □No □Yes. Explain. (Please include dates and reason)

_____

_____

Has your child ever had surgery? □No □Yes. Explain. (Please include dates and type)

_____

_____

Does your child experience hearing difficulties? □No □Yes. Explain. _____

Has your child ever had a formal hearing evaluation since newborn period? □No □ Yes. Explain. (Please include dates, where performed, and results) _____

Does your child experience vision difficulties? □No □Yes. Explain. _____

Has your child been seen by an eye specialist? □No □Yes. Results: _____

Does your child wear glasses or contact lenses? □No □Yes

Comments: _____

_____

Has you child ever had neuroimaging (Brain MRI, Head CT, etc.)? □No □Yes. (Please include dates, where performed, and results)

Has you child ever had an EEG? □No □ Yes. (Please include dates, where performed, and results)

Birth History:

□ PLEASE CHECK if patient is ADOPTED. If so, can this be discussed in front of patient? □ Yes □ No

Did mother receive regular prenatal care? □No □Yes

Did mother have exposure to any of the following? □Drug Use □ Alcohol Use □ Cigarettes

If so, please describe the substance and extent of exposure

Non-prescription medication taken during pregnancy: _____

Prescription Medication taken during pregnancy:_____

Birth Weight: _____Mother's Age at time of delivery: _____Father's Age at time of delivery: _____

How many weeks was the pregnancy: _____ What number pregnancy was your child: _____

What number live birth was your child: _____ Mode of Delivery: □ Vaginal □ Cesarean

Use of assistive devices (forceps or vacuum): □No □Yes. Explain._____

Has mother had any (check all that apply): □ Miscarriages □ Stillbirths □ Terminations

If so, please provide any relevant medical reasons (genetic defect, ectopic pregnancy, etc.) _____

_____

Did mother have any health problems during this pregnancy? Check all that apply.

□Anemia □ Bleeding □Diabetes □Fever □Frequent Illness/Infection □Excessive Vomiting

□High Blood Pressure □Preeclampsia/Eclampsia/Toxemia □Surgery □Other _____

Additional comments:

Were there any complications during labor or at the delivery? □ No □ Yes.

Explain._____

_____

Did your child show any of the following signs of distress during or immediately after the birth?

□Poor Color □Not Breathing □Not Crying □Cord wrapped around neck □Poor APGAR Score

Did your child require any form of resuscitation at delivery? Check all that apply. □ Oxygen

□Medication □ Chest Compressions □ Other. Explain. _____

_____

Did your child have any of the following medical difficulties in the newborn period? □Apnea or Bradycardia □Jaundice (□ Phototherapy) □ Seizures □Infections □Anemia (□Transfusion) □Low Blood Sugar □ Other. Explain._____

_____

Was there a need for your child to be admitted to the NICU (neonatal intensive care unit) following the birth? □No □Yes. If so, please describe (Duration of stay, need for breathing support, feeding tube, etc.)

_____

_____

Additional comments:

Developmental History:

Has your child ever experienced any delayed verbal or motor milestones? □ No □ Yes

Has your child ever experienced any regression, or lost any motor or verbal skills they once possessed? □No □Yes

❖If you have no concerns regarding your child's development, then skip to Educational History❖

To the best of your knowledge, please indicate the age at which your child developed the following skills. If you cannot recall the exact age, indicate whether NL for normal, ADV for advanced, or D for delayed

Head Control		Pointed Purposefully	
Rolled Over		Said First Words	
Sat Alone		Used 2-Word Phrases	
Crawled		Used 3-Word Phrases	
Babbled (gaga, dada)		Identified Body Parts	
Pulled to Stand		Read	
Cruised Furniture		Wrote Name	
Walked Alone		Rode a Bike	

Is your child toilet trained? □No □Yes. If so, please indicate when._____

Has your child had poor hand coordination? (i.e., trouble with buttoning, snaps, opening bottles, tying shoes) □No □Yes. Describe._____

_____

Does your child have difficulty with overall body coordination? (i.e., learning how to kick or throw a ball, frequent falls) □No □Yes. Describe. _____

_____

Is your child overly sensitive to any of the following stimuli? Check all that apply. □Light □Sound □Touch □Food Textures □Fabric/Clothing □ Other._____

Does your child exhibit any of the following sensory seeking behaviors? Check all that apply.

□Chewing on Clothing □Licking others □Biting without wish to harm others

□Need for deep pressure □Need for excessive contact □Other_____

Educational History:

Name of School:_____School District:_____

Current Grade in School:_____ Average Grades (ie., A, C):_____

□Private □Public □Home School □Cyber School □Other_____

Do you have concerns regarding your child having learning difficulties? □No □Yes

❖If you have no concerns regarding learning difficulty, then skip to Emotional/Behavioral History❖

Areas of academic strength: _____

Areas of academic difficulty:_____

If your child has an Individualized Education Program (IEP) or 504 Accommodation Plan, please state the reason for this: _____

Has your child been diagnosed with a Learning Disability? □No □Yes. Describe:_____

Is your child pulled out for learning support? □ No □ Yes. If so, for which subject (s)?_____

Has your child ever had to repeat a grade □No □Yes. If so, which grade and why?_____

Is you child currently receiving any of the following supports? (Check all that apply and indicate how often, where and when these are provided (school, privately)

□ Physical Therapy _____ □ Speech Therapy _____

□ Occupational Therapy _____ □ Other_____

Emotional/Behavioral History:

Do you have any concerns regarding your child's emotions or behavior? □No □Yes.

Describe:_____

❖ If you have no Emotional or Behavioral concerns, then skip to Sleep & Dietary History ❖

Do you have any concerns about managing your child's behavior? □No □Yes. Describe:_____

Disciplinary Methods Tried	Efficacy of Disciplinary Method

Has your child ever seen a behavioral specialist, counselor, or psychiatrist? □No □Yes.

Explain.

Does your child exhibit any of the following behavioral concerns?

□ Temper Tantrums □ Aggression □ Oppositional/ Defiant Behavior □ Hyperactive

□ Impulsive □ Inattentive □ Other

Explain:

Does your child experience any of the following? Check all that apply.

□ Anxiety □ Sadness/ Depression □ Obsessive thoughts □ Compulsive behavior

□Fears/Phobias □ Other

Explain:

Has your child ever been given a prior Psychiatric Diagnosis: □No □Yes

Explain.

Has your child previously taken medication to manage mood, emotions, or behavior? □No □Yes
If so, please provide details below:

Medications	Dates	Response to Medications

Sleep History:

Does your child experience any of the following?

□ Trouble falling asleep □Intermittent awakening during the night □Trouble waking up in the morning

□ Excessive Tiredness during waking hours □Bedwetting □Need to co-sleep (with parent, sibling, etc.)

Sleep pattern may impact your child's health. Please describe your child's sleep pattern during a typical academic school year.

	WEEKDAYS	WEEKENDS
Time of Waking Up		
Time No Longer Tired in AM		
Time Getting Into Bed		
Time Actually Falling Asleep		
If tired during the day, at what times and for how long?		
If night time awakenings occur, please note suspected cause (snoring, urination), frequency & duration		

Does your child seem to have trouble catching his/her breath while sleeping? □No □Yes.
If your child snores, are you concerned that your child's snoring may disrupt his/her sleep? □No □Yes.
Has your child ever had a sleep study? □No □Yes. Results: _____

Dietary History:

Does your child have any food restrictions or allergies? Explain._____

_____

Does your child follow a specialized diet? Explain._____

Social History:
Main language(s) spoken in the home:_____

Parents/Other:

1. _____
   Name Relationship to Child Profession
2. _____
   Name Relationship to Child Profession

Marital status: □ Married □ Never Married □ Separated □Divorced

Other pertinent caregivers/ details:

If your child has siblings, please list their names and ages: _____
_____

Please list all individuals living in the home, indicating their relationship to your child. Please describe any important specifics you would like to share regarding living arrangements/custody issues.

_____
_____
_____

Please list child's personal strengths: _____
_____
Please list child's favorite activities/interests: _____
_____

Family History:

Please indicate if any other family members have had any of the following:

Medical Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Cardiac/ Heart Disease					
Bleeding or Clotting Disorder Explain:					
Thyroid Disease					
Diabetes					
Cancer					
Stroke or Intracranial Bleed Explain:					

Neurological Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Delay in Speech					
Delay in Motor Skills					
Learning Disability					
Tic Disorder/Tourette					
Seizures/ Epilepsy					
Headaches/Migraines					
Attention Deficit /Hyperactivity					
Autism					
Intellectual Disability					
Neurological Regression/ Loss of Prior Skills					
Genetic/ Congenital Disorders					
Psychiatric Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Anxiety					
Depression					
Bipolar Disorder					
Obsessive Compulsive Disorder					
Schizophrenia/ Psychosis					

Other comments regarding family history:

Review of Symptoms: (Please circle any symptoms your child has exhibited over the **past week**)

System				
Constitutional	Weight loss/gain (circle which)	Fever	Fatigue	□ No current concerns Other:
Ophthalmologic	Visual changes	Eye pain	Blurred vision	□ No current concerns Other:
Ears, Nose, Mouth, Throat	Sore throat	Ear infection	Hearing difficulties	□ No current concerns Other:
Cardiovascular	Heart racing	Heart skipping beats	Chest pain	□ No current concerns Other:
Respiratory	Wheezing	Shortness of breath	Cough	□ No current concerns Other:
Gastrointestinal	Nausea/ vomiting	Constipation	Diarrhea	□ No current concerns Other:
Genitourinary	Bedwetting	Pain urinating	Urinary tract infection	□ No current concerns Other:
Musculoskeletal	Muscle pain	Joint pain	Joint swelling	□ No current concerns Other:
Integumentary/ Skin	Eczema	Rash	Itchy skin	□ No current concerns Other:
Neurological	Headache	Feeling faint	Tics	□ No current concerns Other:
Psychiatric	Sadness	Anxiety	Mood swings	□ No current concerns Other:
Endocrine	Excessive thirst	Excessive urination	Poor physical growth	□ No current concerns Other:
Hematologic/ Lymphatic	Lymph node swelling	Easy bleeding	Easy bruising	□ No current concerns Other:
Allergic/ Immunologic	Itchy eyes	Sneezing	Runny nose	□ No current concerns Other:

The information above is complete and accurate to the best of my knowledge.

Parent/ Guardian Signature Relationship Date

The information above has been reviewed and formally discussed in depth with the family.

Physician Signature Date

Rev. 12/31/18 br