# NORTHCOURT PEDIATRICS

**Doctor requested: ☐ Kirsten P Magowan MD ☐ Cynthia A Steinem MD**

**PLEASE LIST ALL CHILDREN IN THE FAMILY *INCLUDING* THIS PATIENT (If you have a complicated or unusual family situation, please use a separate sheet for details)**

| Child # | FIRST | LAST | M.I. | DOB | SEX | OUR PATIENT | SAME HOME | SAME PARENTS | PATIENT SS# |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | / / | M / F | Y / N | Y / N | Y / N | |
| 2 | | | | / / | M / F | Y / N | Y / N | Y / N | |
| 3 | | | | / / | M / F | Y / N | Y / N | Y / N | |
| 4 | | | | / / | M / F | Y / N | Y / N | Y / N | |
| 5 | | | | / / | M / F | Y / N | Y / N | Y / N | |
| 6 | | | | / / | M / F | Y / N | Y / N | Y / N | |

**If you have more than 6 children in your family, please check here_____ and list on a separate form**

****PRIMARY CAREGIVER (lives with patient - will be Primary Contact )**
**please select ONLY ONE even if you share care equally**

MOTHER_____FATHER_____OTHER(please specify)_____

FIRST NAME_____LAST NAME_____MI____DOB_____

SS # _____-_____-_____ DRIVER'S LICENSE#_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

Landline Phone_____Cell Phone_____

Work Phone_____Employer_____

email_____Authorize Patient Portal Access ☐Yes ☐No

**ADDITIONAL PARENT/LEGAL GUARDIAN:**

FATHER___MOTHER___Step-Father____ Step-Mother____ Grandmother___ Grandfather_____ Other_____

FIRST NAME_____LAST NAME_____MI____DOB_____

SS # _____-_____-_____ DRIVER'S LICENSE#_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

Landline Phone_____Cell Phone_____Work Phone_____

email_____Portal Access ☐Yes ☐No Employer_____

Patient name: _____ Birth date: ____/_____/_____

**PATIENT'S** CELL:( _____) -_____-_____(or check one) ☐has no cellphone ☐decline to share

**Note: especially for our older patients, this is often helpful for us if we are unable to reach a parent about an appointment or issue.**

To comply with New York State law, Northcourt Pediatrics requires that a parent or legal guardian (not step-parent unless they are a legal guardian) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical appointment without a parent or legal guardian or a signed consent, treatment may be denied.
Please indicate for each contact if you wish to allow them to authorize treatment and immunizations when accompanying your child to an appointment. Authorization will remain in effect until revoked in writing or patient turns 18 years old. We must obtain an authorized individual's signature each time immunizations are administered.

**PRIMARY CONTACT** Custodial ☐Yes ☐No

1. FIRST NAME_____LAST NAME _____Relationship to patient _____

Landline Phone_____Work Phone_____Cell Phone_____

When Confirming Appointments, do this first (check 1)☐Text ☐Email ☐Call Cell ☐Call Landline ☐Call Work

When Calling, use this number first, (check 1) ☐Call Cell ☐Call Landline ☐Call Work

**(Please refer to our Appointment Confirmation Policy for further information regarding our confirmation process)**

**ADDITIONAL CONTACTS**

2. FIRST NAME_____LAST NAME _____Relationship to patient _____

Landline Phone_____Work Phone_____Cell Phone_____

Custodial ☐Yes ☐No Take to Appointment ☐Yes ☐No Authorize Vaccines, Labs & procedures ☐Yes ☐No

3. FIRST NAME_____LAST NAME _____Relationship to patient _____

Landline Phone_____Work Phone_____Cell Phone_____

Custodial ☐Yes ☐No Take to Appointment ☐Yes ☐No Authorize Vaccines, Labs & procedures ☐Yes ☐No

4. FIRST NAME_____LAST NAME _____Relationship to patient _____

Landline Phone_____Work Phone_____Cell Phone_____

Custodial ☐Yes ☐No Take to Appointment ☐Yes ☐No Authorize Vaccines, Labs & procedures ☐Yes ☐No

**For additional contacts please fill out an additional form**

I further agree to reimburse Northcourt Pediatrics for the cost of any services to that are not covered, or are assigned to patient responsibility by the minor's insurance.

*Patient or Patient's Legal Representative (Please Print)* _____

*Description of Representative's Authority (e.g. "Parent", "legal guardian", etc.)*_____

Signature _____Date: _____

## OPTIONAL FOR PATIENTS OVER 16 YEARS OLD

**AUTHORIZATION FOR UNACCOMPANIED VISITS (do not complete if patient is < 16 years old)**

My child is at least 16 years old. I ☐ do ☐do not authorize my child to receive routine care, unaccompanied until revoked in writing or patient is 18 years. (I understand that immunizations will require specific additional written authorization at the time of each visit).

Signature _____Date: _____

Patient name: _____ Birth date: ____/_____/_____

| **FAMILY MEDICAL HISTORY**<br>***Have any family members had the following:*** | No | **Yes** | **If Yes – explain, you may put details on next page** |
|---|---|---|---|
| Nasal allergies or other allergies | | | |
| Asthma / lung disease | | | |
| Heart disease or heart condition | | | |
| High blood pressure | | | |
| High cholesterol | | | |
| Diabetes or other endocrine problem | | | |
| Cancer | | | |
| Anemia | | | |
| Bleeding disorders | | | |
| Epilepsy or convulsions | | | |
| Mental retardation or developmental disorders | | | |
| Neurological disorder including ADHD/ADD | | | |
| Liver disease | | | |
| Other GI disease / disorder | | | |
| Kidney disease | | | |
| Bed-wetting (after age 10) | | | |
| Hearing impairment | | | |
| Vision impairment or eye disorder | | | |
| Immune problems, recurrent infections or HIV/AIDS | | | |
| Alcohol Abuse | | | |
| Drug Abuse | | | |
| Mental Illness | | | |
| Tuberculosis | | | |
| Other issues: | | | |
| | | | |

| **SOCIAL HISTORY** | **No** | **Yes** | **Comments** |
|---|---|---|---|
| Lives with both mother and father in same house | | | |
| If no, - Lives with: | | Relation: | |
| Visitation status of non-custodial parent (if any) | | | |
| | | | |
| Are there Siblings? | | | |
| Are there pets in the home? | | | |
| Are there guns in the home? | | | |
| If yes, are guns locked and kept separate from ammunition? | | | |
| Are there any smokers in the home? | | | |
| Do you have well water? | | | |
| Other issues: | | | |
| | | | |

**I attest that all the medical history information is true and correct to the best of my knowledge:**

Signature _____ Relationship to patient _____

Print Name: _____ Today's Date: _____

Patient name: _____ Birth date: ____/_____/_____

You may list details here by family member

Examples of family members:

| | | |
|---|---|---|
| **Maternal (Mother's side):** | **Maternal Uncle** | **Paternal (Father's side):** |
| **Mother** | **Maternal Aunt** | **Father** |
| **Maternal Grandmother** | **Maternal Cousin** | **Paternal Grandmother** |
| **Maternal Grandfather** | **Maternal Great-Grandmother** | **Etc.** |

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Patient name: _____ Birth date: ____/_____/_____

| DEVELOPMENTAL HISTORY | No | Yes | If Yes - explain |
|---|---|---|---|
| Are you concerned about your child's physical development? | | | |
| Are you concerned about your child's attention span? | | | |
| Has he/she failed or repeated a grade? | | | |
| Is he/she in a special or resource classes? | | | |
| How is your child's behavior in school? | | | |
| What kind of grades does he/she make in academic subjects? | | | |
| When did your child: Sit up mos. Crawl mos. Walk mos. | | | |
| First sentence (age) Toilet trained (age) | | | |

**Current Medications and Dosage: (include any over the counter, herbal, or supplements)**

_____ _____

_____ _____

_____ _____

Allergies: _____

_____

**Does your child have any current medical conditions or issues?**

_____

_____

**Does your child see any specialists? If so, who and where?**

_____

_____

**Is there anything else regarding your child's health that you think we should know that has not already been asked?**

_____

_____

_____

*** IF WE CANNOT OBTAIN COMPLETE IMMUNIZATION RECORDS BEFORE YOUR FIRST VISIT WE WILL ADMINISTER ALL VACCINES THAT ARE DUE***

**THIS FORM MUST BE COMPLETED AND RETURNED AT OR BEFORE 1ST VISIT**

**I attest that all the medical history information is true and correct to the best of my knowledge:**

Signature _____ Relationship to patient _____

Print Name: _____ Today's Date: _____

Patient name: _____ Birth date: ____/_____/_____

# NORTHCOURT PEDIATRICS

**Kirsten P. Magowan MD, PC * Cynthia A Steinem MD**

**7278 Buckley RD * North Syracuse NY 13212 (315)-452-1712 * FAX (315)-452-0394**

## BILLING POLICY

**INSURANCE:**

**PARTICIPATING**

**If you have valid insurance with a company that we participate with, we will bill your insurance directly. Copays are required at the time of the visit, regardless of who is responsible for the child's medical bills. Co-insurance and deductibles are due when they are assigned. There is a $25 service charge for any co-payment or past coinsurance or deductible not paid at the time of the visit. Please check with your insurance to determine what kind of copay, if any, your contract requires. After we receive an Explanation of Benefits from the insurance you will be responsible for any remaining balance due. If you feel you have been billed erroneously, or your insurance company has not paid your claim properly, please inform us immediately. We will do everything possible to help, but in the event of a dispute between you and your insurance, you are responsible for your balance and it is up to you to get reimbursed by your insurance.**

**PRIVATE & SELF-PAY**

**If you have no valid insurance, or if you have insurance with which we do not participate, we require payment at the time of the visit. If you have no outstanding balance and you pay in full at the time of the visit we offer a prompt pay discount. If we subsequently receive payment from an insurance company and your account is otherwise in good standing we will refund any payments you have made that are not patient responsibility.**

**OUTSIDE SERVICES**

**Diagnostic labwork, imaging, or any other outside services will be billed separately by those providers. It is your responsibility to understand your insurance and what your financial responsibility will be for those charges.**

**OVERDUE BALANCES**

**Please consider keeping your credit card on file with us to pay any balances due. This will prevent any late charges, and keep your account in good standing. It will also allow us to collect copays or other fees if someone other than you brings your child to our office. If you have an outstanding balance, which is not on hold you will receive a monthly statement. If, for any reason, you are unable to pay your balance in full, please contact our office. We are more than willing to work out suitable payment options. If you have received more than one notice for a particular balance and have not contacted our office you will be subject to collection procedures. If you receive a Final Notice, contact us immediately to avoid legal action.**

**RETURNED CHECKS:**

**Any check returned unpaid will result in a $25.00 returned check fee and you will be rebilled for any prepay discounts applied to your account.**

**PAYMENT METHODS**

**We accept Cash, Personal Check, DISCOVER, MASTERCARD and VISA**

**I understand this policy and agree to abide by its terms:**

Signature _____ Relationship to patient _____

Print Name: _____ Today's Date: _____

Patient name: _____ Birth date: ____/_____/_____

# Northcourt Pediatrics Appointment Cancellation Policy

## Confirming Appointments:

We expect confirmation of every appointment. We will try to confirm your appointment 2 days in advance using the method you have selected on our contact form: Text, Email, or Phone. Usually Texts and emails will have a link that you can click to confirm. This is the easiest way to confirm. Simply click the link and it will guide you through the very quick and easy process. In some instances we may need additional information and your text may ask you to call us to confirm. If you are not able to keep your appointment you must call us to cancel. If you haven't confirmed and we do not speak with you personally, we will leave a message asking you to call us back to confirm your appointment. You should call us by 10 AM the following day. If you have not confirmed your appointment by 10 AM the day before, we will call all your other contacts in an attempt to confirm your appointment. We will also try to contact you the morning of your appointment. If you still have not confirmed your appointment by the morning of your appointment, we reserve the right to offer your appointment slot to another patient, and we may not be able to see you if you come in for your appointment.

Please be aware of our appointment/cancellation policy.

## Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Northcourt Pediatrics promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call before 10 AM the day before your appointment.
Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

## How to Cancel Your Appointment:

To cancel appointments, please call 315-452-1712. If you do not reach the receptionist you may leave a message with the answering service. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

## Late Cancellations:

Late cancellations after 10 AM on the day before the appointment) will be considered a "no-show".

## No-Show Policy

A "no-show" is someone who misses an appointment without canceling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to keep a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will be charges as follows:

| | |
|---|---|
| Cancellation of scheduled appointment before 10 AM on the day before the appointment: | **NO CHARGE** |
| 1st Late Cancellation or No Show : | **NO CHARGE** |
| ***After the 1st Cancellation or No Show, the following will apply:*** | |
| 2nd Late Cancellation or No Show in a 12 month period: | **$25.00** |

You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company. Future appointments will not be scheduled until this fee is paid.
After 3 late cancellations or no shows, or if you have not replied within 30 days to telephone messages and/or letters/notices, you will be discharged from our practice.

**Note:** If you have not confirmed your appointment, but you do arrive on time for it, we will try to accommodate you. You will not be charged for a NO SHOW, but you may have to reschedule the appointment.
*Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations. We do attempt to contact you 2 days in advance of your appointment, and we ask that you either confirm either electronically or by phone, and always call us to cancel or reschedule an appointment. Thank you for understanding the importance of confirming or canceling your appointment in a timely manner.*

**I understand this policy and agree to abide by its terms:**

Signature _____ Relationship to patient _____

Print Name: _____ Today's Date: _____