

# 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 \_\_\_\_\_

**\* INSURANCE INFORMATION**

Policy Holder FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ OTHER \_\_\_\_\_

\* COMPANY \_\_\_\_\_ POLICY # \_\_\_\_\_

**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 Take to Appointment  Yes  No Authorize Vaccines, Labs & procedures  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: \_\_\_\_\_

<b>FAMILY MEDICAL HISTORY</b>	No	Yes	If Yes – explain, you may put details on next page
<i>Have any family members had the following:</i>			
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:			
<b>SOCIAL HISTORY</b>	<b>No</b>	<b>Yes</b>	<b>Comments</b>
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: \_\_\_\_\_

You may list details here by family member

Examples of family members:

**Maternal (Mother's side):**

**Mother**

**Maternal Grandmother**

**Maternal Grandfather**

**Maternal Uncle**

**Maternal Aunt**

**Maternal Cousin**

**Maternal Great-Grandmother**

**Paternal (Father's side):**

**Father**

**Paternal 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 \_\_\_\_\_

\_\_\_\_\_

<b>DEVELOPMENTAL HISTORY</b>	<b>No</b>	<b>Yes</b>	<b>If Yes - explain</b>
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 1<sup>ST</sup> 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: \_\_\_\_\_

# 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: \_\_\_\_\_

# Northcourt Pediatrics

Effective 6/1/24 we have revised our Appointment Confirmation and Cancellation Policy

## Confirming Appointments:

**Our text # is 315-401-0374. Our voice # is 315-452-1712. Please add these numbers to your contacts, and accept calls/texts from those numbers. If you have previously opted out of our texts but wish to opt back in, please text UNSTOP to our text #. We expect confirmation of every appointment. You should receive a text a week before the appointment asking you to call to confirm. Please reply YES to the text and we'll mark it CONFIRMED. You will then receive a reminder text the day before the appointment. If you are not able to keep your appointment you must call us to cancel. Our phones are on from 9:00 AM to 4:00 PM daily, closed for lunch from Noon to 1:00 PM.**

If you haven't confirmed, you may receive additional texts asking you to confirm. PLEASE reply YES to confirm, or call us as soon as possible to reschedule. If we still do not hear from you, we will try to call you and speak with you personally, or will leave a message asking you to call us back to confirm your appointment. If you have not confirmed your appointment by NOON the day before, 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. We may call all your other contacts in an attempt to confirm your appointment. We will also try to contact you the day before and the morning of your appointment.

Please note: If you are unable to receive texts, or you choose to opt out of receiving texts, please let us know. You will need to confirm appointments by calling us, or returning our call if we leave you a message. If you change your phone number, please call us to update it in our system.

## Cancellation of an Appointment:

To cancel appointments, please call 315-452-1712. Our phones are on from 9:00 AM to 4:00 PM daily, closed for lunch from Noon to 1:00 PM.

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. Appointments are in high demand, and your early cancellation will allow us to offer your appointment slot to another patient.

Late cancellations after Noon on the day before the appointment will be considered a "no-show", and will be billed a cancellation fee.

## No-Show Policy

"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". Late cancellations and no-shows will be charged as follows:

New Patient, first appointment: Due to the extra time allotted for a new patient's first appointment, there is an extra charge if you miss the appointment, and you may be discharged from the practice.

New Patient first visit missed appointment: .....	<b>\$75.00</b>
1st Late Cancellation or No Show: .....	<b>\$25.00</b>
2nd Late Cancellation or No Show in a 3-year period:.....	<b>\$50.00</b>
3rd Late Cancellation or No Show in a 3-year period: .....	<b>\$75.00</b>

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 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: \_\_\_\_\_