Child & Teen Medical Center
Love...Kindness...Excellence

Child & Teen Medical Center
Blaine & Fridley locations
763-333-7733 phone/763-333-7711 fax

CTMC-Patient Demographic Form

Patient Information:

Last Name (Legal):	First Name (Legal):	Full Middle Name:	Date of Birth (DOB): Month: Day: Year:
Gender:	Does Child live with both parents:	If not, who is the legal guardian:	*Please submit any judgements, decrees and/or birth certificate if there are any discrepancies in legal guardianship of the child*

RACE : White /American Indian/Alaskan Native /Asian/Black/African American/Hispanic/Latino/Native Hawaiian/Other Pacific Islander/Chose not to disclose /Unknown

(may choose more than 1)

ETHNICITY/COUNTRY OF ORIGIN: United States/Iran/Iraq/Laos/Lebanon/Mexico/Russia/Serbia/Somalia/Declined/
Other:_____

PRIMARY LANGUAGE: English/Arabic/Hmong/Laotian/Russian/Sign Language/Somali /Spanish/Thai/Urdu/Chose not to disclose/Other:_____

Does child/parent require an interpreter: **Agency/interpreter used:**

Patient Address:	Apt/Unit	City/State	Zip Code: County: School District:
Primary Contact Number: # _____ Who's phone is this?_____	Type of phone #	* Primary e-mail address for patient portal access/medical records: _____ * Who's e-mail address is this?_____	***CLINIC POLICY:*** ***Appointment reminders, recommended appointments and patient follow-up will be done by means of calls, voicemail, texts and/or e-mail***

Parents/Legal Guardians:

Name: _____ Relationship: DOB:	Phone #'s: _____(H) _____(C)	Place of Employment: _____ Work phone:_____	Home address: □ same as above
Name: _____ Relationship: DOB:	Phone #'s: _____(H) _____(C)	Place of Employment: _____ Work phone:_____	Home address: □ same as above

Emergency Contact (s):

Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family?
Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family?

Insurance:

Primary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#
Secondary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#

Preferences/Information:

Primary/Preferred Provider at CTMC:	Primary Pharmacy: Name:_____City:_____ Number:_____	Other siblings at FCTMC? * * *	*Hospital child was born at: *Other clinics in which patient has been seen at:
Name of person completing this form Name:	I attest this information provided above is correct to the best of my knowledge: Signature: *(Parent or legal guardian required)*	Relationship to patient:	Date:

*****OVER*****

****Please read back side of form regarding important clinic policies****

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CTMC CLINIC POLICIES *To show your understanding, please initial each section of the policies below*

In compliance with the Federal Consumer Protection Act, Child & Teen Medical Center, P.A. (CTMC) wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

1. You must present your insurance card at each visit.
2. Co-payments assigned by your insurance carrier are due at the time of service.
3. We will furnish you with a monthly statement of your account showing the amounts billed, and any payments and credits to the account
4. We will file most insurances. You are responsible for denied claims, and all patient responsibility amounts such as deductibles as per your insurance policy.
5. Payments for services are considered due and payable at the time of service unless active insurance is presented.
6. Payments are due within 30 days of billing unless payment plan arrangements are made with our Business Office.
7. Finance charges are incurred after 90 days at an 8% annual interest rate.
8. There is a returned check fee of $35.00
9. Telehealth visits (phone, e-mail and/or web-based audio visual)/specialist consultations in lieu of an office visit may be billed to your insurance and applicable deductible/co-payment amounts will be patient responsibility.

Financial initials:

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits due to me under the terms of my policy to Child & Teen Medical Center, P.A. I understand the clinic's charge may exceed the insurance company/Medicaid payment, and if greater than such, I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

Benefits initials:

OUTSIDE COSTS

Lab tests that need to be sent out, medical equipment and visits scheduled with specialty providers within our clinic will incur separate billing outside of Child and Teen Medical Center. All billing questions for the above listed entities will need to go through that specific entity. Child and Teen Medical Center does not administer billing for these items.

Outside costs initials:

RELEASE OF INFORMATION

I hereby authorize Child & Teen Medical Center, P.A. to furnish information regarding my child's health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by CTMC and to furnish any information necessary to complete any health forms I might submit on behalf of my child's school camp, athletic organization or the like.

Release of Info initials:

CONTACT INFORMATION

Child & Teen Medical Center, P.A. may use my contact information for appointment reminders, follow up calls, satisfaction surveys and secure patient health information reporting through text, phone messages, and/or emails (private patient portal). You are consenting to receive directed and automated messages from us about you or your child's healthcare and hold CTMC and technology vendors harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice, text messages or from providing us, your healthcare provider, with a number that is not your own. We respect your need for privacy and will not send you telemarketing related messages or share your contact details with anyone.

Contact consent initials:

NOTICE OF PRIVACY PRACTICES

This Notice describes how the medical information about you may be used and disclosed. Please review the privacy policy attached to the new patient clip board. Please let us know if you would like a copy for your records.

Privacy Initials:

APPOINTMENT CANCELLATION POLICY

Your appointment time is reserved exclusively for you/your child. *We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to show up for their scheduled appointments (more than 3 times). Patients/parents who have missed multiple appointments may be asked to seek medical care elsewhere.*

To respect the needs of other patients, we require that you contact our office to reschedule at least 24 hours prior to your scheduled appointment time. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated. To cancel an appointment, please call our office. If you do not reach a representative, you may leave a voicemail. YOU MAY NOT CANCEL AN APPOINTMENT VIA EMAIL.

Cancellation initials:

LATE/TARDY POLICY

If you are going to be more than 10 minutes late for your appointment, we request that you call our office. If the schedule allows, the appointment time will be shifted to accommodate the delay or you will be moved to walk-in status and not guaranteed your preferred provider. Depending upon the type of visit scheduled, we may request to reschedule the appointment. We work diligently to stay on schedule and suggest that you arrive 5-10 minutes prior to your appointment time to allow for any necessary paperwork. *Patients who are consistently late may be asked to seek medical care elsewhere.*

Late Policy initials:

I agree to all clinic policies as described above:

Signature:_____ Relationship to patient:_____ Date:_____

Child & Teen Medical Center
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Patient Name: _____

DOB: _____ Acct: _____

Date: _____ Completed by: _____

MEDICAL HISTORY FORM

Current Medications:		
Drug Name:	Dose	How often:

Medical Problem/Health History List:		Hospitalizations: Reason/Date	
1.	5.	1.	Date:
2.	6.	2.	Date:
3.	7.	3.	Date:
4.	8.	4.	Date:

Surgical History:	
Date:	Surgery:
Date:	Surgery:
Date:	Surgery:

Allergies:	
Source/Type (medication/food/environmental):	Reaction:
1.	
2.	
3.	
4.	

Family History:

Relation: *see below	Status: (alive/deceased)	High BP	High CHOL	Diabetes	Heart Disease	Asthma	Allergic Rhinitis	OTHER
Father								
Mother								
Siblings								
PGF								
PGM								
MGF								
MGM								
M-Uncle								
M-Aunt								
P-Aunt								
P-Uncle								

**PGF=Paternal Grandfather, PGM=Paternal Grandmother, MGF=Maternal Grandfather, MGM=Maternal Grandmother, M-Uncle=Maternal Uncle, M-Aunt=Maternal Aunt, P-Aunt=Paternal Aunt, P-Uncle=Paternal Uncle*

******OVER******

Child & Teen Medical Center
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Patient Name: _____

DOB: _____ Acct: _____

Date: _____ Completed by: _____

MEDICAL HISTORY FORM-page 2

Review of Systems: Please check **NO** or **YES** Box to indicate if your child currently has any problems in one or more of the following areas. **If yes, please explain the problem.**

Area	NO	YES	Explanation/comments:
General/Constitutional: (fever, weight loss or gain, tired)			
Eyes: (blurred vision, eye pain, discharge, etc)			
Ears, Nose, Throat, Mouth: (hearing loss, ear ache,nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc)			
Respiratory: (asthma, chronic bronchitis, wheezing, shortness of breath, etc)			
Cardiovascular: (diabetes, hypertension, high cholesterol, heart problems)			
Gastrointestinal: (diarrhea, constipation, hernia, ulcers, etc)			
Genitourinary: (painful urination, frequent urination, impotence, jaundice, etc.)			
Lymphatic: (anemia, bleeding problems, problems with blood transfusions, etc)			
Musculoskeletal: (arthritis, joint pain, muscle pain, cramps, stiffness, swelling, etc)			
Skin: (pimples, warts, growths, rashes, etc)			

Patient Name:

DOB:

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Child and Teen Medical Center (CTMC) to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to CTMC I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with CTMC to get payment for my care. This includes clearing up any disputes about charges. If I am eligible for payment from more than one type of coverage, CTMC will return any extra payments to the payer. If I have an unpaid bill at CTMC, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from CTMC

Release of Information for Treatment, Payment and Health Care Operations

I consent to and authorize CTMC to use and disclose my protected health information for **treatment**, **payment** and **healthcare operation purposes**, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to consultants who are being advised or consulted in connection with my treatment, insurance companies, health plans, e-prescribing services, record locator services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to CTMC and/or a clinically integrated network or accountable care organization in which CTMC participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within CTMC. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or CTMC's Privacy Officer.

Other Third Party Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to the recommended medical care for my child (e.g., grandparent, daycare provider, etc.):

Name:	**Relationship to child:**
1._____	_____
2._____	_____

Mobile Phone Consent

Yes, CTMC may call my provided mobile phone number about the care, treatment, services and accounts using pre-recorded messages, automatic telephone dialing systems and/or text messages. Standard text message and minute usage rates may apply. I am aware information in a voice or text message may not be secure and that providing this consent is not a condition of receiving treatment.

My signature here means I have read this information and understand it. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Patient Name:_____ **DOB:**_____

Print Parent/Guardian Name: _____ **Date:**_____

Parent/Guardian Signature: _____

Relationship to Patient:_____ **Name of Interpreter (if used):**_____

Parent Email Address:_____

Child & Teen Medical Center

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New Patient Survey Form

Today's Date: _____ New Baby: ☐ No ☐ Yes- Hospital born at: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip_____

Name of Primary Insurance: _____ Through (circle) Employer/Private State

Name of Secondary Insurance: _____ Through (circle) Employer/Private State

****

How did you hear about our clinic?

- Patient here in the past (returning to the clinic)
- Other siblings come to the clinic

  Sibling(s) Name(s):_____
- Ob-Gyn Clinic

  Clinic Name:_____
- Hospital (Name of Hospital)

  Hospital Name:_____
- Insurance Company
- Friend or Family referral (Name of Friend/Family)

  Name:_____ Child(ren)'s Name(s):_____
- Internet Search (Name)/Website (Name)/Facebook

  Website Name:_____
- Clinic Mailings/Advertisements/Drive By (Please circle)
- Other (please list)

Thank you for completing our survey!

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Fridley Clinic:
500 Osborne Road NE Suite 215
Fridley, MN 55432
763-333-7733 Phone

Blaine Clinic:
11107 Ulysses St NE
Blaine, MN 55434
763-333-7711 Fax

Authorization for Release of Protected Health Information

PATIENT INFORMATION:

Name (Last, First, MI) _____ Date of Birth _____

Street Address _____ City/State/Zip _____

Home Phone # _____ Daytime Phone # _____

RELEASE RECORDS TO: (circle one)

Child & Teen Medical Center: Fridley
500 Osborne Rd NE Suite 215
Fridley, MN 55432

Child & Teen Medical Center :Blaine
11107 Ulysses St NE
Blaine, MN 55434

RELEASE RECORDS FROM:

_____
Name/Clinic/Provider

_____
Street Address

_____
City/State/Zip

WHICH RECORDS ARE TO BE RELEASED {check all applicable categories):

O Office Visit Notes
O Lab Results
O Vanderbilt ADHD Assessments
O X-Ray Reports
O Physicals/Pre Ops
O Other: _____
O Entire Records
O Growth Charts

••• All records pertaining to a sensitive nature, such as STD testing and/or psychiatric/mental health will be released unless indicated here:

O *DO NOT RELEASE RECORDS OFA SENSITIVE NATURE AS DESCRIBED ABOVE*

PURPOSE FOR RELEASE:

O Further Medical Treatment
O Change of Clinics
O Legal/Attorney Request
O Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand this authorization is valid for one year unless otherwise noted. Information will NOT be released past the date of signature unless specifically stated- Extended date:_____ Parental initials:_____
- I understand that I may revoke this authorization at any time providing notification in writing and it will be effective on the date notified except to the extent action has already been taken.
- I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and Rule 164.524.
- I understand a copy of this authorization will be treated in the same manner as the original.
- I understand by signing this authorization I agree that Fridley Children's & Teenagers' Medical Center and all their staff members are allowed to disclose the following protected health information to the above stated person(s) of entity.
- I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
- I understand that once information is released pursuant to this authorization, Child and Teen Medical Center cannot prevent the re-disclosure of the information to another third party.
- I understand that all parties involved will adhere to the April 14, 2006 HIPAA ruling. In addition, HIPAA requires that all patients be able to access their own medical records, correct errors or omissions, and be informed how personal information is shared/u sed. Other provisions involve notification of privacy procedures to the patient.

Signature:	Date:
Relation to patient:	Contact #:

For office use only:
*Date received:*_____ *Date completed:*_____ *Initials:*_____ *Original: chart/parent*