Mercy Clinic Child Neurology
REGISTRATION FORM

Date of Appointment: _____

PATIENT DEMOGRAPHICS

Name: _____ SSN: _____

Sex: ☐ Male ☐ Female Birth date: _____ Nickname/Preferred Name:

_____

Patient Address

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ E-mail: _____

Best Contact # for Appointment Reminders: _____

Preferred Communication Method: ☐ Mail ☐ My Mercy

Mother Name: _____ Home Phone: _____

DOB: _____ Work Phone: _____

Cell Phone: _____

Father Name: _____ Home Phone: _____

DOB: _____ Work Phone: _____

Cell Phone: _____

☐ Married ☐ Separated ☐ Divorced ☐ Life Partner

Biological Siblings (list names): _____

_____

PRIMARY CARE PROVIDER INFORMATION

Pediatrician: _____

Phone Number: _____

Referring Doctor's Name: _____

Referring Doctor's Phone number: _____

RESPONSIBLE PARTY/GUARANTOR

Name: _____ DOB: _____ SSN: _____

Address: _____

_____

City: _____

State: _____ Zip: _____ Phone: _____

Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION(Other than parents)

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

_____ Relationship to Patient: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER ACCOUNT INFORMATION

Insurance Coverage (Medicaid Patients: Subscriber is ALWAYS the patient)

Insurance Name: _____ Secondary Insurance Name: _____

Insurance Effective Date: _____ Secondary Insurance Effective Date: _____

Subscriber Name: _____ Secondary Subscriber Name: _____

Subscriber DOB: _____ Secondary Subscriber DOB: _____

Subscriber Employer: _____ Secondary Subscriber Employer: _____

Please complete these forms and bring with you at the time of your appointment. This will assist us in the evaluation of your child.

Child's Name:_____ Age:_____
First Last

Date of Birth:_____ Date of this visit:_____

Parents' Names:_____

Phone Numbers: Home:_____ Work:_____

Primary Care MD:_____ Who referred you?_____

Other physicians currently providing care for your child:_____

CURRENT PROBLEMS:
Please describe the patient's neurological problem and your current concerns. Indicate when the problem began, how it has progressed and how it is interfering with the child's ability to function. Include information on prior testing for this problem (CT or MRI scans, etc.)

_____

_____

_____

_____

CURRENT MEDICATIONS & DOSES:

_____

_____

MEDICATION ALLERGIES:_____

PAST MEDICAL HISTORY:
Is child adopted or a foster child?_____ Birth Weight:_____

If premature, gestational age at birth:_____

Did mother or child have any problems during the pregnancy or labor?_____

Complications of pregnancy, labor or delivery:_____

_____

Neonatal complications:_____

Child illnesses, hospitalizations and ER visits_____

_____

_____

Surgeries or serious injuries:_____

_____

Allergies to medications, foods, or other substances_____

Are immunizations up to date?_____

Developmental History: (For children under age 10 years)

Approximate age child did the following:

Rolled over:	_____	Used gestures/pointing:	_____
Held toy:	_____	Said first words:	_____
Sat alone:	_____	Used sentences:	_____
Crawled:	_____	Removed clothing:	_____
Walked:	_____	Toilet trained:	_____

Describe any feeding/eating problems:_____

_____

Describe child's sleeping habits:_____

_____

Describe your child's temperament by using at least five adjectives (i.e. quiet, restless, active, affectionate, withdrawn, whining, etc.):_____

_____

Does your child have any concerning behaviors such as rocking, head banging, breath holding, hair twirling, hand-flapping, etc.? Please describe:_____

_____

FAMILY HISTORY:

How old is mother?_____ Father?_____ Brothers?_____ Sisters?_____

How many times has mother been pregnant?_____ Any miscarriages?_____

Do you have a child with a serious illness or neurological disorder?_____

_____

Circle and describe issues below occurring in biological family:

Seizures/epilepsy:_____

Intellectual Disability":_____

Learning problems:_____

Birth defects:_____

Headaches:_____

Vision/hearing problems:_____

Muscle problems:_____

Behavior disorders:_____

Psychiatric disorders_____

Diabetes:_____

Strokes:_____

High blood pressure:_____

Heart disease:_____

Other family diseases:_____

NAME:_____D.O.B:_____DATE:_____

SOCIAL HISTORY: Please describe family and living situation, child's school and grade, and any issues regarding parental custody, etc.:_____

REVIEW OF SYSTEMS IF YES PLEASE EXPLAIN

CATEGORY	PROBLEM		IF YES EXPLAIN
General	Weight gain or loss, fatigue, fever, excess sweating, exercise intolerance, sleeping problems	☐Yes ☐No	
Ears, nose, mouth, throat	Dental work, infections, hearing change, other	☐Yes ☐No	
Eyes	Vision changes, infection, other	☐Yes ☐No	
Skin	Acne, birthmarks, other	☐Yes ☐No	
Respiratory	Shortness of breath, asthma, cough, other	☐Yes ☐No	
Cardiovascular	Irregular heart rate, heart murmur, chest pain, other	☐Yes ☐No	
Gastrointestinal	Nausea, vomiting, diarrhea, constipation, abdominal pain, other	☐Yes ☐No	
Neurological	Headache, seizures, weakness, fainting, unsteady walking, dizziness, other	☐Yes ☐No	
Genitourinary	Increased or decreased urine output, urinary tract infections, menstrual problems, other	☐Yes ☐No	
Musculoskeletal	Pain, arthritis, muscle aches, stiffness, scoliosis, other	☐Yes ☐No	
Psychiatric	Major stress, irritability, anxiety, depression, other	☐Yes ☐No	
Endocrine	Thyroid, growth problems, puberty problems, other	☐Yes ☐No	
Hematologic Lymphatic	Anemia, bleeding problems, lymph nodes, other	☐Yes ☐No	

Mercy

Participation in Secure Health Information Networks

Authorization and Consent Form

What are you agreeing to by signing this form?

To give your permission to allow your health care providers to share your health records electronically, through their computers, to better care for you.

That you have received information about sharing your health records through secure Health Information Networks.

Please read the statements below.

(If you are a patient's legal representative, "me", "my", or "I" refer to the Patient)

By signing this form, I understand and agree that Mercy participates in my state's Health Information Network as well as the national health information network. Mercy and other participants in these networks will:

1. Will be able to see all of my health records from both before and after today's date.
2. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
3. May share *all* of my health records with providers who are treating me; this includes but is not limited to:
   - Illnesses or injuries (like diabetes or a broken bone)
   - Test results (like X-rays or blood tests)
   - Medicines that I am taking or have taken

   This also may include, but is not limited to sensitive data:
   - Alcohol or substance abuse problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health and developmental disabilities
   - Head and spinal cord injuries
   - Family planning information (including abortions)
   - Sexually transmitted diseases
4. May copy or include my information in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
5. Have penalties in place for anyone sharing my data in the wrong way.
6. The Health Information Network will keep track of who views my health records to make sure they are secure. I can ask my doctor or the Health Information Network for a list of who has looked at my records.

I also understand and agree that:

1. Using my health information for marketing or advertising purposes, or to determine insurance or employment eligibility is strictly prohibited.
2. My consent will remain in effect until the day I cancel my account by "Opting Out" or the Health Information Network no longer exists, whichever comes first. If I suspect or learn that my health information was access in the wrong way, I can find information at the following state websites.
   - Missouri http://www.missourihealthconnection.org/consumers
   - Oklahoma http://www.smrtnet.org/for-patients
     or http://www.coordinatedcare-ok.com
3. My consent to join the Health Information Network is voluntary.
4. This form replaces all previous Health Information Network consent and opt-out forms I have completed before today.
5. I may ask for a copy of this form after I sign it.

By signing this form, I give all Health Information Network participating providers the right to share all of my health records, including sensitive data, through the Health Information Network's Network for purposes of providing care to me.

My Name *(print please)*

My Date of Birth

My Address / City / State / Zip Code

My or My Legal Representative's Signature*

Date of Signature

Printed Name of Legal Representative
(If applicable)

Relationship of Legal Representative
(If applicable)

** If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will be automatically opted out unless he or she chooses to join the Health Information Network.*

Name: _____

DOB: _____ MR#: _____ CSN #: _____

Physician and Hospital Services Agreement

1. **Annual Consent for Services:** I agree to the services that may be performed by a Mercy physician or non-physician provider ("provider)") or facility. I understand I can withdraw this agreement at any time. The agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.

2. **Telehealth Services:** I give permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission,there may be certain services that I am not able to receive at a Mercy facility. I also understand and agree that : (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benfits to which I am entitled;(ii) I will be informed of the alternatives,if any, to the telehealth services that are available to me;(iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.

3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient names below at the rates listed in Mercy's Charge Description Mater as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorneys fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

4. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy health care professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each health care provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or the employer fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security act, is correct. I request the payment of authorized benefits be made in my (or the patient's) h=behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part AS and Part B, including, but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim.

Name: _____

DOB: _____ MR#: _____ CSN #: _____

6. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment, and health care operations. The NOPP is considered part of this Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy's website.
7. **Images and Monitoring:** I understand that Mercy may make and use recordings, films, and other images for identification, diagnosis, treatment, performance improvement, or educational purposes. I understand that Mercy may provide or make available monitoring services through mobile application, medical device, or other technology. I understand that Mercy facilities may use video monitoring in patient care areas when there is a clinical need and in common areas for security purposes. I consent to such images, technology, and video monitoring with the understanding that any images, audio, or data are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.
8. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
9. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.
10. **Personal Valuables:** I understand that as a patient, I am encourages to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of usual value, Mercy is not responsible for the loss or damage to these items.
11. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.
12. **Independent Contractor/Provider:** I understand that separate bills may be sent for professional serviced from non- Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.
13. **Phone Calls, Text Messages:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account or my experience, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone, voice message, and text message and authorize the use of automated dialing and texting technology and artificial or pre-recorded voice, even if I am charged for the call or text under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state, or federal law. I agree that Mercy and its collection agencies may monitor and/or record and communication.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ **Date:** _____ **Time:** _____

If signed by other than patient, indicate relationship: _____

Mercy Clinic "No Show" Policy

Mercy Clinic has developed the following policy for "No Shows'. A No Show is when a patient does not come in for their scheduled appointment, or cancels their appointment less than two (2) hours prior to the appointment. This policy was developed to improve access to our providers, as No Shows leave open appointment time slots in which another patient waiting for care could have been treated.

The following represent Mercy Clinic's guidelines on No Shows:

- Established Patients: a total of three (3) No Shows in a twelve (12) month timeframe within a practice may be considered grounds for termination from the practice. However, the number of No Shows and timeframe may vary based on specialty.

- New Patients: a series of two (2) No Shows in a twelve (12) month timeframe within a practice
  will not be allowed any future appointments to be made with that provider. However, the number
  of No Shows and timeframe may vary based on specialty.

If you are having trouble remembering your appointments, please consider using our free text reminder service, Televox. You can receive appointment text reminders two days in advance by texting MERCY to 622622.

By signing below, you recognize the importance of keeping appointments, and understand Mercy Clinic's No Show Policy.

Name of Patient: _____ Date: _____

Signature of Patient or Patient Representative: _____