Cornerstone Pediatrics
Michael Marsh, M.D. P.A
Board Certified Pediatrician

Patient/Child Information:

Name:_____ DOB: _____ male or female
Last First Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____@ _____

Parent/Guardian Information:

Names:_____ Relationship to patient:_____

Primary Phone #: _____ Secondary Phone #:_____

Do we have permission to leave a message with medical information? _____

Business Phone # :_____ Place of Employment # : _____

In case of emergency contact: _____

Primary Phone #: _____ Secondary Phone #: _____

Referred By: _____

Insurance Information: THIS MUST BE COMPLETED IN FULL

Policy Holder's Name: _____

Policy Holder's SSN: _____ *DOB*: _____ *Required*

Name of Insurance Company: _____

Insurance Mailing/ Claims Address:_____

City: _____ State: _____ Zip: _____

Policy ID number: _____ Group Number: _____

Do you have other health insurance? Yes / No

I understand that if I am unable to keep an appointment, I will advise the office at least 24 hours in advance or I may be charge the usual fee. I also am aware of the office "no show" policy for missed appointments. I authorize the release of any medical or other information necessary to process any insurance claims and authorize the payment of insurance benefits directly to Michael Marsh, M.D.P.A., unless I am paying charges in full at the time of service. I will be responsible for any expense not covered by insurance. In the event that my account becomes past due, I understand that interest and collection charges may be added to my balance.

_____ _____
Signature Date

Initial History Questionnaire

Today's Date _____

Patient Name _____
Date of Birth _____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live._____
_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?
_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?
_____

Birth History

Birth weight _____

Was the baby born at term? ____Early? ____Late? ____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____
_____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____
_____

Was initial feeding ☐ Breast? ☐ Bottle?
Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____
_____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____
Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____
Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____
Has your child had any surgery? ☐ Yes ☐ No Explain _____
Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____
Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____
Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

If your child is in school:
How is his/her behavior in school?_____
Has he/she failed or repeated a grade in school? _____
How is he/she doing in academic subjects?_____
Is he/she in special or resource classes? _____

Family History

Have any family member had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal Allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding Disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver Disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney Disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

_____

_____

Past History

Does your child have, or has he/she ever had:

Chicken pox	☐ Yes	☐ No	When _____	
Frequent ear infections	☐ Yes	☐ No	Explain _____	
Problems with ears or hearing	☐ Yes	☐ No	Explain _____	
Nasal Allergies	☐ Yes	☐ No	Explain _____	
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain _____	
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____	
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____	
Blood transfusion	☐ Yes	☐ No	Explain _____	
Frequent abdominal pain	☐ Yes	☐ No	Explain _____	
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____	
Bladder or kidney infection	☐ Yes	☐ No	Explain _____	
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain _____	
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When _____	
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain _____	
Any chronic or recurrent skin problems	☐ Yes	☐ No	Explain _____	
Frequent headaches	☐ Yes	☐ No	Explain _____	
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain _____	
Diabetes	☐ Yes	☐ No	Explain _____	
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain _____	
Any other significant problem	☐ Yes	☐ No	Explain _____	
Use of alcohol or drugs	☐ Yes	☐ No	Explain _____	

Cornerstone Pediatrics Office Policies for Patients and Parents

Waiting Rooms: We have two waiting rooms in our office, sick and well. The well side is for newborns first appointments, annual wellness checks and school physicals only. The sick side is for all illnesses, injuries and follow up appointments. Please wait in the appropriate waiting room for your visit.

Payment: Cornerstone Pediatrics offers a competitive rate for patients without insurance who pay for all services at the time of service. Please inquire with the front office for a complete list of rates for services needed for your child. All visits must be paid on the day of the visit this includes all copays and deductibles. Any remaining balance after filing with insurance will be billed to the address that is provided to us, we cannot look to more than one party for financial responsibility. Cornerstone Pediatrics will not intervene in any custody dispute or financial responsibility dispute between parents or responsible parties. Returned checks will incur a fee of $25 plus any charges incurred by the bank.

Minors: Cornerstone Pediatrics cannot see any patient under the age of 18 without an adult present at the visit. Please do not send your minor child to the office for a visit alone. You may sign a release if you would like an adult sibling, aunt, uncle or grandparent to attend the visit of your minor child in your place.

Refunds: Should your insurance process your claim differently than quoted, any refund due to you will be issued only after all outstanding claims have been processed and paid to us in full. If you have any questions concerning the status of a possible refund, please contact the billing department at our office.

Medical Records: In the event that you need a copy of your child's medical records from services provided in our office, a release of records form must be signed by the parent or guardian of a minor or by the patient if age 18 or older. Records can then be mailed or faxed to you or the doctor's office you request within 30 days. We are happy to provide you with a copy of your child's shot records at any time. Please keep our office up to date by providing us with a copy of any immunizations received outside of our office. In addition, we are happy to complete all daycare, sports physicals, and camp forms if your child has had a wellness check in our office within the last year at no additional charge.

Nurse Calls: If you are in need of advisement from a nurse, please contact our office at any time. The front office staff will take a detailed message for our nursing staff. We know having a sick child is hard on the parents and we want to assist you as quickly as possible. Nurse calls will be returned in an order of urgency and then in the order that the calls were received. In addition, we have a nurse available by phone after hours. If you are unsure if your child needs to be seen urgently or if your insurance requires a referral to go to urgent care, please call our office and press zero for an operator. The operator will page a nurse to return your call. The nurse will assist you with any questions you may have and assist you in determining if your child needs to be seen before the next available appointment in our office.

Cornerstone Pediatrics Late and Missed Appointments Policy

Policy Change effective 1-1-2018

The well child check appointment scheduled for your child is scheduled so that your child will be seen in a timely manner. Our office also schedules sick appointments so your child may be seen as soon as possible. It is very important that you notify us at least 4 hours in advance if you will not be able to keep your appointment. This notification will allow us to give the appointment to someone else. Appointments that are more than 20 minutes late will have to be rescheduled to another day. An appointment that is more than 20 minutes late without notification to the office or an appointment not attended will be marked as a no show appointment. The first two no show appointments for your child will be considered as a grace or warning reminders of our policy. In the event a third appointment is no showed at our office, we will mail a letter to advise you that further no show appointments will be at a chargeable fee to your account. All future no show appointments, will be charged $68 for a scheduled sick or injury visit and $120 for a wellness visit. This will be added to your child's account and we will not be able to treat your child/children until that balance is paid in full. Our goal at Cornerstone Pediatrics is to provide medical care to as many patients as possible when we are needed. No show appointments prevent us from providing medical care to ill and injured children. We hope this policy will encourage parents to cancel unneeded appointments so that we may offer the time to another child.

I understand the new appointment policy at Cornerstone Pediatrics and will abide by its provisions.

_____

Child's Name / Date of Birth

_____

Parent's Signature

_____

Date

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my records.

_____ _____

Signature of Parent or Guardian Relationship to Patient

_____ _____

Date Printed Patient Name

INSURANCE BENEFITS

Our office staff will verify insurance benefits prior to the visit. We must have confirmation from the insurance company of coverage in order to file with your insurance. It is important that we have the most current insurance information for your child to accurately obtain your benefits. Please add your newborn child to the insurance within 30 days of birth. If your child has double insurance coverage, you must make both insurances aware of the other. You must also disclose both insurances to our office for proper filing. This will assist you in avoiding denied claims and fees due later on. Anything denied by your insurance plan you will be responsible for. All copays and deductibles are collected prior to the appointment. Any remaining amount due or denied charges after the claim is processed will be billed to you with payment due within 30 days of receipt.

_____ _____

Signature of Parent or Guardian Date

General Consent to Treatment

Having come to Dr. Marsh for evaluation or treatment, I hereby consent to and authorize Dr. Marsh and other staff members involved in my child's care to administer such diagnostic procedures and treatments as they may consider advisable to maintain my child's health and to assess and to evaluate and treat their injury or illness. I understand I have the right to refuse any suggested exam, test or treatment. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____

Signature of Parent or Guardian Date

Cornerstone Pediatrics

Consent form to allow other listed individuals to seek treatment for your child in your absence and t0 allow our office staff to speak to the listed adults concerning your child's health and treatment.

In the space provided, list all adult(s) that you give permission to seek treatment for your child (or yourself if 18 years or older) in your absence. Please include their relationship to your child and their contact number. Your child cannot be seen in your absence if their name is not listed below, nor may we speak to someone concerning your child's health or treatment. Older siblings must be 18 years of age to bring a younger sibling to an appointment.

Name	Relationship	Contact Number

_____

Child's Name

_____

Date of Birth

_____

Parent or legal Guardian Signature and contact phone number

_____

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Expires: _____

Name of Patient: _____ Date of Birth: _____

I the undersigned, hereby authorize a release of protected health information for the above specified patient, according to the guidelines specified below.

Information Released From:

Information Released To:

DR. MICHAEL MARSH
1929 FORT WORTH HWY
WEATHERFORD, TX 76086
PHONE 817-596-3531 FAX 817-599-8822

Information to be released will include drug and alcohol/mental health/ communicable disease information, including HIV test results and AIDS related information, if any: (check all that apply) Dates of service: (optional) _____

_____ Release of entire medical record
_____ Consultation Reports
_____ Laboratory Reports
_____ Radiology Reports
_____ Other _____

_____ Pre-insurance Physical
_____ Pre-employment Physical
_____ Drug Screen
_____Operative Reports

The reason for the release of information. (Be specific. Any other use is forbidden) _____

_____

(Article 4495b, Section 5.08 (j) Texas Revised Civil Statures requires that any authorization for release of medical records include "the reason or purpose for the release" of information.)

I understand that these records are confidential and cannot be disclosed without written authorization except as otherwise provided by law. I also understand that the information being disclosed may be subject to re-disclosure by the receiving party, and may no longer be protected. I understand that the treatment or payment cannot be conditioned on signing this authorization, except in certain circumstances such as participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization at any time by notifying the Doctor's office in writing, except to the extent that the action has been taken in reliance in it and that, in any event, this authorization will expire 180 days from the date of my signature unless otherwise specified by date, event or conditions as follows:

_____

The releasing party, its employees, officers and my attending physician(s) are released from legal responsibility or liability for the release of this information to the extent indicated and authorized herein.

_____ _____
Signature of patient or authorized legal representative Date

_____ _____
Relationship to Patient Witness Signature

This facsimile may contain PRIVILEGED, CONFIDENTIAL AND/OR OTHERWISE PROTECTED INFORMATION intended only for the use of the addressee. Unauthorized distribution or use of the facsimile or its contents is strictly prohibited. If you are not the addressee, the person responsible for delivering this message to the addressee, or have received this facsimile in error, please immediately notify us by telephone at the number above and destroy this information. Thank you.