



New Pediatric Patient Intake Forms

Patient Information

Name: _____ Date of Birth: _____ Age: _____
First and Last

Address: _____
Street City State Zip

Race (circle one): American Indian Alaska Native Asian Black or African American
Native Hawaiian or Pacific Islander White

Ethnicity: _____ Sex (circle one): Male / Female

Persons involved with patient's care (circle all that apply): Mother Father Legal Guardian

Date of Last Examination: _____

Child's Previous Pediatrician: _____ Phone: _____

Mother's Name: _____ Date of Birth: _____ Age: _____
First and Last

Race (circle one): American Indian Alaska Native Asian Black or African American
Native Hawaiian or Pacific Islander White

Ethnicity: _____ Preferred Method Contact: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Email: _____

Father's Name: _____ Date of Birth: _____ Age: _____
First and Last

Race (circle one): American Indian Alaska Native Asian Black or African American
Native Hawaiian or Pacific Islander White

Ethnicity: _____ Preferred Method Contact: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Email: _____

Name of Legal Guardian (if not a parent): _____
First and Last

Relationship to Patient: _____ Preferred Method Contact: _____

Address: _____

Street _____ *City* _____ *State* _____ *Zip* _____

Cell Phone: _____ Home Phone: _____ Email: _____

Insurance Information

Under whose policy is the child insured?: _____

Primary Insurance: _____ Phone: _____

Member ID: _____ Group #: _____

Name of Policy Holder: _____ DOB: _____

Secondary Insurance: _____ Phone: _____

Member ID: _____ Group #: _____

Name of Policy Holder: _____ DOB: _____

Emergency Contact Information

Emergency Contact/ Permission to release medical information to:

1. _____ Phone #: _____ Relation: _____

Emergency Contact/ Permission to release medical information to:

2. _____ Phone #: _____ Relation: _____

Reason for this visit: (if more than one, write in order of importance)

1. _____

2. _____

3. _____

Child's medical history

Please circle any that have been diagnosed and comment below:

- | | | |
|-------------------|--------------------------|--------------------------|
| Asthma | GE Reflux | Vision Problems |
| Allergic Rhinitis | Constipation | Developmental Delay |
| Eczema | Anemia | Seizures |
| Wheezing | Recurrent Ear Infections | ADD/ADHD |
| Food Allergies | Recurrent Strep | Mental Illness |
| Murmur | Urinary Tract Infection | Substance Abuse |
| Prematurity | Diabetes | Congenital Heart Disease |

Other medical diagnoses: _____

Surgical history :

Procedure: _____ **Date:** _____

Procedure: _____ **Date:** _____

Procedure: _____ **Date:** _____

Birth history:

Birth Length: _____ **Birth Weight:** _____ **Delivery Method:** _____ **If C-Section, why?** _____

Infant Feeding (circle one): Breast Bottle Both

Hearing Screening (circle one): Pass Fail **Heart disease screening (circle one):** Pass Fail

Social history:

Who does the child live with? _____

What is the number of people that live at the child's home? _____

Anyone smoke at home (if yes, specify who)? _____

Any pets (if yes, indicate what type)? _____

Does your child attend daycare (if yes, specify hours per day)? _____

Does your child spend time at relative's home (if yes, specify who) _____

How many hours does your child sleep in a day? _____

What is the status of the child's parents (married, divorced, single, other)? _____

Does the child have any dietary restrictions? (circle one): Yes No

If yes, please explain: _____

Do your religious beliefs prevent you from obtaining certain medical care for the child? (circle one): Yes No

If yes, please explain: _____

Current medications that the child is taking:

Medication Name:	Dosage:	For the treatment of?

Current allergies that the child has:

Please list any allergy and symptom(s) it caused.

Environmental: _____

Medications: _____

Food: _____

General Consent Form

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure so that you may make the decision whether to undergo a recommended suggested treatment plan. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment or procedure for any identified condition(s).

By signing this form, you indicate that:

- You voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary.
- You have the legal right to consent to medical treatment because you are the patient or are the parent/guardian of the patient.
- The information that you or the patient has answered in the attached intake form is both complete and accurate, to the best of your knowledge. This includes information about the patient's medical history, condition(s), and current or previous medical care. You acknowledge that the treating providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by you or the patient.

You understand that:

- You have the right at any time to discontinue services.
- You have the right to discuss the treatment plan with the treating provider about the purpose, potential risks and benefits of any test ordered for the patient. If you have any concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

Patient's Name: _____

Patient's Date of Birth: _____

Name of Patient's Representative if patient is under 18: _____

Relationship of Patient's Representative: _____

Signature of Patient or Patient's Representative: _____

Date: _____

Benefits Assignment and Financial Responsibility

You are personally responsible for payment at the time of service for all charges that result from care provided by Primary Steps Pediatric Clinic, PLLC.

Notice to Divorced Parents: Primary Steps Pediatric Clinic does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as a guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement place that obligation on your former spouse.

Patients that do not have health insurance: By signing below, you agree to be financially responsible for the care we provide to your child and agree to make full payment at the time of service.

Patients that have health insurance: You must supply all necessary information for the accurate billing of your claim, including your insurance card, employer information, and demographic information. You understand you are financially responsible for charges not covered by your insurance company. You understand that such charges may include a copayment, coinsurance, or other deductible amount and that such amount are due at the time of services.

If we are not contracted with your health plan, we may require full payment at the time of service. In this case, we may supply you with a copy of your itemized statement so that you can file for reimbursement from your health plan. Should your health plan require a more detailed description of the services, please have them request it in writing.

Assignment of Benefits: You attest to the following:

I hereby assign and authorize payment made directly to Primary Steps Pediatric Clinic, PLLC of all covered health insurance benefits. I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to Primary Steps Pediatric Clinic for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. My assignment of benefits covers Primary Steps Pediatric Clinic, PLLC for all services now rendered or rendered in the future until this assignment is revoked.

Release of Information: You attest to the following:

I authorize Primary Steps Pediatric Clinic, PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my treating providers and Primary Steps Pediatric Clinic, PLLC to act as my agent in helping obtain payment from my insurance companies.

Patient's Name: _____

Patient's Date of Birth: _____

Name of Patient's Representative if patient is under 18: _____

Relationship of Patient's Representative: _____

Signature of Patient or Patient's Representative: _____

Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 08/25/2025

How we may use and disclose your health information without your authorization:

Primary Steps Pediatric Clinic, PLLC will not use or disclose your health information for any purpose that is not described in this notice, without your written authorization. Primary Steps Pediatric Clinic, PLLC may use and disclose your health information without your written authorization for the following purposes:

- **Treatment**: We will use and disclose your health information in the course of providing, coordinating and/or managing your care and related services. For example: protected health information obtained by treating health professionals may be shared with one or more other health professionals for assistance with rendering a diagnosis, developing an appropriate treatment plan, and/or to enhance the quality of your care. In such cases, your identity and personal details will be protected to the extent possible.
- **Payment**: We will use your health information to bill and collect payment from you, from an insurance company, and from other third-party payers for services you receive at Primary Steps Pediatric Clinic, PLLC. For example: Your health plan may be contacted to get prior approval for coverage of treatment you are going to receive or to determine whether your plan will pay for the treatment and services you receive at Primary Steps Pediatric Clinic, PLLC.
- **Healthcare Operations**: We will use your health information to manage, operate, and support the business activities of Primary Steps Pediatric Clinic, PLLC. For example: Protected health information obtained by treating health professionals may be used to support budgeting and financial reporting; conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; and other business management and general administrative activities as permitted by HIPAA.
- **Imminent Harm**. If there is reason to believe that you may be at risk of imminently harming yourself or someone else, we may need to take steps to ensure safety, including contacting emergency services, family, friends, caregivers or notifying potential victims.
- **Minors**: If you are a minor, Primary Steps Pediatric Clinic, PLLC will share your protected health information with your personal representative. A minor's personal representative may include the minor's parent, guardian, or other person acting in loco parentis
- **Required by Law**: We will disclose your protected health information when required by federal, state or local law. This may include reporting communicable diseases, certain types of wounds, abuse, to disease registries, and to health oversight agencies.

- Abuse, Neglect, and Domestic Violence: Your protected health information will be disclosed to the appropriate government agency if there is belief that you have been or are currently the victim of abuse, neglect, or domestic violence and such report is required by law.
- Judicial and Administrative Proceedings: As sometimes required by law, we may disclose your protected health information in connection with litigation. For example, when required in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or an order protecting the information requested has been obtained. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.
- Law Enforcement: We will disclose your protected health information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.
- Coroners and Medical Examiners: We disclose protected health information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.
- Public Health: Your protected health information may be disclosed and may be required by law to be disclosed for public health risks. For example, we may be required to: report reactions to medications or problems with health products; or report a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.
- Health Oversight Activities: We may disclose your protected health information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.
- Inmates: If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose protected health information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.
- Military, National Security, and other Specialized Government Functions: If you are in the military or involved in national security or intelligence, we may disclose your protected health information to authorized officials.
- Worker's Compensation: We will disclose only the protected health information necessary for worker's compensation in compliance with worker's compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.
- Practice Ownership Change: If our practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

- Breach Notification Purposes: If for any reason there is an unsecured breach of your protected health information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your protected health information may be disclosed as a part of the breach notification and reporting process.

- Research: Your protected health information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

- Business Associates: We may disclose your protected health information to our business associates who provide us with services necessary to operate and function. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your protected health information.

Uses and disclosures that require your authorization:

We will not disclose or use your protected health information in the situations listed below without first obtaining written authorization from you. In addition to the uses and disclosures listed below, other uses not covered in this notice will be made only with your written authorization.

- Disclosure of Psychotherapy Notes: Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

- Marketing Purposes. We will not use your protected health information marketing communications (without an authorization), and we will not sell or disclose your protected health information to other entities that want to market their products or services to you.

- Sale of Protected Health Information. We will not sell your protected health information without your authorization. In this context, a sale of your protected health information would be the exchange of any compensation for your protected health information, only. As explained elsewhere in this notice, if our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner.

If you provide us with authorization, you may revoke it at any time by submitting a request in writing to: Primary Steps Pediatric Clinic, PLLC at admin@primarystepsclinic.com.

However, once your protected health information has been disclosed to a third party, it may no longer be protected by HIPAA and may be redisclosed by the third party.

Uses and disclosures of protected health information related to reproductive health care:

We are prohibited from sharing your medical information related to reproductive health care for the following activities:

- To conduct a criminal, civil or administrative investigation or impose penalties on any person for seeking, obtaining, providing or facilitating lawful reproductive health care. For example: We will not share your protected health information if we know it will be used to investigate, prosecute or impose a penalty on your provider who orders testing used in making reproductive health care decisions.
- To identify any person seeking, obtaining, providing or facilitating reproductive health care. For example: We will not share your protected health information with anyone who wants to identify you or your health care provider regarding decisions made about your reproductive health care services.

We will obtain a written attestation that your protected health information related to reproductive care will not be used for prohibited purposes when it is requested from:

- Health Oversight agencies;
- Judicial or administrative courts;
- Law Enforcement, including requests to identify you; or
- Coroner or Medical Examiner.

For example, we will obtain a written attestation before disclosing your medical information related to reproductive health care when requested under a court order.

Where to file complaints:

At Primary Steps Pediatric Clinic, PLLC, we are committed to providing voluntary, client-centered care. If at any time you feel dissatisfied, uncomfortable, or have concerns about the services you are receiving, or if you feel that your privacy rights have been violated, please contact: Primary Steps Pediatric Clinic, PLLC at admin@primarystepsclinic.com.

Open communication is important to us, and we are here to support your wellness and ensure your concerns are addressed promptly. We will not retaliate against you for filing a complaint.

You may also file a complaint by contacting the **Office for Civil Rights, Region VI, U.S. Department of Health and Human Services**, by mail at 1301 Young St., Suite 1169, Dallas, Texas 75202; by telephone at (800) 368-1019, (214) 767-0432 (fax), or (800) 537-7697 (TDD). You can also visit <https://www.hhs.gov/ocr/privacy/hipaa/complaints>.

Your rights with respect to protected health information:

The following are statements of your rights, subject to certain limitations, with respect to your protected health information:

- **You have the right to inspect and copy your protected health information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your protected health information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the protected health information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your protected health information:** You have the right to request only a summary of your protected health information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your protected health information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured protected health information, you have the right to be notified of such breach.

- **You have the right to request amendments:** At any time if you believe the protected health information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your protected health information. An “accounting” being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your protected health information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

Primary Steps Pediatric Clinic, PLLC is required by law to:

- Maintain the privacy of protected health information;
- Provide individuals with notice of its legal duties and privacy practices;
- Notify affected individuals following a breach of unsecured protected health information; and
- Abide by the terms of its notice of privacy practices that are currently in effect.

Primary Steps Pediatric Clinic reserves the right to revise the terms of this notice. Primary Steps Pediatric Clinic will notify you of such changes by posting an updated notice to its website, and by sending an updated notice to you via your email or physical address.

If you have any questions in reference to this form, please submit your questions to: Primary Steps Pediatric Clinic, PLLC at admin@primarystepsclinic.com.

Acknowledgment of receipt of Notice of Privacy Practices

Patient's written name: _____

Patient's Signature/Representative: _____

Date: _____

Relationship with Patient: _____