Madison Pediatric Associates

Initial History Questionnaire

PATIENT NAME

PATIENT SOCIAL SECURITY NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐M ☐F

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, ages, and where they live now.

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 the 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 illnesses or medical conditions? ☐YES ☐NO Explain _____

Has your child had any serious injuries or accidents? ☐YES ☐NO Explain _____

Has your child had any surgeries? ☐YES ☐NO Explain _____

Has your child ever been hospitalized? ☐YES ☐NO Explain _____

Is your child allergic to any medication or drugs? ☐YES ☐NO Explain _____

Does your child take any regular medications? ☐YES ☐NO Explain _____

Development

Are you concerned with your child's physical development? ☐YES ☐NO Explain _____

Are you concerned about your child's mental or emotional development? ☐YES ☐NO Explain _____

Are you concerned with your child's attention span? ☐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? _____

General

Have any family members 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:

Chickenpox	☐YES	☐NO	When _____
Frequent Ear Infections	☐YES	☐NO	Explain _____
Problems with Ears or Hearing	☐YES	☐NO	Explain _____
Nasal Allergies	☐YES	☐NO	Explain _____
Problems with Eyes or Vision	☐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	Explain _____
FOR GIRLS - Are there problems with her periods?	☐YES	☐NO	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	☐YES	☐NO	Explain _____
Frequent Headaches	☐YES	☐NO	Explain _____
Convulsions or other Neurological 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 _____



Patient Profile

Patient Information

Name:_____ Gender: ☐ **M** ☐ **F**

Place of Birth (Hospital Name):_____

Date of Birth:_____Social Security #_____

Primary Language: ☐ English ☐ Spanish Other:_____

Race: ☐ White ☐ African American ☐ Asian ☐ Multiracial ☐ Other_____

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Parent/Guardian Information

FATHER/OTHER	**MOTHER/OTHER**
Name	Name
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Social Security #:	Social Security #:
Date of Birth:	Date of Birth:
Email:	Email:
Employer: Work#:	Employer: Work#:

Insurance Information (Please note that you will be asked for your insurance card at every visit.)

Primary Insurance	**Secondary Insurance**
Policy Holder	Policy Holder
Insurance Co Name	Insurance Co Name
Member ID	Member ID
Group #	Group #
Ins. Address	Ins. Address

Family Information (List any siblings that have been seen at this office)

Name(s): DOB:

Caregiver Authorization

I/We _____acting as the parent(s)/legal guardian(s) of_____(child's name/DOB) give consent for the following caregiver(s) to seek, obtain, and provide consent for routine medical care and treatment including consent for vaccinations.

Caregiver's Name:_____

Relationship to child:_____Consent Valid _____to_____

Caregiver's Name:_____

Relationship to child:_____Consent Valid_____to_____

Pharmacy Information

Pharmacy Name_____ Phone:_____

City_____

I give my permission to allow my healthcare provider to obtain medication history from my pharmacy, my health plans, and my other healthcare providers.

Parent/Guardian's Initials (for consent):_____

By initialing the consent form you are giving your healthcare provider permission to collect prescription information and are giving your pharmacy and your primary health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

Emergency Contact Information (Other than Parents)

Name:_____

Address:_____ Phone:_____

_____

Name:_____

Address:_____ Phone:_____

_____

I authorize MPA (Madison Pediatric Associates) to share my/my child's information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those for treatment.

I acknowledge that the practice has provided me with a copy of its privacy practices, which provides a detailed description of the use and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

I give consent for MPA to call me on my mobile phone regarding my or my child's medical needs.

_____

Parent/Guardian Printed Name Signature Date



PATIENT PORTAL CONSENT FORM

PATIENT'S NAME_____ DOB_____

Parent/Guardian Printed Name:_____

_____ _____

Parent/Guardian Signature Date

Email:_____

Cell Phone Number:_____

Phone Service Provider:_____

☐ ACCEPT

I _____ **AGREE** to the terms of accessing my child's patient portal through Madison Pediatrics. I understand that Madison Pediatrics will send me a link via e-mail or text message that will provide access to my child's medical records under the circumstances that I have to create the account myself.

☐ DECLINE

I _____ have received all the information necessary to gain access to my child's patient portal, but at this time **I DECLINE.** I understand that if at any time I wish to gain access, all I have to do is ask and the information will be sent to me electronically to gain access.



Financial Policy

Thank you for choosing Madison Pediatric Associates, PSC as your primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients/parents must complete this form prior to seeing a physician.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and resolve any outstanding balances in a timely manner.

INSURANCE: Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual, and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered and not covered. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the parent/legal guardian. **In the event of a separation/divorce, the parent bringing the child for the appointment is responsible for payment**.

DEMOGRAPHIC INFORMATION & INSURANCE CARDS: It is important that we have updated demographic data from both parents so that we will be able to contact you in the future. **We must always have a current copy of your current insurance card on file.** If your insurance changes, it is your responsibility to let us know. If prior encounters need to be re-filled with a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become your financial responsibility.

NETWORK PROVIDERS: It is your responsibility to know if your physician is considered "in-network" by your insurance. Please call your insurance to verify if there is a question regarding network eligibility.

CO-PAYS & DEDUCTIBLES: I understand that any co-pays are due at the time of service. If not paid at the time of service, a $10.00 fee will apply. I understand that I am responsible for the balance not covered by my insurance.

CANCELLATION OF APPOINTMENTS: As a courtesy to other patients and physicians, we require advanced notice prior to canceling appointments. After three no-show appointments, the patient including any siblings/children of the guarantor will be released from the practice.

PAYMENT: We accept cash, check, credit, debit, and HSA/FSA cards. There is a card surcharge fee of 3% (excluding HSA/FSA cards if staff is notified).

ASSIGNMENT OF BENEFITS/ AUTHORIZATION: As a parent or legal guardian, I authorize payment of medical benefits to be made directly to Madison Pediatric Associates for service rendered. I further agree to be fully responsible for all lawful debts incurred for services provided.

I understand that I am responsible for any non-covered charges or any unpaid balances related to my insurance and I will be charged a 35% collection fee in the event my account is turned over to a collection agency. I also give Madison Pediatric Associates my permission to call me on my mobile phone regarding billing issues.

_____ _____

Signature of Parent/ Legal Guardian Date

Notable Office Policies

Revised 3/23/2026

Arrival Times: Patients are generally asked to arrive at least **5-10 minutes before their scheduled appointment**. New patients may be required to arrive **30 minutes early** to complete registration. The scheduled patient is expected to be in the office at the time of check in.

Handling Late Arrivals (15+ minutes past appointment): If a patient arrives late, the practice may attempt to accommodate them, but this is subject to the schedule and severity of the situation. In some cases, the appointment may need to be rescheduled to ensure that other patients are not delayed.

No-Show Policy: A "No Show" occurs when a patient fails to attend a scheduled appointment without providing **notice**. Please notify the office @ 859-624-2020 prior to the appointment to prevent a “No Show” if you cannot make it to the appointment for any reason. If you fail to do so you will be notified by letter of the “No Show”. New patients will not be rescheduled if they no-show their first appointment.

Repeated No-Shows: Established patients/families are typically allowed 3 no-show occurrences within a 12 month period before facing potential dismissal from the practice. Dismissal will include siblings/all patients listed on the account This policy is in place to maintain efficiency and ensure that other patients can receive timely care.

Communication: Practices often use reminder calls or messages to confirm appointments and remind patients of their responsibilities regarding cancellations and rescheduling. If a patient cannot be reached, they are still responsible for keeping their scheduled appointment.

Co-pay Policy: If your health plan uses co-pays, payment is expected at the time of service. If a co-pay is due and not collected by the end of the business day the patient will be assessed an additional $10.00 charge for billing.

Vaccination Policy: The providers at Madison pediatric Associates strive to keep your child healthy and feel that vaccinations are an important part of preventative care. Because of advances in medical science, your child can be protected against more diseases than ever before. Some diseases that once injured or killed thousands of children have been eliminated completely, and others are close to extinction – primarily due to safe and effective vaccines. Therefore, Madison Pediatric Associates follows the vaccination guidelines and schedules recommended by the AAP. If you chose not to vaccinate your child or want to discuss an alternative schedule, please notify your child’s provider or a clinical staff member to discuss reasons vaccines are recommended. If you still decline vaccination, you may be asked to release care to another office that’s policy aligns with your wishes.

Billing Policy: If your account has a balance due you will be billed to the address on file on the 23rd of each month. Prompt payment is appreciated to avoid additional collection fees. If an account has a balance more than 90 days old, you will receive a final attempt at collection letter. If payment is not received by the date indicated on the letter your account will be sent to a collection agency and will incur additional fees. **We cannot provide care for a patient that has a collection balance that has been turned over to a collection agency until the entire balance plus fees are paid in full.** We ask that you pay balances promptly upon receipt of a bill and update our office with any address changes for responsible parties to avoid additional fees.

Notice of Privacy Practices

Effective Date: 6/24/2026

Overview

Madison Pediatric Associates, PSC is committed to protecting the privacy and security of your personal and health information. We handle protected health information (PHI) in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA), where applicable.

Information We Collect

We may collect:

- Contact information (name, email address, phone number)
- Account and billing information
- Health-related information you provide
- Information necessary to provide our services
- Technical information such as device, browser, and usage data

How We Use Information

We use information to:

- Provide and improve our services
- Communicate with you
- Process payments and manage accounts
- Comply with legal and regulatory obligations
- Support healthcare operations where permitted by law

HIPAA and Protected Health Information

When we receive or maintain PHI, we use and disclose it only as permitted by HIPAA and other applicable laws. We implement administrative, physical, and technical safeguards designed to protect PHI from unauthorized access, use, or disclosure.

Information Sharing

We do not sell your personal information. We may share information:

- With service providers who support our operations
- With healthcare providers, health plans, or business associates as permitted by law
- When required by law, court order, or government request
- To protect rights, safety, and security

Security

We maintain reasonable security measures designed to protect personal information and PHI. No method of electronic transmission or storage can be guaranteed to be completely secure.

Your Rights

Subject to applicable law, you may have the right to:

- Access your information
- Request corrections to inaccurate information
- Request restrictions on certain disclosures
- Receive communications through alternative means
- Obtain information about certain disclosures of your PHI

Data Retention

We retain information only as long as necessary to provide services, comply with legal obligations, resolve disputes, and enforce agreements.

Contact Us

If you have questions about this Privacy Policy or your privacy rights, contact:

Madison Pediatric Associates, PSC
Email: kidshealth@madisonpeds.com
Phone: 859-624-2020
Address: 793 Eastern Bypass, Suite 110, Richmond, KY 40475

Changes to This Policy

We may update this Privacy Policy from time to time. Any changes will be posted with an updated effective date.