north seattle PEDIATRICS

PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name _____ Middle _____ Last _____

Nickname _____ Male____ Female____ Birth Date ____ / ____ / ____ Primary Physician _____

Parent 1 Name _____ Date of Birth _____

Parent 2 Name _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Are the home address and billing address the same? ☐ Yes ☐ No (Enter billing address below)

Billing Name _____ Billing Address _____

City _____ State _____ Zip Code _____

Email Address _____ Owner of Email _____

Primary Phone Number _____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

2nd Phone Number _____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

3rd Phone Number _____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

4th Phone Number _____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

☐ I authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
☐ I **do not** authorize North Seattle Pediatrics to leave a detailed message on my voicemail.

☐ I give permission for North Seattle Pediatrics to text me a message to call back.

Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____ Prefer not to answer_____

Race: White_____ American Indian/Alaskan Native_____ Asian_____ Black/African American_____ Native HI/Pacific IS_____ Prefer not to answer_____

Preferred Language _____ Other Language _____

Do you need an interpreter? Yes_____ No_____ What Language? _____

Insurance Information

Primary Insurance Name _____ Copay _____

ID Number_____ Group Number _____

Subscriber's Name_____ Birth Date _____ Start Date _____

Employer_____

Secondary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer_____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. **I understand that I am responsible for my entire bill unless this form is complete.**

Parent/Guardian/Patient Signature_____Date_____

north seattle PEDIATRICS

Patient History

Patient Name:_____Date of Birth:_____Gender:_____Today's Date:_____

Please list all other individuals living in the child's home:

Name	Relationship to Child	Birthdate	Biological Parent Y / N	Adoptive Parent Y / N	Foster Parent Y / N	Other

Are the child's parents: ☐Married ☐Unmarried, living together ☐Separated ☐Divorced ☐Other (specify)_____

If divorced: ☐ Joint Custody ☐ Single Custody

If one or both parents do not live in the home, how often does the child see this parent(s)?_____

Are there siblings not listed? Y / N If so, please list their names, birthdates, and where they live:_____

_____

Which languages are spoken regularly in the home?_____

Do you have any communication requirements needing vision/hearing support or to help you better understand your visit today?_____

Does anyone besides parents provide care for your child? (i.e. relatives, nanny, friend) Y / N

If yes, who:_____

Does your child attend daycare?_____Is your child in school?_____

Are there guns in the home? Y / N If yes, are they locked? Y / N

Are there pets in the home? Y / N If yes, what kinds?_____

Is there any tobacco/vaping/marijuana exposure? Y / N

What are the parent's/parents' occupations?_____

Does your family have dietary preferences/restrictions (please list)?_____

Medical History

Were there any significant complications during pregnancy or delivery for your child?_____

_____

Does your child have any major medical problems for which they are followed by a doctor or specialist?_____

_____

Has your child had any surgeries or hospitalizations?_____

Any Emergency Room visits over the past year (for example: concussions, broken bones, or asthma attacks)?_____

_____

north seattle PEDIATRICS

Family History

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Do any of your **CHILD'S** biologic **parents**, **siblings**, or **grandparents** have the following conditions for which they are followed by a doctor or treated with medications regularly? Please CIRCLE any that apply.

Condition – please circle	Who	Details / Comments
ADHD		
Allergies (please list to what: hayfever, food, medications)		
Anemia		
Asthma		
Arthritis, Autoimmune disease		
Autism or developmental disability		
Bedwetting after 7 years old		
Bleeding or clotting disorders		
Cancer (please list type)		
Childhood hearing loss/Deafness		
Colitis (Crohn's, Ulcerative Colitis, Celiac disease)		
Depression, anxiety, or other mental illness (please specify)		
Dental decay or significant cavities		
Diabetes (specify adult or child onset)		
Drug/Alcohol abuse		
Eczema/Skin disorders		
Epilepsy or seizures		
Heart disease before 55 years old		
High blood pressure		
High cholesterol		
Hip dysplasia		
Kidney disease		
Lazy eye/Strabismus		
Learning disability		
Liver disease		
Migraine headaches		
Neurologic disorders (seizures, multiple sclerosis, other)		
Obesity		
Stroke before 55 years old		
Sudden death before 55 years old		
Suicide		
Thyroid disorders		
Tobacco use/Vaping		
Tuberculosis		

Additional Family History:_____

north seattle PEDIATRICS

Please list the name and date of birth of all children in your family.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

My Kids Chart

Patient Portal

Access to records is available for all children under 18 years of age. When a patient turns 14 years old in the State of Washington, by law, their record automatically becomes private. They may grant permission to a parent or guardian to access their chart by signing an additional release form.

Please list the name and email of the parent/guardian that would like access to the patient portal:

Parent/Guardian Name: _____

Email address **PLEASE PRINT CLEARLY**: _____

Authorization for Other Caregivers

The person listed below is designated as our agent to give consent (verbal or written) to surgical or medical treatment by any licensed physician or provider at North Seattle Pediatrics for my minor child. Such consent may include but is not limited to, administration of necessary anesthetics, medical treatment, test, X-ray examinations, transfusions, injections, immunizations or drugs and the performing of whatever procedures may be deemed necessary or advisable.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of their best judgement, may deem advisable. This authorization shall remain effective unless revoked in writing by the undersigned.

The undersigned hereby authorize (***person other than parent/guardian***):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

My signature below certifies that all of the above information is true and accurate.

_____

Signature of parent/guardian Printed name of parent/guardian Date

For office use only:

Date account set-up		Initials	

north seattle PEDIATRICS

Authorization to Use or Disclose Protected Health Information

Patient Name:_____ Previous Name:_____ Date of Birth:_____

Parent Name:_____ Contact Phone Number:_____

I. My Authorization

_____ **may use or disclose the following health care information (check all that apply):**

□ All health care information in my medical record

□ Health care information in my medical record relating to the following treatment or condition:

_____

□ Health care information in my medical record for date(s):_____

□ Other (e.g., x-rays, bills) – specify date(s):_____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

□ HIV/AIDS □ Sexually Transmitted Diseases

□ Mental Health or Illness □ Drug and/or Alcohol Abuse □ Reproductive Care (minors only)

Minors - a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older).

You may disclose this health care information to:

North Seattle Pediatrics
10330 Meridian Avenue North #210
Seattle, WA 98133

Reason(s) for this authorization to use of disclose my health care information (check all that apply):

□ at my request

□ other (specify)_____

This authorization ends:

□ on date:_____

□ when the following event occurs:_____

□ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

- to receive research-related treatment in connection with research studies **or**
- to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by North Seattle Pediatrics in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- fill out revocation form –a form is available from North Seattle Pediatrics **or**
- write a letter to North Seattle Pediatrics.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it my re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship to patient (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

Your Family Matters
10330 Meridian Avenue North Suite 210
Seattle, WA 98133-9451
(206) 368-6080 Fax (206) 368-6088
northseattlepediatrics.com

Thank you for choosing North Seattle Pediatrics for your medical care.
Please review our policies and procedures below and sign where indicated.

PATIENT NAME:_____

- Patients must arrive 15 minutes before their scheduled appointment time and provide their insurance card, photo ID and insurance copay if applicable at check-in. We have a contractual obligation to your insurance company to collect copays at time of service.
- A no show or late cancellation fee of $100 will be charged to patients who do not provide 24 hour notification to cancel an appointment or for patients who miss their appointment. After 3 no shows or late cancelled appointments you may be discharged from the practice.
- If you arrive 15 or more minutes late to your appointment you may be asked to reschedule.
- Copays not paid at time of service will be assessed a $15.00 fee.
- **If your child is being seen for a Well Child Check and you have other concerns that are not related to routine, wellness care, those concerns may generate other charges to your insurance.**
- Any outstanding balances due to deductibles, co-payments, and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full please contact our billing department to make payment arrangements. Non-payment of charges will result in the account being turned over to a collections agency and your family will be discharged from the practice.
- Our phones are open 8:00am-6:00pm Monday-Friday, and 9:30am-12:00pm on Saturdays. After hours, we offer a telephone triage consultation service that puts you in touch with a pediatric-trained triage nurse at Seattle Children's Hospital. Our office is charged for each call placed to this nurse triage service. In order to offset this expense we charge $10.00 per call which is a portion of this fee. Your insurance will not be billed for this fee and it will be your responsibility.
- Please allow 3 business days for all forms and prescription refill requests.
- North Seattle Pediatrics will use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. North Seattle Pediatrics is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance to HIPAA.
- We keep a record of the health care services we provide your child. You may ask us to see and copy that record (copy charges may apply). You may also ask us to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Contact the Record's Custodian to see the record or to get more information about it.

I,_____,the parent or legal guardian of _____ authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

I acknowledge with my signature that I have read and understand the information above.

_____ _____

Parent/Guardian/Patient Signature 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.

North Seattle Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of **North Seattle Pediatrics.** The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

Laura Morano, Clinic Administrator
206-368-6079

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.

- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our **office** to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Laura Morano
206-368-6079

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Laura Morano** at **North Seattle Pediatrics.** You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.

- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.northseattlepediatrics.com**

7. Effective date

This Notice is effective as of **November 2, 2026.**