1133 College Ave, Ste G210
Manhattan, KS 66502

Please indicate your preferred provider:
Dr. Biberstein ___ Dr. Haug ___ Dr. Duff ___ Dr. Gallagher ___ Dr. Crane___
Dr. Klingler ___ Dr. Dove ___ Dr. Meng ___ Dr. Bell ___

Please let us know how you heard about us:
Hospital ___ Relative ___ Friend ___ Family Already Established ___
Phone Book ___ The Internet ___ Other Advertising/Social Media ___

Patient Information: Please complete all forms and return to the Front Desk.

Last Name: _____ First Name: _____
Address: _____ City: _____ Zip: _____
Patient Date of Birth: _____ Gender: Female ____ Male ____

Mother's Name: _____ Father's Name: _____
Cell Phone: _____ Cell Phone: _____
Work Phone/Employer: _____ Work Phone/Employer: _____

Email: _____ Preferred Method of Contact: Phone___ Text___ Email___

Race: White ____ Black/African American ____ American Indian/Alaskan Native ____ Hawaiian Native/Pacific Islander ____
Hispanic ____ Asian ____ Other ____ Unknown ____

Ethnicity: Hispanic or Latino: Yes ___ No ___ Preferred Language: _____

Insurance Information: Please provide copy of insurance card.
Name of Health Insurance Company: _____
Policy Holder – Name: _____Date of Birth: _____ Gender: M___ F___
Relationship to patient: _____ Effective Date of Coverage: _____
Insurance Subscriber ID: _____ Employer/Group ID: _____

Assignment of Benefits & Authorization to Release Medical Information:
I request that payment of authorized benefits by Medicaid or any Insurance Carrier listed be made to Pediatric Associates for any services furnished to me by Pediatric Associates. I authorize Pediatric Associates to release medical information about me to the Division of Family Services, HCFA listed insurer(s), their agents or the listed responsible person(s) as needed to determine benefits. I understand that I am financially responsible for any non-covered charges.

_____ Initial here if applicable: Upon my verbal request, I authorize Pediatric Associates to fax health assessment and immunization records to schools, daycare facilities, or other related organizations. I understand that release of medical records for any other purpose may require completion of medical record release.

This Child Qualifies for vaccination through the VFC Program because he/she (circle all that apply):

a) Is enrolled in Medicaid b) Does not have health insurance c) Is American Indian/Alaskan Native
d) Has KanCare e) This patient does NOT qualify for VFC vaccines

Signature: _____ Date: _____

Pediatric Associates of Manhattan, PA
1133 College Ave, Ste G210 Manhattan, KS 66502
Phone (785) 537-9030 Fax (785) 537 -3334

Greg A. Biberstein, MD
R. Mark Duff, MD
Rebecca S. Klingler, MD
Louis P. Meng, MD
Sonder M.S. Crane, MD
Steven J. Haug, MD
Jason R. Gallagher, MD
Kate M. Dove, DO
Patricia C. Bell, MD

NOTICE OF FINANCIAL RESPONSIBILITY:

Billing Guarantor

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default.

I hereby grant permission to Pediatric Associates of Manhattan, P.A. (PAM) to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Associates of Manhattan, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Pediatric Associates of Manhattan, PA may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will be fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

Pediatric Associates of Manhattan, PA is not a party to specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment or the like. PAM is not obligated to the financial terms of these "Arrangements."

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at PAM is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service, regardless of the insurance arrangements. Upon request, PAM will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

I have read and understand my responsibilities for payment of service at Pediatric Associates of Manhattan, P.A.

Signature Printed Name Date

Relationship to Patient _____

Pediatric Associates of Manhattan, P.A.
GREG BIBERSTEIN, M.D., F.A.A.P. - STEVEN J. HAUG, M.D., F.A.A.P. MARK DUFF, M.D., F.A.A.P. JASON GALLAGHER, M.D., F.A.A.P.
REBECCA KLINGLER, M.D., F.A.A.P. -KATE DOVE, D.O., F.A.A.P.
LOUIS MENG, M.D., F.A.A.P - PATRICIA BELL., F.A.A.P., SONDER CRANE, M.D., F.A.A.P.
1133 College Avenue, Suite G-210
Manhattan, Kansas 66502
Ph 785-537-9030
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Pediatric Associates Vaccine Policy Statement

- Vaccines have been proven to be effective in preventing serious illness and death related to certain diseases.
- Based on all available literature, evidence, and current studies, vaccines do not cause autism or other developmental disabilities. The benefits of vaccines far outweigh any perceived or unproven risks of harm to children.
- Vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers.
- All children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics. The recommended vaccines and the schedule given are the results of years of scientific study and data gathering by thousands of scientists and physicians.

Because of vaccines, most parents today have never seen a child suffer from specific diseases such as polio, tetanus, whooping cough, bacterial meningitis, measles or complicated chickenpox. Such success can make us complacent about vaccinating. Unfortunately, as vaccine rates drop, certain diseases are reemerging with tragic results.

Deviation from the standard vaccine schedule goes against our medical advice as providers at Pediatric Associates. If you are considering a vaccine schedule that is different from the standard schedule, you would need to discuss this with your child's pediatrician. Please be advised that delaying or "splitting up the vaccines" goes against expert recommendations and may put your child at risk for serious illness or even death.

We will no longer accept the risk that unimmunized or under-immunized children or teens pose to other children and their families in our practice and in our communities. If, despite our best efforts, a child remains unimmunized or under-immunized, we will ask you to find another provider who shares your views on immunizations.

Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness and disability, and even death. Please be advised that when we receive urgent phone calls after hours we assume that the children have received their routine vaccinations, and the provider should be notified if this is not the case. The advice and evaluation process is generally much more extensive for a child who has not received vaccinations.

We recognize that parents have many decisions to make regarding their child's medical care. Our desire is to do everything we can to protect your child's health as they grow and develop. A vital part of your child's health relies upon vaccines. We understand that the choice may be a very emotional one for some parents. We are happy to provide education and recommend resources for further information about vaccinating your child.

Our policy states:

1. All children must receive all vaccines recommended by the AAP that are mandated for school entry by the State of Kansas.
2. All children must begin receiving their immunizations at age 2 months.
3. We strongly recommend utilizing the immunization schedule as determined by the AAP, ACIP and CDC. "Alternative" vaccine schedules put children, adolescents and adults at an increased risk of illness. There is no medical benefit whatsoever to delaying vaccines and this may put your child at risk of vaccine administration errors. Pediatric Associates will accept delays of vaccine administration only if they are within the "window" period of the recommendations of the AAP, ACIP and CDC.
    a. If a parent or caregiver elects to limit their child to 2 vaccines at a time, they must come into the office at 1-2 week intervals to stay within the recommended "window" for the vaccines.
    b. If a parent or caregiver elects to limit their child to 1 vaccine at a time, they must come into the office at weekly intervals to stay within the recommended "window" for the vaccines.
4. Exceptions for the AAP window include: Hepatitis B, Hepatitis A, influenza and Gardasil.
5. Hepatitis A and Hepatitis B series must be completed as required by daycare or school entry.
6. The influenza vaccine is strongly recommended for all children 6 months and older.
7. The Gardasil vaccine series is strongly recommended for children, ideally between the ages of 11 and 13 years, but is not mandatory.
8. Parents or caregivers who do not follow the AAP and CDC vaccine schedule must sign a copy of our vaccine policy as well as a waiver acknowledging that the family understands the risks of not vaccinating their child according to the AAP and CDC recommended schedule.
9. Families who do not follow the Pediatric Associates vaccine policy will need to find another physician to care for their child. We will care for your child for 30 days while you make this transition.

Our providers welcome discussion about our vaccine policy with any of our families. We hope that you understand that we have devised this policy in order to protect children, their families and our communities from serious diseases and potential death by administering safe and effective vaccines in a reasonable, organized and practical way.

I, _____, have read the above policy and acknowledge the information provided.

Signature of parent/guardian:_____ Date:_____.

Patient Name: _____ Date of Birth: _____

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Acknowledgement of Review of Notice of Privacy Practices

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

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name of Parent or Legal Guardian Legal relation to child(ren)

List each child that is seen at our practice (please print):

Child's First Name	Child's Last Name	Child's Date of Birth

List persons allowed to receive protected health information by phone or mail:

Name	Relationship to patient	Primary contact phone number

Pediatric Health History Form

Child's Name_____ **Child's Date of Birth**_____

Your Name and Relationship to Child_____

(Use back side of form if more space is needed)

Past Medical History

Pregnancy/Neonatal (for children under 1yr)

Place of birth_____

☐ Biological Child ☐ Adopted ☐ Stepchild ☐ Foster

Pregnancy Complications_____

If C-Section, list reason_____

Premature?_____ Weeks Gestation_____

Birth Weight _____

Infancy/Childhood/Adolescence

Has your child ever been diagnosed/treated...

- ☐ Asthma or breathing problems
- ☐ Other wheezing/bronchiolitis
- ☐ Environmental Allergies or Eczema
- ☐ Food Allergies
- ☐ Recurrent Ear Infections--#_____
- ☐ Pneumonia
- ☐ Urinary Infections
- ☐ Genetic Syndrome
- ☐ Seizures
- ☐ Anemia
- ☐ Developmental Delays
- ☐ Depression/Anxiety
- ☐ Other:_____

Explain above if need:_____

_____

Hospitalizations or Surgeries?_____

_____

_____

_____

Specialist Doctors_____

_____

Allergies *to medications or foods:*

_____

_____

_____

Daily Meds: Include vitamins/supplements/OTC

_____

_____

_____

_____

Social History

Who Lives at home with Child?

_____

_____

_____

Any Smokers at home?_____

Attends Daycare?_____

Attends School?_____

School Performance Concerns?_____

Peer Relationship Concerns?_____

Family History

Connect Condition with a line:

Condition	Family Member:
ADD/ADHD	
Anemia	
Asthma	
Alcoholism	Mother
Blood Disorder	Father
Cancer	Brother
Depression/Anxiety	Sister
Diabetes	Paternal Grandmother
Heart Attack	Paternal Grandfather
High Blood Pressure	Maternal Grandmother
High Cholesterol	Maternal Grandfather
Kidney Disease	
Migraines	
Seizures	
Stroke	
Thyroid Disease	
Other: _____	

Details_____

_____

_____