Sarah Hart, MD
Sara Woodring, MD
Caleb Buege, MD
Stacey Poehner, APRN

Pediatrics of Bullitt County

Casey Lewis, MD
Dan Kischnick, MD
Jenna Thurman, MD
Jennifer Pentecost, APRN

Welcome to Pediatrics of Bullitt County! Our providers and staff are devoted to delivering you the highest quality care and the best possible experience.

At Pediatrics of Bullitt County your child will receive care that is carefully designed around evidence-based practice with the goal of helping your child be as healthy and happy as they can be. We are committed to providing you with health education and self-management support to help you manage any of your child's chronic conditions. We strive to be a partner; in your child's health, even between visits, and want to be involved in every aspect of their healthcare.

We encourage you to call us any time you need medical advice or have concerns about illness. In many cases we can help you avoid going to an urgent care or emergency room. All calls to our office are answered based on the urgency of the call and all routine calls will be answered within 24 hours. We offer extended appointment times upon request to better serve your needs. Outside of our normal hours of operation, our after-hours on-call system will triage your questions. Just call our regular office number and leave a message with the telephone service. You may first be directed to a nurse triage line that uses evidence based national guidelines to obtain important information about your child and answer your questions. There is always a provider on call to assist if needed. We are always available to help regardless of the day or time.

Please let us know at each visit if you have had a visit to the hospital, emergency room, urgent care, or specialty provider. If possible, please bring information about this care to your visits so that we can incorporate the information into your child's record and treatment plan. Please also bring the results of any testing that is completed outside of our office, so that we can include this information in the complete medical record. There may be times that your child will need in-person evaluation outside of our business hours. For minor concerns (e.g. earaches, vomiting without dehydration) that need more immediate attention, we recommend a nearby immediate care center. Concerns of this nature are not appropriate for an emergency room and use of the ER for these concerns will result in unnecessarily high medical costs and potentially denial of coverage from your insurance provider. Most minor complaints can be managed with the help of our after-hours triage line and on-call provider until we can see you in our office. We keep 50% of our daily appointment slots open for acute care and will see your child for illnesses on the same day whenever necessary.

If you must be seen for an emergency, we ask our patients to utilize one of the Norton Children's Hospitals. These emergency rooms provide high quality pediatrics specific care and we have an agreement with these facilities that allows us access to your visit information immediately following your visit. This allows us to seamlessly incorporate the information from this visit into your overall plan of care.

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Norton Children's Medical Center- Brownsboro	Norton Women's and Children's Hospital- St. Matthews	Norton Children's Hospital- Downtown
4910 Chamberlain Ln	4001 Dutchmans Ln	231 E Chestnut St
Louisville, KY 40241	Louisville, KY 40207	Louisville, KY 40202

We realize that your healthcare needs do not stop when you leave our office. For that reason, we have created a patient portal to help you manage your care in between visits to our office. We ask all patients to sign up at their first visit. The patient portal is featured on our website, www.pediatricsofbullittcounty.com, and provides a way for you to access your information at all times. If you have any questions about the patient portal, we will be happy to assist you.

When you need a medication refill please call your pharmacy, our office, or send a message via your patient portal to request a prescription refill. We will respond to all refill requests within 2 business days.

Thank you for choosing Pediatrics of Bullitt County for your healthcare. We look forward to being a part of your healthcare family for years to come.

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Request for Medical Records

Today's Date: _____

Previous Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient(s) covered by this request:

Full Name: _____ DOB: _____

Full Name: _____ DOB: _____

Full Name: _____ DOB: _____

Full Name: _____ DOB: _____

I, the legal guardian of the above-named patient(s), hereby authorize the release of medical records to Pediatrics of Bullitt County. I understand that I have the right to revoke this authorization in writing at any time. This request is valid for one year following the date of my signature.

Signature: _____ Date: _____

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Family Registration

Patient Information			
Please list all children in the family for which the following information applies. Call our office any time demographic information changes.			
Name:	SSN:	DOB:	Gender:
Name:	SSN:	DOB:	Gender:
Name:	SSN	DOB:	Gender:
Name:	SSN:	DOB:	Gender
Address:			
City, State, Zip Code:			
Primary Language Spoken in The Home:			
Race:		Ethnicity: NON-HISPANIC HISPANIC DECLINE	
Emergency Contact (Outside of the Home):		Emergency Contact Phone:	
Pharmacy:		Pharmacy Phone:	
How did you hear about our practice?			

Parent/Guardian Information			
Name:		Name:	
Relation to Child:		Relation to Child:	
DOB:	SSN:	DOB:	SSN:
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone:		Phone:	
Cell Phone:		Cell Phone:	
Employer:		Employer:	
Email:		Email:	
If parents are divorced or separated or there a custody agreement in place, please complete the following section.			
Who has primary custody?			
Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? YES / NO			

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Insurance Information	
Primary Insurance:	Employer:
Member/Subscriber ID:	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:
Secondary Insurance:	Employer:
Member/Subscriber ID:	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:

Contact Preferences Circle any method at which we may contact you.	
Cell/Text	E-Mail
Postal Mail	Telephone
Is it ok to leave a message on any of the numbers you have provided? YES / NO	

Health Information Privacy	
I give the below individual(s) permission to make medical decisions regarding my child(ren) and have my child(ren) receive treatment under their supervision. I understand that it is the office policy NOT to have my child receive vaccinations or have well visits, however, without a parent or legal guardian present.	
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
May we discuss your child(ren)'s medical care with anyone other than the parent/guardians listed on this form? YES / NO	
If yes, whom?	Phone #:

By signing below, you are confirming that you have completed this information completely and accurately. If you would like to see a copy of our Notice of Privacy Practices please see someone at the front desk.

Signature: _____ **Date:** _____

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Pediatric Health History Questionnaire

Childs Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Name: _____

Pregnancy & Birth History		
Mother's age at birth:	Father's age at birth:	
Did mother have any of the following during the pregnancy? (Circle all that apply)		
Fever or Rash	Tobacco Use	
Group B Strep	Alcohol Use	
Diabetes	Street Drug Use (what type)	
High Blood Pressure	Medication Use (prescription or over the counter	
Anemia	Infection (if yes what type and how were they treated)	
Newborn History		
Birth Weight:	Birth Length:	Head Circumference:
Born on Time/Early/Late?	Vaginal or C-Section:	Days in Hospital:
During the first week of life did the patient have any of the following? (Circle all that apply)		
Feeding Trouble	Seizures	Fever
Excess Vomiting	Breathing Trouble	Receive Antibiotics
Jaundice (yellow skin)	Need for Oxygen	Diarrhea
Cyanosis (blueness)	Blood Transfusion	In Intensive Care Unit (NICU)

Family History

Is the child adopted? YES / NO If yes, complete this section to the best of your ability.

Relationship	**Name**	**Living Y/N**	**Age**	**Major Medical Problems/Cause of Death**
Father				
Mother				
Siblings				
If more than 3 siblings continue on the back.				

Specifically have any of the child's relatives had the following conditions?

Condition	**Relative**	**Condition**	**Relative**
Diabetes		Kidney Problems	
Cancer		Heart Disease	
Seizures		Stroke	
Allergies/Asthma		Anemia	
Bleeding Problems		HIV	
High Blood Pressure		Skin Concerns	
Lung Disease		Chemical Dependency	
Mental Illness		Congenital Malformation	
Other		Genetic Conditions	
Are there any religious, cultural, or language considerations that you would like us to that into account?			
Please list the names and ages of anyone living in the home:			

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Past Medical History		
Where has your child gone for check-ups previously?		
Last Medical Check-up:	Last Dental Check-up:	Last Vision Check-up:
Medications (Including supplements/over the counter):		
Is your child up to date on immunizations (provide certificate)?		
Has your child had any of the following? (Circle all that apply)		
Chicken Pox	Vision Problems/Wears Glasses	Asthma
Measles	Heart Problems/Heart Murmur	Allergies
Mumps	Frequent Kidney/Bladder Infections	Broken Bones
Frequent Ear Infections	Bed Wetting (>5 years old)	Head Injury
Frequent Throat Infections	Diabetes	Seizures
Hearing Problems	Fatigue	Skin Problems (Eczema, Hives)
Psychological Problems	Anemia	Muscle/Joint Problems
Has your child had any other conditions not listed above:		
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Has your child been on medication that is not on the current medication list? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Child's Social History	
School Grade:	City Water: Yes / No
Hours of "Screen Time" per day:	Exposure to Secondhand Smoke: Yes / No
Particular (picky) Eater:	Guns in Home: Yes / No
Pets:	Wears Sunscreen: Yes / No
Hours of "Outdoor Activity" per day:	Wears Seatbelt/ Car Seat/ Booster: Yes / No
Sports/Hobbies:	Other:
Will your child live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovations or remodeling? Yes / No	
Will your child live in or regularly visit a house with peeling of chipped paint built before 1967? Yes / No	
Is there anyone living in the home that is being followed or treated for lead poisoning? Yes / No	

Allergies	
Please list any allergies to medications, foods, and/or environmental allergies below:	

Medications	
Please list any medications that your child takes including over-the-counter medications, herbs, vitamins, and supplements. Include the dose and frequency (if more room is needed, continue on back)	

Specialty Providers	
In order to best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them (if more room is needed, continue on back)	
Parent Signature:	**Date:**

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Vaccination Policy

At Pediatrics of Bullitt County, we firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you perform as parents/caregivers. We firmly believe in the safety of vaccines. We firmly believe, based on all available evidence that vaccines do not cause of play any role in the development of autism. The recommended vaccines and the schedule in which they are given are the result of many years of scientific study and data-gathering on millions of children by thousands of our brightest scientists and physicians.

The pediatricians of Pediatrics of Bullitt County feel strongly that children should follow the current vaccination schedule provided by the CDC. We are concerned for the safety and well being of your child, the children who sit in our waiting rooms, and for our staff. In addition to being pediatricians, many of us are parents. We all vaccinate our own children according to the same schedule we use for yours. There is no greater evidence for the confidence we have in the safety and efficacy we have in vaccines.

Be advised that refusing to vaccinate, delaying, or breaking up the vaccines goes against expert recommendations and puts your child at unnecessary risk for serious illness or death. Therefore, if you refuse to vaccinate your child, we will help you find another healthcare provider who shares your views.

We are making you aware of these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be very difficult for some parents. We also recognize that there are many confusing and contradictory voices on the internet and social media forums. If you have any questions, we will do everything that we can to educate you on the safety and efficacy of vaccines. You may also visit any of the following websites for reliable vaccine information; www.CDC.org, www.AAP.org, www.vaccineinformation.org, and www.chop.edu/centers-programs/vaccine-education-center.

Vaccine Schedule

Newborn: Hepatitis B #1	12 Months: Prevnar, Hepatitis A #1, Varicella
1 Month: Hepatitis B #2	15 Months: Hib, MMR
2 Months: Pentacel (Dtap, IPV, Hib), Prevnar, Rotavirus	18 Months: Hepatitis A #2, Dtap
4 Months: Pentacel (Dtap, IPV, Hib), Prevnar, Rotavirus	4 Year: Dtap, IPV, MMR, Varicella
6 Months: Pentacel (Dtap, IPV, Hib), Prevnar, Rotavirus	11 Year: Tdap, Meningococcal, Gardasil recommended
9 Months: Hepatitis B #3	16 Year: MCV, Men B recommended
Flu vaccine is recommended annually for children over age 6 months.	

By signing below, you indicate that you understand the Pediatrics of Bullitt County vaccination policy and schedule.

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Office Policies

Co-Payments: Co-payments are due at the time of service. If you are unable to remint the co-pay amount, the office reserves the right to reschedule your appointment for another day/time that is convenient for you.

Prior Balances: Prior balances are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the office reserves the right to reschedule your appointment for a day/time that is convenient for you.

High Deductible Health Plans: For patients with high deductible health plans, our office will collect $50.00 pre-payments for any visit scheduled that is not for preventive care. The $50.00 pre-payment will be applied to the account, any remaining balances as determined by the insurance carrier, will be billed to the responsible party of the account.

Billing: Our office bills insurance as a courtesy to our patients. If we receive denial information from your insurance payer, you may receive a bill from our office. It is the responsibility of the patient/parent/guardian to reach out to our billing office and/or the insurance company to discuss the balance.

Collections Activity: If our office does not receive prompt payment, we reserve the right to transfer your balance to outside collections after 90 days. If an account is referred to outside collections, we reserve the right to dismiss the patient/family from the practice. The account is subject to additional fees related to the collection's activity.

Appointments: Our office requires a 24-hour notice for all cancelled appointments. If the appointment is not canceled 24 hours before the scheduled time, a no-show fee up to $30 may be charged. Three or more missed appointments without proper notice may result in dismissal from the practice.

Arrival: Please arrive 15 minutes prior to all scheduled appointments. If you are running late for your appointment, call the office. If you are more than 15 minutes late for an appointment, we may need to reschedule for the next available appointment, which may or may not be on the same day.

Phone Calls: Any phone number provided at which I may be contacted, I consent to receive calls or text messages, including communications regarding billing and payment, unless I notify the office to the contrary in writing. Calls and text messages include but are not limited to pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other forms of electronic communication for the office and affiliates, including collections agencies.

By signing below, you indicate that you understand the Pediatrics of Bullitt County office policies.

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