FRONTIER HEALTH AND WELLNESS, LLC

Patient Registration Form – Pediatric/Under Guardianship

Date				
Patient Full Legal Name (First, Middle Initial, Last)	Prefix	Suffix	Previous Name(s)/Alias:	
Date of Birth	Age	Sex	Gender Identity	Preferred Pronoun
School			Grade	Contact Number

Guardianship (If guardianship is anything other than shared or 50/50 FHW Must had legal documentation on file prior to any appointment)

Parent/Guardian Name (G1): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole	Parent/Guardian Name (G2): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole
G1 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No	G2 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No
G1 Address	G2 Address
City/State/Zip	City/State/Zip
Email	E-Mail

Reason for choosing Frontier Health and Wellness ☐ Recommendation from Family/Friend ☐ Location/Convenience ☐ Referral from Provider ☐ Search Engine ☐ Insurance ☐ Other		
If referred by hospital or provider, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

Please Do Not Include Information on Denali KidCare, Medicaid, or Medicare - We Do Not Accept These Plans

Financially Responsible Party	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Frontier Health and Wellness, LLC
Late Cancellation/Missed Appointment Policy

At Frontier Health and Wellness, LLC (FHW) we enforce a strict Late-Cancellation/Missed Appointment Policy

Missed Appointment (MA): Any appointment where the patient arrives 10+ minutes late to their scheduled appointment or misses their appointment without providing notification to FHW.
Late Cancellation (LC): The cancellation or rescheduling of a scheduled appointment less than 2 full Business Days prior to their scheduled appointment date and time.

Examples

Scheduled Appointment: 10:30am Monday **Cancellation Window:** 10:30am the Thursday prior
Scheduled Appointment: 3:30pm Tuesday **Cancellation Window:** 3:30pm the Friday prior

Policy Guidelines

1st and 2nd Intake Appointments

Prior to scheduling the first intake appointment each patient will be charged a $100 deposit. This deposit will be used towards the patient's deductible, Co-Pay and Co-Insurance payments for the Intake Assessment and future follow-up appointments. If the patient has a LC/MA, to their 1st or 2nd Intake Appointment, the $100 deposit will be used as a penalty fee.
Prior to rescheduling the LC/MA, the patient will be charged a deposit of $200 dollars. This deposit goes towards the patient's deductible, Co-Pay and Co-Insurance payments for the Intake Assessment and future follow-up appointments. In the event of a second LC/MA the $200 deposit will be used as a penalty fee, all appointments will be canceled, ***and*** the patient will no longer be eligible for services at FHW.

Regularly Scheduled Appointments

All Occurrences (LC/MA) are tracked and accrue throughout a rotating calendar year. Each Occurrence accrues a higher penalty which may lead to attendance probation and/or dismissal from FHW entirely.

- **1st Occurrence:** No Charge
    - We are aware that on rare occasions there are circumstances that are outside of everyone's control, which is why we allow for one occurrence free of charge.
- **2nd Occurrence:** Penalty - $100 charge
- **3rd Occurrence:** Penalty - $150 charge and attendance probation.
    - **Attendance Probation:** The patient is required to attend their next **4 scheduled appointments** without infraction, or they may face dismissal from the clinic.
- **4th Occurrence:** Penalty - $200 Charge and dismissal from the FHW Clinic.

Appointment Reminder Calls/Texts/Emails

Confirmation/Reminder calls, emails and or text messages are a courtesy that FHW may provide on behalf of its Contracted Providers. The absence of a confirmation/reminder call, email and/or text does not invalidate the Late Cancellation/Missed Appointment Policy.

Acknowledgment

I have read the above Late Cancellation/Missed Appointment Policy from Frontier Health and Wellness on behalf of its Contracted Providers. I understand and accept all the terms set forth above. All my questions and concerns have been answered and addressed by FHW Staff or my Provider prior to signing and submitting this document.

_____	_____	_____
Patient Name	Patient DOB	Date

_____	_____
Patient/Guardian Signature	Guardian Name (If applicable)

Frontier Health and Wellness, LLC

Patient History Questionnaire (Pediatric/Under Guardianship)

To better assist our providers, we are asking that you complete the following questionnaire prior to your initial appointment. If you need more space, please feel free to add pages as needed.

Patient Name: _____ Date of Birth: _____ Form Completed By: _____

Please provide a list of your child's previous (last 5 years) and current medical and mental health providers:

Provider Type	Provider Name	Clinic/Hospital Name	Phone Number	Location (City/State)
Pediatrician N/A ☐				
Previous Pediatrician(s) (last 5 years) N/A ☐				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A ☐				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A ☐				
Therapy N/A ☐				
Psychiatry N/A ☐				
Neuropsych Testing N/A ☐				
Other:				
Other:				

Please list all your child's medications they are currently taking: N/A ☐

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all of your child's previously taken psychiatric medication: N/A ☐

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all supplements/over the counter medications your child is currently taking: N/A ☐

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list any of your child's known allergies as well as the reaction that occurs: No known allergies ☐

Allergen	Severity of Reaction			Type of Reaction
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	

Current or previous substance use: N/A ☐

Substance	Frequency of Use					
Caffeine	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Tobacco/Vaping	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Alcohol	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Opioids/ Prescription Drugs	Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	Tried it once or twice	☐ Never
Marijuana	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Hallucinogens	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Amphetamines	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Other:	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never

Frontier Health and Wellness

Patient History Questionnaire (Pediatric/Under Guardianship)

Family Medical History: N/A ☐

Medical Condition	Patient or Family History	Please list the Family Member(s) affected
Anemia	☐ Patient ☐ Family History	
Asthma/Respiratory Concerns	☐ Patient ☐ Family History	
Cancer	☐ Patient ☐ Family History	
Chronic Fatigue	☐ Patient ☐ Family History	
Concussion(s) or TBI	☐ Patient ☐ Family History	
Diabetes	☐ Patient ☐ Family History	
Epilepsy/Seizures	☐ Patient ☐ Family History	
Heart Disease/Condition	☐ Patient ☐ Family History	
High Blood Pressure	☐ Patient ☐ Family History	
Insomnia	☐ Patient ☐ Family History	
Stomach/ GI Problems	☐ Patient ☐ Family History	
Stroke	☐ Patient ☐ Family History	
Substance Abuse	☐ Patient ☐ Family History	
Thyroid Disease	☐ Patient ☐ Family History	

Psychiatric history: N/A ☐

Psychiatric Condition	Patient or Family History	Please list the Family Member(s) affected
ADHD	☐ Patient ☐ Family History	
Anger	☐ Patient ☐ Family History	
Anxiety	☐ Patient ☐ Family History	
Bi-Polar Disorder	☐ Patient ☐ Family History	
Depression	☐ Patient ☐ Family History	
Inpatient Psychiatric Care	☐ Patient ☐ Family History	
OCD	☐ Patient ☐ Family History	
PTSD	☐ Patient ☐ Family History	
Schizophrenia	☐ Patient ☐ Family History	
Suicide	☐ Patient ☐ Family History	

Please list any of your child's surgical history or hospitalizations. N/A ☐

Surgery/Reason for Hospitalization	Date(s)	Hospital	Doctor/Attending	Location (City, State)

Has your child had any bloodwork completed within the last 6 months (if yes, who ordered the labs to be drawn): ☐Yes ☐No

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What school does your child attend?_____ Are they on an IEP? ☐Yes ☐No A 504 Plan? Yes No

Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Pediatric

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Sad most of the day				
Not interested in activities that used to be fun				
Cannot fall asleep most of the time				
Sleeping more than usual				
Loss of energy				
Do not spend as much time with friends as usual				
Do not bathe or clean self regularly				
Acting angry much of the time				
Acting unusually happy much of the time				
At times needing little or no sleep				
Exhibits Sexual Behavior e.g. touching own or others privates				
Talks so fast it is hard to understand				
Tense, nervous, worrying much of the time				
Panic Attacks: heart pounding, can't breathe, sweating				
Saw or had something bad or scary happen				
Often remembering something bad or scary happening				

_____ _____ _____

Client Name (Please Print) Age Date

Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Pediatric

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Having bad dreams over and over				
Easily upset when reminded of something bad or scary				
Staying away from or will not talk about things that remind you of something bad or scary that happened				
Jumpy or scared easily				
Doing things over and over without a clear reason i.e. washing hands, touching things, checking locked doors				
Having problems paying attention				
Easily distracted				
Often forgetful				
Often fidgeting with hands or feet				
Lots of physical movement				
Talking a lot				
Behavioral problems at school				
Often acting without thinking				
Often loses temper				
Often argues				
Will not follow rules or directions				

_____ _____ _____

Client Name (Please Print) Age Date

Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Pediatric

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Bullies, threatens or intimidates others				
Starting physical fights				
Stealing				
Lying				
Runs away				
Cruelty to animals				
Fire Setting				
School suspensions				
Change in school performance				
Does not make eye contact with others				
Has problems communicating				
Uses same movements over and over (i.e. wringing hands, rocking back and forth, clapping fingers)				
Does not notice when others are trying to speak or play with him/her				
Not interested in making friends or playing with others				
Is not easily soothed when upset				
Did not start talking until after 12 months old				
Does not play make believe				

_____ _____ _____

Client Name (Please Print) Age Date

Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Pediatric

Recent = within the past 30 days **In the past = greater than 30 days**	**None**	**Recently**	**In the Past**	**Supported By: Please provide further explanation**
Child has moved many times with different care givers				
Unchangeable false beliefs or ideas. i.e. really believes that he/she has special powers or abilities				
Hearing voices when no one is there				
Seeing things when nothing is there				
Voices tell him/her to harm self				
Voices tell him/her to harm others				
Talking with words that do not make sense to others				
Shows little emotion on face				
Refusal to maintain adequate body weight within normal range				
Refusal to maintain adequate body weight within normal range				
Very scared of gaining weight				
Thinks is fat when very skinny				
At times eats way too much food				
Exercises way too much				
I take laxatives to lose weight				
Forces self to vomit				

Please use the back of this page or a separate page if you have other information you would like to tell your provider

_____ _____ _____

Client Name (Please Print) Age Date