



Benjamin A. Brooks, M.D.

2220 North Monroe • Decatur, IL 62526
ph: 217.423.PEDS (7337) • fx: 217.423.7338

Welcome to Brooks Kids. We are pleased and excited that you have chosen to be with us! Help us to establish your child as our patient by completing the following information packet. Of note, demographic and income-related questions will not be used to your disadvantage. If you have questions regarding the information you are filling out, please do not hesitate to ask the receptionist.

Our promise to you.

At Brooks Kids our goal is to provide quality, personal, up-to-date, courteous, timely, professional and informative pediatric care. For your convenience, our website is available for patient use 24 hours a day, 7 days a week. Registration allows full site access, and email information remains confidential. Emails are never turned over to third parties. For emergency care, Dr. Brooks can be reached via his office number during office hours, or the answering service after-hours at 875-8561.

Patient responsibilities are as follows:

Truancy and last-minute cancellations. We observe a simple “three-strikes rule”. Three missed/last-minute cancels are grounds for dismissal. Cancelled appointments require a prior days notice. *Note: Missing your initial appointment is regarded as a double-strike.

Tardiness. Fifteen minutes late for an appointment is considered tardy. Tardiness means the appointment slot has passed by, and patients arriving on time will be seen on schedule. When arriving tardy, there will be two options. Rescheduling is one option. Waiting for an appointment slot to open is the other. For tardy shows we do not guarantee an opening will become available. Even after waiting, rescheduling may become the only option, so please try not to be tardy. More than 30 minutes late is considered a missed appointment. See policy on missed/last-minute cancellations. Patients who have come to their appointments on time should be honored first. Being able to keep a schedule allows us to provide you with more efficient care.

Rude behavior. Honor “The Golden Rule” and treat others as you would have them treat you. Rudeness is strictly frowned upon, and may be grounds for dismissal.

Non-compliance. Certain recommendations may be flexible, and Dr. Brooks works hard to provide options in medical management when appropriate. However, in some instances failure to comply with the medical plan despite his strong urgings may result in dismissal.

ER abuse and “doctor-hopping.” Dr. Brooks is comfortable with second-opinions and specialist opinions when needed. Seeking primary care, non-urgent care from the emergency department, urgent care settings or other primary physicians without Dr. Brooks’ recommendation causes confusion and poor coordination of care. Let Dr. Brooks know if you believe you have an emergency.

Food and drink. No food or drink is allowed in the clinic, with the sole exception of infant formula.

***Keep us up-to-date on your contact information*.** A reliable phone and address on the chart is the guardian’s responsibility. Please keep us current. We may need to contact you about a lab result, appointment reminders or changes.

Personal Hygiene. Be considerate of those around you. Please observe proper personal hygiene.

Account balances. Ultimately, bills are the guardian’s responsibility. We do our best to bill insurance for you if we are provided with proper billing information, but you will be expected to handle your balance. Please keep us updated on changes with insurance.

**Brooks Kids DBA
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SECTION A:

Patient Name: _____
Last First M.I.

DOB: _____ / _____ / _____ Sex: male / female

Social Security Number: _____ - _____ - _____

Home Address: _____
Street City Zip

Telephone: _____
Home Mobile

Ethnicity / Race: (circle those that apply) African American; Hispanic;
Asian; Caucasian; Other

Emergency Contact: _____
Someone not living with patient name
relation to patient

Emergency Contact Phone: _____

Guardian Name: _____
relation to patient

Guardian SS#: _____ - _____ - _____

Guardian info:
Employment: Y / N If yes, Employer Name: _____
Employer Phone: _____

Spouse (of guardian) Name: _____
Spouse (of guardian) SS#: _____ - _____ - _____

Spouse's info:
Employment: Y / N If yes, Employer Name: _____
Employer Phone: _____



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IF COVERED BY MEDICAID SKIP THIS SECTION AND GO TO SECTION C

SECTION B:

INSURANCE INFORMATION

NAME OF COMPANY _____

STREET _____

CITY/ZIP _____

NAME OF INSURED _____

D.O.B. ____ / ____ / ____

PATIENT'S RELATIONSHIP TO INSURED _____

POLICY# _____

GROUP# _____

EFFECTIVE DATE ____ / ____ / ____

SECONDARY INSURANCE INFO

NAME OF COMPANY _____

STREET _____

CITY/ZIP _____

NAME OF INSURED _____

D.O.B. ____ / ____ / ____

PATIENT'S RELATIONSHIP TO INSURED _____

POLICY# _____

GROUP# _____

EFFECTIVE DATE ____ / ____ / ____

SECTION C:

MEDICAID CARD I. D.# _____

EFFECTIVE ____ / ____ / ____



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SECTION D:

Name of patient/child: _____

Patient SS#: _____ - _____ - _____

Number of children under the age of 18 living in the home: _____

Name of guardian: _____

Relation to patient: _____

The above and previous information is true and correct. This information is subject for review and verification. I understand that I must provide written documentation to support this information and, if I do not provide the documentation, or if I falsify information, services can be terminated. I agree to notify Dr. Benjamin A. Brooks of any changes in my household income information by the first appointment after the changes have occurred.

Date: _____

Parent / Legal Guardian print name: _____

Parent / Legal Guardian signature: _____

Witness: _____



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CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME _____

D.O.B. _____

ADDRESS _____

I, _____ (guardian), authorize Benjamin Brooks M.D. to receive records pertaining to the above mentioned patient from _____.

Please include:

- Vaccination record
- Problem List
- Copy of growth chart (weight, height and head circumference)
- Most recent three progress notes / well child visits
- Labs and X-ray readings from the last 12 months
- Entire chart

- This authorization specifically authorizes you to disclose records of alcohol and/or substance abuse.
- This authorization specifically authorizes you to disclose information regarding infectious disease, sexually transmitted diseases, HIV or AIDS.
- This authorization specifically authorizes you to disclose information regarding mental health services.

Signature: _____ Date: _____

I, understand that I may revoke this authorization in writing at any time, except to the extent that my healthcare provider has already taken actions in reliance on it. If not previously revoked, this authorization will expire 6 months from my date of my signature or as otherwise

specified by the date, event or condition(s) as follows: _____

I understand that information disclosed may be subject to re-disclosure and no longer protected by Federal privacy regulations.

I understand this authorization is voluntary and is not necessary to assure treatment. I may receive a copy of this authorization upon request.

Guardian signature: _____/Relationship: _____ Date: _____

Witness Signature: _____ Date: _____



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Patient's Full Name: _____ DOB: _____

CONSENT FOR TREATMENT: I authorize and consent to the performance of medical or surgical treatment and/or laboratory testing considered necessary or advisable by Benjamin A. Brooks, M.D. and his office staff care professionals.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of medical and surgical benefits to Benjamin A. Brooks, M.D. or services rendered by Benjamin A. Brooks, M.D. in person or under his supervision. I understand I am financially responsible for any balance not covered by my insurance. I also understand that if this bill goes to collections and an attorney, I am fully responsible for all reasonable costs for collection and/or attorney fees that are incurred, as well as court costs.

RELEASE OF INFORMATION: I authorize the medical practice of Benjamin A. Brooks, M.D. to release information to any hospital, referring physician or physician being referred to by this practice.

X _____ X _____
 Signature of patient (or guardian) Date Signature of Guarantor(responsible for payment) Date

CONSENT FOR USE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS: My "PHI" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "PHI" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my "PHI" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my "PHI" is used or disclosed to carry out treatment, payment or healthcare operations of the practice. My Provider is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that my provider has taken action in reliance on this consent.

I understand I have a right to review my provider's Notice of Privacy Practices prior to signing this document.

X _____
 Signature of Patient (or Guardian) Initials Date

RELEASE OF INFORMATION TO SIGNIFICANT OTHERS: I hereby authorize Benjamin A. Brooks, M.D. with D/B/A Brooks Kids and/or his staff to verbally discuss my case and condition with the individuals listed hereunder:

f Significant Other	Relationship	Name of Significant Other	Relationship

I further agree that a photocopy of this agreement shall be as valid as the original.

X _____
 Signature of Patient (or Guardian) Initials Date



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PERMISSION/CONSENT FOR TREATMENT

I, _____, give permission to: _____

and: _____

and: _____

to act in my absence as guardian of the children listed. This includes consenting for assessment and treatment by Dr. Benjamin Brooks in my absence.

Furthermore, I also grant the above mentioned individual, on my behalf, the authority to sign consent for any and all immunizations, lab procedures, and/or procedures as may be deemed necessary by Dr. Brooks. This agreement shall stand indefinitely unless I, the guardian of the listed patient (s) of Dr. Brooks, deem otherwise. In such a case, this written statement shall be removed.

PARENTS PLEASE NOTE: This legality must be completed for each child separately on their respective charts.

Guardian Signature: _____

Witness: _____

Date: _____ / _____ / _____



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RECEIPT OF “NOTICE OF PRIVACY PRACTICES”

I, the undersigned, have received a copy of the latest “Notice of Privacy Practices: from:

Benjamin A. Brooks, M.D.
D/B/A Brooks Kids

This document describes:

- How the physician practices and their business associates may use and/or disclose my “protected health information.”
- My rights related to my “protected health information.”

I understand terms of the “Notice of Privacy Practices” are subject to change. I may keep abreast of these changes by:

- Reading the latest revision on the web-site of the physician practice.
- Reading the latest revision posted in the doctor’s office.
- Requesting a copy of the latest revision.

I know I have the right to refuse to sign this receipt. If I do not sign, the physician’s office staff will document their efforts to obtain a signed receipt from me.

“Notice of Privacy Practices” received by (please print):

Relation to patient

Signature

Date

Created on 07/19/04
Revised 05/01/07



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Brooks Kids Medical Questionnaire

Pregnancy and Birth:

Tobacco, alcohol or sreet drugs during the pregnancy? _____ If so, what? _____
 What was your due date? _____ What was the birth date? _____
 Was the delivery natural or C-section? _____ Birth weight? _____
 Where there problems with the delivery? _____
 How many days was the baby in the hospital? _____
 Were there any complications during this stay? _____

Past Medical History:

Does your child suffer from any ongoing medical conditions (circle all that apply and explain below)?

Chicken pox; Scarlet fever; Kawasaki's disease; Asthma; Anemia; Bleeding disorders; Blood transfusions; Mumps;
 Measles; Whooping cough; Ear infections; Eczema/Atopic dermatitis; Hepatitis; Urine infections; Joint problems;
 Rheumatic fever; Seizures; Hearing loss; Vision loss; Seasonal allergies; Recurrent constipation

Details: _____

Serious Injuries / Accidents (when-where)?: _____

Hospitalizations (When-where-why?): _____

Immunizations up to date? _____ (Please bring your shot record to your visit)
 Allergies to: Drugs _____ Foods _____ Seasonal (which?) _____
 What age & describe the reaction _____

Family Profile:

Parents: Married – Separated – Divorced
 Mother: Year of birth: _____ Highest school grade: _____ Smokers in the home: _____
 Father: Year of birth: _____ Highest school grade: _____ Pets: _____
 Siblings: (list brothers and sisters and ages): _____

Family Medical History:

For the following problems indicate the **blood** relative with the follow abbreviations: (F) father, (M) mother, (B) brother, (S) sister, (mGM or mGF) maternal grandmother or maternal grandfather, (pGM or pGF) paternal grandmother or grandfather, (A) aunt, (U) uncle:

Anemia _____	Bleeding disorder _____
Asthma _____	Mental retardation _____
Diabetes _____	Hepatitis _____
Cancer _____	AIDS / HIV _____
Cystic Fibrosis _____	Musc. Dystrophy _____
Tuberculosis _____	Prison time _____
Arthritis _____	Seizures / epilepsy _____
Heart attack under age 45 _____	High Blood Pressure _____
High Cholesterol _____	Obesity _____
Anorexia _____	Migraines _____
SIDS _____	Birth Defects _____

Drug addiction (including nicotine, alcoholism and caffeine; please specify who/which drug): _____



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FINANCIAL POLICY

1. The physician provides services to you and your children, not insurance companies. Therefore, be advised financial responsibility ultimately falls to you.
2. Co-pays are due on the day of the visit. As a courtesy, we will submit your claim to your insurance company. Any balance amount after insurance payment and/or deductibles will be billed to you. We accept cash, *check, Mastercard, Visa or Discover cards. Please note, insurance plans vary greatly in what they will reimburse, from full / 100% coverage to nothing at all. We hope you understand this fact is completely beyond our control.
3. Patients without insurance or with plans with which Doctor does not participate are expected to pay office visits at the time of service. Patients should check with their insurance prior to their appointment to verify coverage.
4. **ATTN DIVORCED PARENTS: THE PARENT WHO BRINGS THE CHILD TO THE DOCTOR FOR MEDICAL SERVICES IS RESPONSIBLE FOR THE BILL.** Doctor will not be placed in the middle of a divorce/separation situation.
5. **CHARGES INCURRED AS THE RESULT OF A LIABILITY CLAIM ARE THE PATIENT'S RESPONSIBILITY.** When provided with complete billing information, we are willing to work with you in collecting from other insurance. Please realize that litigation is usually lengthy and the doctor needs to be paid in a timely manner.
6. If your account becomes delinquent our office has the right to turn it over to a collections agency. You will then be responsible for all late fees, collection fees, and attorney fees that could amount to 50% of your total bill. This amount would be in addition to the total amount originally billed.

* Bounced checks will incur fees. Ask office manager for details.

By signing below I acknowledge that I have read, understand and agree to this financial policy.

Patient/Responsible Party

Date