PATIENT INFORMATION

Patient's Name**:** _____

First Middle Last

Date of Birth: ____/_____/_____ Age:____ Sex: □ MALE □ FEMALE

Patient's Street Address: _____

City: _____ State: _____ Zip: _____

Primary Care Doctor Name: _____ Phone: _____-_____-_____

How would you prefer to be contacted? □ Phone □ Mail

The State requires us to ask the following:

Race: □ ASIAN □ HISPANIC □ BLACK □ WHITE □ DECLINED

Language: □ ENGLISH □ SPANISH □ SIGN LANGUAGE □ OTHER □ DECLINED

Ethnicity: □ LATINO □ NOT LATINO □ DECLINED

Education (If applicable)

School Name: _____ Level: _____

School Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____-_____-_____

Parent/Guardian Information (If applicable)

Name: _____ D.O.B: ____/_____/_____

Relationship to Patient: □ Parent □ Guardian/Others pls. specify_____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____-_____-_____ Cell Phone No. : _____-_____-_____

Email Address: _____

Primary Insurance Information

Insurance Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Policy Type: □ Individual □ Cobra □ Group □ HMO □ PPO

ID Number: _____ Group Number: _____

Policy Holder's Name: _____

First Middle Last

Social Security Number: _____-_____-_____ D.O.B: _____/_____/_____

Relationship to Patient: □ Parent □ Self □ Guardian/Others pls. specify: _____

Secondary Insurance Information

Insurance Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Policy Type: □ Individual □ Cobra □ Group □ HMO □ PPO

ID Number: _____ Group Number: _____

Policy Holder's Name: _____

First Middle Last

Social Security Number: _____-_____-_____ D.O.B: _____/_____/_____

Relationship to Patient: □ Parent □ Self □ Guardian/Others pls. specify: _____

_____ _____

Patient Name (Print) Patient/Guardian Signature

_____

Date

NOTICE AND PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), protects health information created of maintained by health care providers throughout the United States.

Prior to receiving care in our office, each patient shall receive and be asked to acknowledge that they have received a Notice of Privacy Practices that explains their right under HIPAA and our use of their health information for treatment, payment, and health care operations without further authorization.

Also as part of the HIPAA regulations, each patient has the right, with some restrictions, to:

- Review his or her own medical record;
- Request an amendment or correction to the medical record;
- Add supplemental information to the record;
- Restrict use and disclosure of your medical information;
- Authorize formal consent before health information is released other than for treatment, payment or as part of health care operations and
- Know who requested and received medical information for other than treatment, payment, or health care operations

In protection of your information, Pediatric Care Physicians, LLC and their employees are prohibited, with some exceptions, from releasing your health care information to anyone not involved in your health care or in office operations, including family members, unless you have provided written consent. The Authorization for Release of Information form allows Pediatric Care Physicians, LLC to release your information to a particular agency or individual that you designate.

_____ _____

Patient Signature Date

FINANCIAL POLICIES

Thank you for choosing Pediatric Care Physicians, LLC. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

If your insurance plan requires a **copayment,** it is payable at the time of visit. If you present without the copayment, we reserve the right to reschedule you or to bill you a **$10.00** administration fee.

If you fail to provide the necessary insurance demographic to file your claim, you will be responsible for payment in full at the time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

PARENTS, GUARDIANS OR PATIENT (if applicable) MUST INITIAL FOR ACKNOWLEDGEMENT

_____ A **$1.00** per page for release of medical records to a maximum charge of $**100.00**

_____ A **$25.00** fee will be charged for missed appointments.

_____ If for any reason a payment is dishonored by your bank, there will be a **$25.00** service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

_____ We require **72 hours** for referrals. Please be advised that pre-certifications and prior authorizations are approved on a case by case basis by your insurance plan.

WE STRONGLY URGE YOU TO FAMILIARIZE YOURSELF WITH THE BENEFITS, EXCLUSIONS, AND DEDUCTIBLES OF YOUR INSURANCE PLANS.

I hereby certify that I have read Pediatric Care Physician's financial policy and understand my financial responsibility and agree to the terms states in this Financial Policy.

_____ _____

Patient Name (Print) Patient Signature

_____

Date

NAME: _____ DATE: _____/_____/_____

(PRINT)

SIGNATURE: _____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction, on uses and disclosures on their protected health information (PHI). The individuals is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to individual's office instead of the individual's home.

I wish to be contacted in the following manner (CHECK boxes that apply)

□ Home tel. ____-_____-_____	□ Work Tel. _____-_____-____	□ Written communication
□ O.K. to leave message with detailed information	□ O.K. to leave message with detailed information	□ O.K to mail to my home address
□ Leave Message with call-back number only	□ Leave Message with call-back number only	□ O.K. to mail to my home address
		□O.K. to fax
		Fax No. _____-_____-_____

Other:

Persons Authorized to receive information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Pediatric Care Physicians, LLC Use only

Date Acknowledgement received: _____/_____/_____

OR Reason Acknowledgement was not obtained: _____

_____

_____

_____

PLEASE KNOW YOUR INSURANCE

We strongly urge you to familiarize yourself with the benefits and exclusions in your insurance contract. We accept many insurance carriers and each has its own individual clauses. Our practice cannot guarantee that all services provided will be covered. Those services rejected or not covered will be billed to the patient.

Also, please be advised to notify your insurance and have your Primary Care Physician updated to our doctors, otherwise, you will be responsible for payment.

Patient Name: _____ Date: _____/_____/_____

Identification Number: _____

ADVANCE VACCINE BENEFICARY NOTICE OF NONCOVERAGE

NOTE: If your health insurance doesn't pay for the vaccinations, you may be responsible for payment of the vaccinations. Health insurance companies do not pay for all your medical services that is why it is important to understand your health insurance policy. We expect your health insurance may not pay for the vaccinations due to the reason(s) listed below. Please be advised if you ask for the vaccine(s) and it is drawn from the vial(s) and you change your mind, you will be responsible for the cost, as we cannot charge your health insurance company.

Vaccine(s)	Reason(s)
90633- Hepatitis A 90655- and/or 90656- Influenza 90645- Hemophilus Influenza B 90649- Gardisil 90670- Pneumococcal conjugate 90698- Pentacel 90680- Rotavirus 90700- Dtap 90713- Poliovirus 90715- Adacel 90716- Varivax 90723- Pediarix (Dtap-HepB-IPV) 90744- Hepatitis B 90734- Menactra 90707- Measles, Mumps, & Rubella 90460- Administration of Vaccine	Non- Covered Service Deductible

G. Options: Check only **one** box. We cannot choose a box for you.

□ **OPTION 1.** I want the **VACCINE(S)** listed above. You may ask to be paid now, but I also want my health insurance billed for an official decision on payment. I understand that if my health insurance doesn't pay, I am responsible for payment, but I can appeal their decision as well. If my health insurance does pay, I will be refunded by Pediatric Care Physicians, less co-pays or deductibles.

□ **OPTION 2.** I want the **VACCINE(S)** listed above, but do not bill my health insurance. You may ask to be paid now as I am responsible for my payment. I cannot appeal if my health insurance is not billed.

□ **OPTION 3.** I don't want the **VACCINE(S)** listed above. I understand with this choice I am not responsible for payment.

H. Additional Information:

I. Signature: _____ **J.** Date: _____/_____/_____

MEDICAL RECORDS RELEASE

DATE: _____

PHYSICIAN FROM WHICH RECORDS ARE REQUESTED:

(Please list Physician's **complete name, address, and telephone number**)

_____

_____

_____

_____

Please release all records, radiology and other test results to:

Pediatric Care Physicians, LLC

2119 Route 88 East

Brick, NJ 08724

PHONE: 732-899-0008 FAX: 732-899-0447

Patient's Name: _____

Patient's Signature: _____

Parent's/Guardian's Signature: _____

Pediatric Care Physicians, LLC

(Please fill out completely)

Child's Full Name: _____

Date of Birth: _____/_____/_____

Birth History

Pregnancy: [ ] Healthy [ ] Problems _____

Group B Strep Status: [ ] Positive [ ] Negative Antibiotics Given: [ ] Yes [ ] No

Birth Weight: _____ lbs _____ oz

Delivery: [ ] Vaginal [ ] C-section

Infection: [ ] Yes [ ] No

Jaundice: [ ] Yes [ ] No If yes….. Billi-rights [ ] Yes [ ] No

Circumcision: [ ] Yes [ ] No

Diet: [ ] Breast [ ] Formula

Other Complications: _____

Child's Past Medical History (please circle all that apply)

ADHD	DIABETES	SEIZURE/EPILESPY
ALLERGIES	EAR INFECTION	SICKLE CELL ANEMIA
ARTHIRITIS	FRACTURE(S)	SINUSITIS
ASTHMA	GASTRIC REFLUX	SPEECH DELAY
ANEMIA	HEAD INJURY	STREP THROAT
BEDWETTING	HEARING IMPAIRMENT	VISUAL DISTURBANCE
BRONCHIOLITIS/BRONCHITIS	HEART DISEASE	(GLASSES)
BURN	HEART MURMUR	OTHER:
CAVITIES	HISTORY OF CHILD ABUSE	OTHER:
CEREBRAL PALSY	INGESTION OF POISON	OTHER:

CHICKEN POX	LEARNING DIFFICULTY
CONSTIPATION	MIGRAINE HEADACHES
DEPRESSION	MONONUCLEOSIS
DEVELOPMENTAL DELAY	PNEUMONIA

HOSPITALIZATIONS

DATE/AGE: _____ REASON: _____

DATE/AGE: _____ REASON: _____

SURGERIES

DATE/AGE: _____ REASON: _____

DATE/AGE: _____ REASON: _____

ALLERGY HISTORY (Please circle all that apply)

Animals	Milk	Soy
Bees	Nuts	Others:
Dust/Dust Mites	Pollen	
Egg white	Shellfish	

ALLERGY TO MEDICATIONS

MEDICATION: _____ REACTION: _____

MEDICATION: _____ REACTION: _____

SOCIAL HISTORY

Activities/Sports: _____

Daycare/Preschool/School: _____

Environment:

Home over 20 yrs. old: [ ] YES [ ] NO Water: [ ] CITY [ ] WELL

Tobacco Smoke Exposure: [ ] YES [ ] NO Pets: _____

SAFETY/SELF CARE

Firearms in home: [ ] YES [ ] NO → LOCKED? [ ] YES [ ] NO

Car Seat: [ ] YES [ ] NO Seatbelt: [ ] YES [ ] NO

Helmet use: [ ] YES [ ] NO

Brushes teeth: [ ] YES [ ] NO Dental Care: [ ] YES [ ] NO

FAMILY HISTORY (Please place a ✓ for all that apply)

DISEASE	MOM	DAD	SISTER	BROTHER	MATERNAL	PATERNAL
Allergies						
Asthma						
Blood Diseases						
Cancer(state type)						
Birth Defects						
Diabetes						
Gastrointestinal						
Hearing Impairment						
Heart Disease						
High Blood Pressure						
Joint Disease						
Kidney Disease						
Liver/Gall Bladder						
Muscle/Bone Disease						
Neurological/Seizures						
Psychiatric						
Thyroid Disease						