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. _____

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*

PEDIATRIC CARE PHYSICIANS, LLC
MARIA COLLADO, M.D. F.A.A.P. 2211 ROUTE 88 EAST, STE 2A BRICK, NJ 08724

NAME: _____ DATE: _____ SIGNATURE: _____
(Print)

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 : _____

PEDIATRIC CARE PHYSICIANS, LLC

MARIA COLLADO, M.D. F.A.A.P 2211 ROUTE 88 EAST, STE 2A BRICK, NJ 08724

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.

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
2211 Route 88 East, Suite 2A
Brick, NJ 08721

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

PATIENT'S NAME: _____

PATIENT'S SIGNATURE _____

PARENT'S/GUARDIAND'S SIGNATURE: _____

PEDIATRIC CARE PHYSICIANS, LLC
MARIA COLLADO, M.D. F.A.A.P 2211 ROUTE 88 EAST, STE 2A BRICK, NJ 08724

NOTICE AND PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996(HIPAA), protects health information created or 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 rights 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 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 Jersey Shore Medical and Pediatric Associates, 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 stated in this Financial Policy.

_____

Patient Name (Print)

_____ _____

Patient Signature *Date*

Pediatric Care Physicians, LLC

(Please fill out completely)

Child's Full Name: _____

Date of Birth: _____

Birth History

Pregnancy: [ ] Healthy [ ] Problems _____

Group B Strep Status: [ ] Pos [ ] Neg Antibiotics Given: [ ] Yes [ ] No

Birth Weight: _____lbs _____oz

Delivery: [ ] Vaginal [ ] C-section

Infection: [ ] Yes [ ] No

Jaundice: [ ] Yes [ ] No If yes....billi-lights [ ] Yes [ ] No

Circumcision: [ ] Yes [ ] No

Diet: [ ] Breast [ ] Formula

Other Complications: _____

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

ADHD	Diabetes	Seizure/Epilepsy
Allergies	Ear Infection	Sickle Cell Anemia
Arthritis	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: _____

Current Medications:

1) _____ 2) _____

3) _____ 4) _____

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

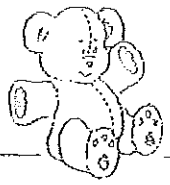
Car Seat: [ ] Yes [ ] No Seatbelt: [ ] Yes [ ] No

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	FRATERNAL
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						



PEDIATRIC CARE PHYSICIANS, LLC

MARIA COLLADO, M.D., F.A.A.P. GERALD ALMAZAN, M.D.

Patient Name: _____ Date: _____

Identification Number: _____

Advance Vaccine Beneficiary 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 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 D. 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, you will be refunded by Pediatric Care Physicians, less co-pays or deductibles.

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

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

H. Additional Information:

I. Signature:_____ J. Date:_____

PEDIATRIC CARE PHYSICIANS, LLC

2211 Rt.88 East Ste. 2A
Brick, NJ 08724
732-899-0008

UNDERSTANDING YOUR HEALTH INSURANCE

Your doctor's office staff is required to follow the rules of your health insurance policy. The office staff does their best to send bills on time to health insurance companies so you will not have to pay for medical care that is covered by your plan. In some cases, the office staff may ask for your assistance when bills are sent to your health insurance company to ensure your bills are paid on time.

Frequently asked questions

1.) What is a health insurance policy?

Your health insurance policy is an agreement that your health insurance will pay for covered medical care as long as your premium is paid. Your health insurance may NOT pay for every bill. This is why it is important for you to know which medical treatments the health insurance will pay for. You are responsible for paying any medical costs that the health insurance does not pay for.

2.) What are some common insurance terms?

Copayment or "co-pay" The part of your medical bill you must pay each time you visit the doctor. This is a pre-set fee determined by your policy.

Co-insurance The part of your bill, in addition to a co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill, for example, 20%.

Deductible The cost you must pay before your health insurance starts paying for medical treatment, for example, $500 per individual or $1500 per family. In most cases a new deductible must be satisfied each calendar year.

Non-covered charges Costs for medical treatment that your health insurance company does not pay. You may wish to determine if your treatment is covered by your health insurance policy before you are billed for these charges by the doctor's office.

3.) What steps should be followed if I am expecting a baby?

-Contact the mother's or father's health insurance company to ask how to add the newborn to health insurance coverage.

-Select a pediatrician's office to treat the baby

-Sign up the expected baby with the pediatrician's office. The newborn's hospital stay and follow-up are typically not covered under your health insurance policy. Therefore, the doctor's office will ask for the newborn's health insurance information.

4.) What is a "coordination of benefits" form?

Many health insurance companies require patients to fill out a form that tells the company whether they or a family member has other health insurances. Your health insurance company needs this information to work with other insurers to determine which company pays for what service. It is important to fill out the form and it to be returned otherwise, your medical bills may not get paid.