Pediatric Care Physicians, LLC

Patient Information/Demographics

Today's Date: _____

Patient's Name: _____

First Middle Last

Date of Birth: _____ Age: _____ Sex: ___Male ___Female

Patient Home Address: _____

City: _____ State: _____ Zip: _____

Patient's Primary Language: _____

Patient's Ethnicity: ___Hispanic or Latino ___ Not Hispanic or Latino ___Prefer not to disclose

Patient's Race: ___American Indian/AK Native ___Asian ___Black or African American

___Native Hawaiian/Pacific Islander ___White ___Prefer not to disclose

Preferred Pharmacy: _____ Phone Number: _____

EMERGENCY CONTACT: (in the event the parent(s) cannot be reached)

Contact Name: _____ Relationship: _____

Phone: _____

Parent/Guardian Demographics:

Parent 1 First/Last Name: _____

Date of Birth: _____ Relationship to Patient: _____

Parent 1 Cell: _____ Parent 1 Work Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Parent 2 First/Last Name:_____

Date of Birth: _____ Relationship to Patient: _____

Parent 2 Cell: _____ Parent 2 Work Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Guarantor/Insurance Information:

Insurance Carrier Name: _____

Policy/ID Number: _____ Group Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Effective Date: _____ Employer: _____

Policy Holder's Name: _____

First Middle Last

Policy Holder's Date of Birth: _____

Policy's Social Security Number: _____

Relationship to Patient: _____

Secondary Insurance Information (If applicable):

Insurance Carrier Name:

Policy/ID Number: _____ Group Number: _____

Street Address: _____City: _____ State: _____Zip: _____

Effective Date: _____ Employer: _____

Policy Holder's Name: _____

First Middle Last

Policy Holder's Social Security Number: _____

Relationship to Patient: _____

CONSENT

Consent to Release:

I hereby authorize the physicians of this practice to release and all medical information to the above named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until it is revoked in writing. I have read this authorization and understand it.

Consent to Assignment:

I hereby assign payment of medical services to this practice to which I am entitled to or have incurred for medical and/or surgical expense relative to services rendered here. I understand that I am financially responsible to said group of charges not covered for this assignment. I further agree, in the event if non-payment to bear the cost of collections, and/or court cost and reasonable legal fees should this be required.

Consent to Treat:

I authorize this practice to provide medical care to my child and authorize treatment of care in my absence if my child is accompanied by the following caregiver: (Check all that apply)

__ Grandparent/s/Siblings Name: _____

__ Nanny/Babysitter: _____

__ Other Qualified Relative: _____

Signature of Parent/Legal Guardian: _____

Date: _____

On-Site Laboratory Testing:

We can effectively and efficiently determine if your child has the flu/strep by performing in-office testing. Some insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests out to an external labs result in waiting days for results that we can provide to you much more quickly. We believe it is important to treat your child as quickly as possible, and therefore offer these services in our office.

In-office labs and fees include:

Rapid Flu $25.00

Rapid Strep $10.00

Urinalysis $10.00

Advance Beneficiary Notice of Non-Coverage

You may be held responsible for balances accrued in the event that your insurance does not pay for your child's immunizations/office visits. Please familiarize yourself with your healthcare coverage policies and limitations.

Please sign the following waiver indicating that you are aware that these charges may apply in the event that your insurance company does not cover these services.

Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does pay for these services.

Patient/Responsible Party Signature_____ Date: _____

CHILD's NAME: _____ DOB: _____

COPAYMENTS AND DEDUCTIBLES:

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service.

Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic.

If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered.

We are happy to discuss arrangements for payment by installment if you need to do so. Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make payments due at the time of the visit.

.**ADMINISTRATIVE FEES/POLICIES:**

- A $1.00 per page for release of medical records to a maximum charge of $100.00
- A $25.00 will be charged for missed appointments (No Show)
- If you present without a copayment at the time of the visit, we reserve the right to bill a service to be added to your co-pay.
- A $10.00 billing fee will be added on the balance due if same balance is left unpaid for consecutive billing cycles.
- If, for any reason, a payment is dishonored by your bank, a $35.00 service fee will be added to your bill. You will be required to pay by cash, certified money order or credit card for future services.
- Any outstanding patient balance left unpaid after several attempts from the Billing Office will be transferred to an outside collection agency and your child being discharged from the practice.
- **We require 72 hours notice for referrals. Please be advised that pre-certifications and prior authorizations are approved on a case to case basis by your insurance plan.**

_____ _____

Parent/ Guardian Name and Signature Date

_____ _____

Patient Name Date of Birth

HIPAA & NJPMP Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____,(Parent/Guardian) authorize Pediatric Care Physicians, LLC to use and/or disclose any protected information (immunization records, lab reports, child's health status, etc.) for all of my children to the following entities via telephone/fax/electronic mail:

_____ SCHOOL/DAYCARE/BABYSITTER

_____ OTHER HEALTHCARE PROVIDERS/STATE of NJ.

Please list any exclusion: _____

I wish to be contacted in the following manner (check all that apply)

_____ Leave a DETAILED MESSAGE on my answering machine

_____ Leave a message with the doctor's name and number ONLY

Person/s authorized to receive information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Pediatric Care Physicians, LLC Acknowledgement received: _____

Reason Acknowledgement was not obtained: _____

_____ _____

Patient Name Date of Birth

_____ _____

Parent/Guardian Signature Date

Child's Full Name: _____

Date of Birth: _____

Birth History

Pregnancy: ___ Healthy ___ Complications

Group B Status: __ Negative ___ Positive Antibiotics Given: ___ Yes ___ No

Birth Weight: _____ lbs _____ oz

Delivery: ____ Vaginal ___ C-section

Infection: ___ Yes ___ No

Jaundice: ___ Yes ___ No If yes, Bili-lights ___ Yes ___ No

Circumcision: ___ Yes ___ No

Diet: ___ Breastfeeding ___ Formula What Kind? _____

Child's Past Medical History (Circle all that apply)

ADHD ALLERGIES ARTHRITIS ASTHMIA ANEMIA BEDWETTING

BRONCHIOLITIS/BRONCHITIS BURN CAVITIES CEREBRAL PALSY CHICKEN POX

COSNTIPATION DEPRESSION DEVELOPMENTAL DELAY DIABETES

EAR INFECTION FRACTURE(S) GASTRIC REFLUX HEAD INJURY/CONCUSSION

HEARING IMPAIRMENT HEART DISEASE HEART MURMUR HISTORY OF CHILD ABUSE

INGESTION OF POISON LEARNING DIFFICULTY MIGRAINE HEADACHES

MONONUCLEOSIS PNEUMONIA SEIZURE/EPILEPSY SICKLE CELL ANEMIA

SINUSITIS SPEECH DELAY STREP THROAT VISUAL DISTRUBANCES GLASSES

OTHER:

_____

HOSPITALIZATIONS

Date/Age: _____ Reason: _____

Date/Age: _____ Reason: _____

SURGERIES

Date/Age: _____ Reason: _____

Date/Age: _____ Reason: _____

ALLERGY HISTORY (CIRCLE THAT APPLY)

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

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 visit up to date: ___ Yes ___ No

DISEASE	MOM	DAD	SISTER	BROTHER	MATERNAL	PATERNAL
ALLERGIES						
ASTHMA						
BLOOD DISEASE						
CANCER (TYPE)						
BIRTH DEFECTS						
DIABETES						
GASTROINTESTINAL						
HEARING IMPAIRMENT						
HEART DISEASE						
HIGH BLOOD PRESSURE						
JOINT DISEASE						
KIDNE DISEASE						
LIVER/GALL BLADDER DISEASE						
MUSCLE/BONE DISEASE						
NEUROLOGICAL/SEIZURES						
PSYCHIATRIC						
THYROID DISEASE						

Patient Name: _____

Date of Birth: _____

Parent Signature: _____ Date: _____