ASSOCIATED PEDIATRICIANS, LLC

Information Update/Contact Methods

Acct#_____

PATIENT INFORMATION (18 Years and Older):

Name: _____ DOB:_____ SSN#_____

ADDRESS: _____ CITY _____ ZIP_____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

FAMILY INFORMATION

Language: _____ Ethnicity: _____ Race _____

WHOM DO YOU LIVE WITH (Please Check One):

☐ BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY ☐ MOTHER/STEP-FATHER

☐ FATHER/STEP-MOTHER ☐ GUARDIAN ☐ SELF

INSURANCE HELD BY: ☐ FATHER ☐ MOTHER ☐ OTHER: (Specify) _____

ADDRESS: _____ CITY: _____ ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

HOME #: _____ DOB: _____ SS#: _____

CONTACT METHODS

1) **FOR MEDICAL ISSUES (CALLS/COMMUNICATION FROM DOCTOR OR NURSE) (Check One)**
   ☐ Home Phone ☐ Cell ☐ Other: _____
2) **APPOINTMENT REMINDERS (Check One)**
   ☐ Home Phone ☐ Cell ☐ Text Cell ☐ Email
3) **PATIENT PORTAL (NOTIFICATION OF A MESSAGE TO READ) (Check One):**
   ☐ Text to Cell ☐ Email
4) **EMERGENCY CONTACT :**
   Name: _____ **Phone:** _____ **Relation:** _____

SIGNATURE: _____ DATE: _____

Office Use:
Initial _____ ***Date*** _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.

Signed this _____ day of _____, 20_____.

List Patient(s) Names Below:

_____ _____

_____ _____

Signature _____

Relationship to Patient(s) _____

FINANCIAL PAYMENT POLICY

Please provide us with your correct Insurance / Medicaid information at the time services are rendered. If we do not receive the correct insurance information within 90 days from the date of service, you will be responsible for all charges. Intentionally providing false or misleading insurance information is a crime. Likewise, if you were to receive payment directly from your insurance company for a service that has not been paid by you, it is your responsibility to remint the insurance payment to our office.

Failure to show your insurance card or let us know of any changes will result in any and all bills becoming your responsibility. You are responsible at the time of service:

- To remit payment for any and all co-pays.
- To remit payment for any and all deductibles.
- To know your insurance policy. If your insurance covers immunizations and if services require a referral or prior authorization, please let us know.
- To know if your labs are covered and what facility to go to for your lab work.

If you are uninsured, payment is due at the time of service. If needed, we are willing to work with you on a payment plan. Ask to speak to our patient billing staff.

If you have health insurance, the contract to pay your benefits is strictly between you and your insurance company. If for some reason your health insurance company pays your claim and then retroactively denies the benefits, it is your responsibility to remit payment to us upon receipt of a statement.

If you decide not to present your information today, you will be considered a self-pay patient and will be expected to pay at today's visit.

By signing below, I hereby certify that all the information I have provided regarding my personal information and my health insurance information is true and correct as of this date. I understand that providing false information is a crime. I certify that I have been made aware of my responsibilities to ensure that the medical bills I incur are my medical bills and its my responsibility to ensure that these bills are paid. I fully understand that any unpaid debts will be sent to a professional collection agency and that any unpaid debts could adversely affect my credit.

_____ _____

Signature Date

Childhood Vaccination Policy

Effective 5/14/2015

In the best interest of the health and safety of all patients in our practice, effective 5/14/2015 Associated Pediatricians will no longer be accepting any new families who refuse to immunize their children. Families that are already established with our practice who, for reasons other than valid medical contraindications, have not completed age appropriate immunizations will be expected to begin the process of completing these immunizations within six months and to have completed them within two years. Associated Pediatricians follows the immunization schedule recommended by both the American Academy of Pediatrics and the Advisory Committee on Immunization Practices (AAP/ACIP).

It is well proven that vaccination for childhood diseases is safe and effective. Deciding to not vaccinate or to postpone vaccination is not supported by the medical literature. Delaying immunization places both the individual child and those around him/her at risk. We live in a global society. Recent outbreaks of whooping cough and measles and the persistence of polio in foreign countries highlights just how real these risks are.

If you have vaccine questions we are more than happy to discuss them with you. Although we do not recommend any immunization schedule other than that recommended by the AAAP/ACIP, if you intend to ***fully*** vaccinate your child using an "alternative schedule" we will make every effort to work with you to complete vaccinations in a timely manner.

If you are unwilling or unable to comply with our vaccination policy, we are not the practice for your family. In that event we will help you transfer your records to another health care provider of your choosing. Our goal at Associated Pediatricians is to provide the best medical care for each of our patients. Routine childhood immunizations are the cornerstone of that care. We sincerely hope you can appreciate and share our goals.

I have read and understand the Associated Pediatricians Vaccination Policy:

Signed this _____ day of _____, 20_____.

List Patient(s) Names Below:

_____ _____

_____ _____

Signature _____

Relationship to Patient(s) _____

Patient Name: Date of Birth: Account #:

ASSOCIATED PEDIATRICIANS WELL CHILD VISIT POLICY

The well child visit is an opportunity to discuss your child's growth and development and discuss important age-related safety and behavior topics. This visit also allows us to do a complete physical exam so we can identify medical problems that may not be readily apparent without a thorough physical exam. The purpose of your child's visit is what is called "preventative care"—looking for and discussing issues that may affect your child's growth, development and general well being so that we can identify and prevent smaller issues from progressing into larger problems.

Things that are included in your child's well visit:

- Measurement of weight, height/length, head circumference (2YO and under), blood pressure (3YO and up)
- A complete head-to-toe physical exam done by your provider (doctor or nurse practitioner)
- A discussion with your provider about your child's growth and nutrition/diet
- A discussion with your provider about normal developmental milestones and your child's progression in achieving these
- A discussion with your provider about normal age-related development and safety topics
- Discussion of sports-related screening questions for student athletes and completion of related forms

If needed, your child will receive immunizations (shots) at the well child visit. Please note that these are billed separately to your insurance company. As a courtesy, we verify insurance eligibility for these shots prior to your child's visit. We, however, have limited access to coverage and benefit information and you are ultimately responsible for knowing your plan limitations. If the immunizations are not covered by insurance, you will receive a bill from our office.

In addition to the above, many of our visits include other screening or preventative care. The following are a list of some of the items that fall into this group. These are billed separately to your insurance company and may or may not be covered under your insurance plan. Rest assured that our recommendations for these services are made because they are a part of the American Academy of Pediatric's Bright Futures Guidelines. These guidelines are the gold-standard of care in pediatrics and are important to identifying any issues EARLY before they become larger problems. Most, but not all, insurance companies pay for services recommended under these guidelines.

- Standardized Developmental Surveys (ASQ, MCHAT, etc.)
- Hemoglobin and lead blood test
- Vision Screening (Pediavision)
- Hearing Screening
- Depression, Anxiety, ADHD, lead, and other standardized screening questionnaires
- Application of fluoride varnish

Please also note that well child care does not include care of other chronic medical conditions (asthma, ADHD, allergies, mental health issues) or acute illnesses (ear infections, strep throat, gastrointestinal illnesses, etc) that occur at the same time as the well visit. ***If we evaluate and treat chronic or acute conditions during the course of the well visit we are mandated by your insurance company to document and bill separately for those issues.*** As such, you may be required to pay a copay. Please know that this is required by the insurance companies and we are forced to comply with this policy, as failure to do so would constitute insurance fraud.

I acknowledge I have read and understand the above policy. I agree I am responsible for any and all charges deemed to be my responsibility by my insurance carrier. These include, but are not limited to, co-pays, deductibles, co-insurance, benefits, and any services not covered by my insurance carrier

_____ _____

Parent/Guardian Signature Date

Infants • Children • Adolescents

Associated Pediatricians, LLC

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Protected Health Information Consent

By signing below, I understand that if I so choose, the individuals or agencies I have listed will be given access to my PROTECTED HEALTH INFORMATION from Associated Pediatricians, LLC.

CHOOSE FROM THE FOLLOWING:

_____ I **do not** wish to designate a personal healthcare representative with respect to my protected health information at this time.

_____ I hereby grant permission to Associated Pediatricians, LLC to disclose my **protected health information** to those names listed below.

_____ I hereby grant permission to Associated Pediatricians, LLC to disclose my **protected health information** and give access to my **patient portal account** to those names listed below.

_____ _____
Printed Name Relationship to Patient

_____ _____
Printed Name Relationship to Patient

_____ _____
Patient Signature Date

_____
Printed Name of Patient

_____ _____
Responsible Party Signature Date
(Guardianship Paperwork Required)

_____
Printed Name of Responsible Party