Welcome to the Practice

Thank you for choosing Children's Medicine, P.C. (CMPC) for your child's healthcare needs. Our entire team is committed to giving children of all age's personal and caring attention.

In order to better serve you, we ask that you please do the following:

- Fill out your patient information forms and bring with you to your first appointment.
- Have a copy of your child's medical records sent to the appropriate office prior to your appointment. If immunization records are not received by the appointment date, your child's well visit may be rescheduled.
- Bring a photo ID and your child's insurance card to every visit.

Our providers participate in multiple insurance plans. It is your responsibility to make sure that CMPC is in network with your particular insurance plan. If your plan requires you to select a PCP (Primary Care Physician), you should have one of our providers listed as the designated PCP before your initial appointment

CMPC requires payment at the time of the service. Full payment is expected from those patients that CMPC is not filing insurance for. Patients that CMPC will file insurance for are expected to pay the designated amount required by the insurance plan which include copayments, deductibles and/or coinsurance.

CMPC accepts cash, check, American Express, MasterCard, Visa and Discover as payment options.

Appointment date: _____ Arrive at: _____

If you need to change or cancel your appointment, please notify the office 24 hours in advance. Failure to notify the office will result in a $35 fee attached to your account.

We hope to develop a lasting relationship with your family and look forward to partnering with you in the healthcare needs of your child.

New Patient Information

The following information is essential in forming a complete and accurate record on your child. Please answer all questions fully.

Today's date: _____ Account: _____
Child's full name: _____ Name used: _____
Birth date: _____ Sex: _____ Home phone: _____
Address: _____
County: _____ City: _____ Zip code: _____
Pharmacy street and city: _____
Pharmacy phone: _____
Former pediatrician: _____ Phone: _____ State: _____
Please tell us how you heard about our practice: _____

PARENTAL INFORMATION

Please give first, middle and last name. You may write "same" in address if same as child's.

Father's name: _____ Birth Date: _____
SSN: _____ Home phone: _____ Cell phone: _____
Home address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Work phone: _____
Employer (or if self-employed, name of business): _____
Email _____

Mother's name: _____ Birth Date: _____
Maiden name: _____
SSN: _____ Home phone: _____ Cell phone: _____
Home address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Work phone: _____
Employer (or if self-employed, name of business): _____
Email _____

Custodial Stepmother / Stepfather's Name: _____ Birth Date: _____
SSN: _____ Home phone: _____ Cell phone: _____
Home address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Work phone: _____
Employer (or if self-employed, name of business): _____

Who is responsible for payment?: _____ Home phone: _____
Home address: _____ Work Phone: _____
Emergency contact person: _____ Phone: _____

Parent / Guardian Signature: _____
Date: _____

For Office Use Only:
Date: _____
Initials: _____

Medical History Information

Child's full name: _____ Date: _____

Name used: _____ Date of birth: _____ Due date: _____

Multiple Birth: ❑ Y ❑ N Birth weight: _____ Length: _____ Type of delivery: _____

American born: ❑ Y ❑ N City of Birth: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Declined
❑ Native Hawaiian or Pacific Islander ❑ White

Ethnicity: ❑ Declined ❑ Hispanic or Latino ❑ Non Hispanic or Non Latino

Apgar score (if known) _____ Blood type of mother: _____ Blood type of infant: _____

Illness or medication in pregnancy: _____

Illness in newborn period: _____

Has Your Child had any of the following?

❑ Asthma ❑ Ear Infection ❑ Chicken Pox _____ (Year)

❑ Allergies ❑ Pneumonia ❑ Bronchitis ❑ Urinary Tract Infection

❑ Other Illnesses/ Problems: _____

Hospital stays/surgeries: _____

Is your child allergic to any medications or foods? ❑ Y ❑ N

Please list allergies: _____

_____

Are immunizations up to date: ❑ Y ❑ N ❑ Not sure

Who lives in the household with the Child:

❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather

❑ Siblings ❑ Grandparents ❑ Stepsiblings ❑ Boyfriend / Girlfriend of parent

❑ Other: _____

FAMILY HISTORY

Mother's Name: _____ Age: _____ Health: _____

Father's Name: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Do any family members have the following? (If so, whom?)

Allergies: _____ Asthma: _____ Blood/Bleeding Disorders: _____

Diabetes: _____ Early Heart Disease: _____

Miscarriages: _____ Mental Retardation: _____

Seizures: _____ Tuberculosis: _____

Multiple births: _____

For Office Use Only:
Date: _____
Initials: _____

Consent Form

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). To help us protect your child's PHI please complete the form below.

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Emergency Contact

In the event of an emergency, I give Children's Medicine permission to contact the persons listed below.

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Parental Consent

O There is no one other than the mother or father who will bring my child to Children's Medicine, P.C. for medical treatment.

-OR-

O I give permission for the persons listed below to bring my child to Children's Medicine, P.C. for medical treatment.

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Contact Consent

O There is no one other than the mother or father who can be contacted regarding my child's lab results, billing information, and other PHI.

-OR-

O I give permission for the persons listed below to be contacted regarding my child's lab results and other PHI.

 Check here if same as "Parental Consent" section above _____.
Patient/Parent/Guardian Signature

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Children's Medicine, P.C. can leave normal results on the following phone number: _____

belonging to _____.
Full Name

Request Consent

O There is no one other than the mother or father who can request and/or pick up my child's forms, prescriptions, and other PHI.

-OR-

O I give permission for the persons listed below to request and/or pick up my child's forms, prescriptions, and other PHI.

 Check here if same as "Parental Consent section above _____.
Patient/Parent/Guardian Signature

 Check here if same as "Contact Consent" section above_____.
Patient/Parent/Guardian Signature

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Printed name of Patient/Parent/Guardian Printed name of other Parent/Guardian

Financial Policies

Children's Medicine, P.C. (CMPC) follows the American Academy of Pediatrics guidelines. CMPC is committed to meeting your child's health care needs. This financial policy is provided to give you an outline of our expectations.

Patient Responsibility and Insurance

Our providers participate in numerous insurance plans. Please remember every plan is different and has its own individual requirements. It is your responsibility to understand your benefit plan. If you do not understand your coverage, please call your insurance company or HR department at work. A phone number for the insurance is usually located on your health insurance card.

You are expected to know if well checks, vaccines, labs or any other procedures are covered or may apply to a deductible. Some lab work will be sent to an outside lab, the laboratory will bill you separately. CMPC may need to send you to an outside facility, it is your responsibility to make sure this is within your plan and/or if a referral is required. It is your responsibility to know if your well check is made in the timeframe allowed by your insurance company. We are more than willing to provide care within your insurance guidelines if you let us know at the time of each visit.

CMPC is contractually obligated by your insurance company to collect your copayments, deductibles and co insurances. Copayments are collected at the time of service. You are responsible for balances after the insurance has paid and payment is due with the receipt of the first statement. If CMPC does not participate in your specific plan, then you will be responsible for the day's charges at the end of the visit. Any services determined not to be covered by your plan will be your responsibility.

CMPC will file with most insurance companies. Please remember that your contract is a contract between you and the insurance company. Balances and/or unpaid claims over 60 days must be paid in full or financial arrangements made before any future appointments will be scheduled. CMPC must have a signed financial agreement and payments must be paid in accordance with the agreement or the account will be sent to a collection agency. If arrangements have not been made after 60 days the account will be transferred to a collection company. Unpaid balances transferred to the collection agency will result in family dismissal from the practice. Family may be re-instated to practice once balance been paid in full and a written request for re instatement is received.

We do not file automobile, liability or homeowner's insurances.

You must give correct insurance information. Invalid insurance information will result in full patient responsibility of your bill.

Proof of current, valid insurance and photo ID must be provided at the time of service.

We accept cash, check, American Express, Discover, MasterCard, Visa. Any check dishonored by your bank will result in a $35 return check fee and your account will be a cash only payment basis.

Appointments

CMPC schedules by appointment only. If you bring your child in without an appointment, you will be scheduled in the next available appointment time unless you have a true emergency.

If necessary to cancel a well exam or consult, CMPC requires 24 hours notice of cancellation. Sick appointments and follow ups must be cancelled 2 hours prior to appointment. Failure to cancel appointments in the appropriate timeframe will result in a $35 fee.

If you arrive to the office more than 20 minutes past your appointment time, you may be asked to reschedule. Continuous late arrivals may result in discharge from the practice.

After Hours Calls

CMPC providers are available on call 24 hours a day for calls that are urgent in nature. Our practice is charged per call for after hour calls to the nurse advice line, non-urgent calls may be charged $15 per call.

Forms/Medical Records/ Prior Authorizations

All medical records request must be submitted on CMPC's Authorization for Release of Health Information form. The fee for medical records are based on the number of requested pages, search retrieval & administration, certification fee and postage.
CMPC requires 7 -10 days to prepare records after release has been received.
There is a minimum $10 fee for administrative services for the completion of forms (unless completed at a well check exam).
There is a $25 fee for all prior authorization requests. Payment is required at the time of the request.

Financial Responsibility

CMPC will continue to bill the parent once the child turns 18 unless otherwise notified in writing.
The adult who signs a child into CMPC accepts the responsibility for payment. We will communicate treatment and payment with the parent present. Parents are responsible to communicate with each other about treatment and payment issues.
You will need to bring insurance card, photo ID and payment in full or payment required by insurance plan to every visit.
By signing below, the responsible party acknowledges that he or she has read and understands the financial policy. Failing to sign the financial policy may result in discharge from the practice.

_____ _____
Patient/Parent/ Guardian Signature Date

_____
Patient/Parent/Guardian Printed Name

Please list all patients:

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Insurance Authorization

Guarantor # _____

Signing this document will allow Children's Medicine, P.C. to file your insurance. It will also allow your insurance Company to send check(s) directly to Children's Medicine, P.C.

- I authorize the release of any information necessary to process any/ all claims
- I authorize payment of medical benefits to go to Children's Medicine, P.C.
- I understand that if my insurance company does not cover a service, I will be responsible for payment.
- I have read and understand the "Fees and Payment Policies"

_____
Patient/Parent/ Guardian Printed Name

_____ _____
Patient/Parent/Guardian Signature Date

Please list all patients covered on this policy:

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Full Name of Insured/Subscriber _____

Insured/Subscriber Social Security Number _____

Full Name of Insurance Company _____

ID/Policy/Member Number _____

Group Number _____

Date of Birth of Father _____Date of Birth of Mother_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Children's Medicine's Notice of Privacy Practices.
Parent name

_____ _____
Signature of Parent Date

Child's name and Date of Birth _____ _____

_____ _____

_____ _____