Patient Registration Form 18 & Older or Foster Parent

Caring Pediatrics

Today's Date: _____

Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.

Patient Information
Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F
Home Address: _____
City: _____ State: _____ Zip: _____
Mobile phone: _____ Email: _____

Parent/ Foster Parent Information
Parent Name: _____ Date of Birth: _____
Mobile Phone: ( ) _____Work Phone: ( ) _____

Insurance Carrier Information
Insured's Name: _____ Date of Birth: _____
Name of Insurance: _____
Home Address (if different from patient): _____
City: _____ State: _____ Zip: _____

Alternate Contact (relative or friend)
Alternate Contact Phone: ( ) _____
Relationship to patient: _____

Notice of Privacy Practices
I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about me or my child(ren), as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice of upon request.

☐ **I have read all of the above information and understand/ agree to all provisions therein regarding financial responsibility, permission for treatment and Notice of Privacy Practices**.

Name (print): _____

Signature: _____

Date: _____

Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:

Preferred Language:

Your Race
(select one primary)
☐ American Indian *or* Alaska Native
☐ Asian
☐ Black/African American
☐ Chinese
☐ Filipino
☐ Hispanic
☐ Japanese
☐ Multiracial
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown
☐ Other _____
☐ Decline to answer

Your Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown
☐ Declined to answer

** Please return this form to the Front Desk. Thank you. **

Caring Pediatrics

Patient Name:

Patient Date of Birth:

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

**** PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. ****
The parent/guardian who is present for office visits is the Billing Guarantor - see below for details.

SECONDARY INSURANCE (if any)

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby certify that the information provided here is true and correct. I authorize, Pediatric Healthcare Associates DBA Caring Pediatrics to release the information to my insurance company for processing of medical claims. I assign medical benefits to Pediatric Healthcare Associates for medical services performed. I understand that insurance benefits are determined by the contract that I hold with my insurance company, and that I am responsible for any fees not paid by the insurance company as stated in the policy. I also certify that the person signing the form will be listed as responsible party (Guarantor) for the child(ren) on this account. This is who will receive all the notices.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

☐ I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.

Billing Guarantor Name *(print)*

Date of Birth *(mm/dd/yyyy)*

Sex: ☐ **F** ☐ **M**

Address / City / State / Zip

( ) -
Primary Phone

Billing Guarantor Signature

Today's Date *(mm/dd/yyyy)*

Relationship to Patient:

☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about your child (as a patient of our practice) may be used and disclosed, and how you can get access to your child's individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Caring Pediatrics is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to him/her. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child's IIHI
- Your child's privacy rights in their IIHI
- Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

The following categories describe the different ways in which we may use and disclose your child's IIHI:

1. Treatment. Our practice may use your child's IIHI to treat your child. For example, we may disclose your child's IIHI as follows:

- To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.
- To write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for you.
- To treat or to assist others in the treatment of your child.
- To inform you of potential treatment options or alternatives or programs, such as our Asthma Program.
- To others who you have given permission to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- To other health care providers for purposes related to their treatment.
- To a parent guardian or other responsible person if the patient is a minor.

2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items provided by us for your child. For example, we may disclose your child's IIHI as follows:

- To contact your child's health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your child's insurer with details regarding your child's treatment to determine if the insurer will cover, or pay for, your child's treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your child's IIHI to operate our business. As examples of the ways in which we may use and disclose your child's information for our operations include, but are not limited to the following:

- To evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.
- To other health care providers and entities to assist in their health care operations under certain circumstances.
- To contact you and remind you of your child's appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- When we are required to do so by federal, state or local law.

C. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

1. Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if required by law to do so. For example:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Workers' Compensation. Our practice may release your child's IIHI for workers' compensation and similar programs.

9. Compliance. We are required to disclose your child's IIHI to the Secretary of the Department of Health and Human Services or his designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to section E.3. below.

D. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI

You have the following rights regarding the IIHI that we maintain about your child:

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask us not to contact you work. In order to request a type of confidential communication, you must make a written request to the Site Manager, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request that we limit the use and disclosure of your child's IIHI for treatment, payment and health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your child's care or payment for care, such as family members or friends. You must make your request in writing to the Site Manager. Under federal law, we must agree to your request and comply with your requested restrictions if:

- Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of health care operations (and is not for purpose of carrying out treatment); and,
- The medical information pertains solely to a health care item or service for which the health care provided involved has been paid out of pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is required by law or necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancelation and continue to apply the restriction to information collected before the cancelation.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Site Manager in order to inspect and/or obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your child's IIHI for non-treatment, non-payment or non-operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file your insurance claim. We also will not provide an accounting of disclosures made to you about your child, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Site Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Site Manager or visit our website at www.caringpediatrics.com

7. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.

Caring Pediatrics

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

_____ _____

Signature of Parent or Legal Guardian *Date*

_____ _____

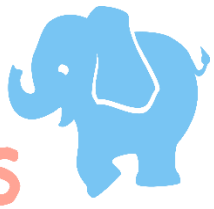
Print Name of Parent or Legal Guardian *Legal relation to child(ren)*

List each child that is seen at our practice (please print):

Child's First Name	Child's Last Name	Date of Birth

***** Please complete and return this page only to our Front Desk Staff. Thank you. *****

Caring Pediatrics



Thank you for choosing Caring Pediatrics to be your health care provider. Pediatric Healthcare Associates is committed to providing quality health care for your child. We are doing everything possible to hold down the cost of medical care. With that in mind we are giving you a copy of our financial policy to review. If you have any questions concerning our policy, please speak with someone from our billing department.

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE: Payment is required at the time of service unless other payment arrangements are made in advance. Participating health insurance plans may have a deductible, co-insurance, or copayment, which is the subscriber's responsibility to pay. Co-payments must be paid at the time of service regardless who brings the child to the office. The person accompanying the child is responsible for paying the co-payment at the time of service. The responsibility for payment for services for any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office. A discount is available for payment in full at time of service. If the co-payment is not made at the time of service, a billing fee will be assessed. We do not bill secondary insurance companies for co-payments.

METHODS OF PAYMENT

Acceptable methods of payments are cash, personal check, VISA, MasterCard, American

Express, or Discover. A service fee of $35.00 will be assessed for all returned checks.

OUTSTANDING BALANCES

Any charges remaining unpaid 15 days after the date of service are considered past due.

Past due accounts must make arrangements with the billing office prior to scheduling well appointments. School, camp or sports forms will not be provided for patients with past due

accounts unless arrangements for payments have been made with the billing office. Accounts over 90 days past due will be considered seriously delinquent and referred to our Collection Agency. Failure to provide payment for services rendered may result in discharge from the practice.

INSURANCE

We bill participating insurance companies as a courtesy. If you do not have insurance with which we participate, full payment is expected at time of service. Our offices cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Insurances have multiple plans that vary with employer group contracts. We ask that you be as familiar as possible with your own insurance plan. We will not change a diagnosis or visit reason to accommodate an insurance plan. Some insurance plans do not cover well exams. You must present your insurance identification card(s) at each visit to ensure correct billing, eligibility, and co-payment information. It is your responsibility to notify this office of any insurance change. If we have been unable to resolve your claim with your insurance company within 45 days of date of service, we will try to notify you and ask that you check into the delay. If the claim is still unresolved after 60 days, whether or not we have notified you previously, we will request payment in full of you directly. You are ultimately responsible for all charges. It is essential that you enroll newborn infants with your insurance carrier within 30 days of the child's date of birth. If the child is not enrolled, the child has no insurance coverage under your policy. If you fail to do this within 30 days following the child's birth you will be billed for the services provided.

RESPONSIBILITY FOR MEDICAL CARE

Every minor child, under the age of 18 must be accompanied by a parent/legal guardian or by an adult who has obtained written consent for treatment from the parent/legal guardian. An exception is an adolescent presenting for confidential services, which we are permitted by state law to provide without notifying the parent.

REFERRALS

If you are enrolled in any insurance plan that requires a referral, you must receive the referral from our office BEFORE SEEING SPECIALIST. This must be done in advance with the referral coordinator and you must allow adequate time to process the referral. Referrals are provided at the discretion of your doctor, based on their knowledge of your child’s health issues. A visit may be required.

MISSED APPOINTMENTS/LATE CANCELLATIONS Missed appointments are costly to us, to you and to other patients who could have used the time set aside for your child. Cancellations are requested 24 hours in advance. There will be a $50.00 charge for missed appointments or appointments that are canceled less than 24 hours in advance. Our staff will attempt to call to remind you of the appointment: however, the responsibility to keep the appointment is yours. You may be asked to confirm your appointment 2 days in advance. Excessive missed appointments may result in discharge from the practice. There is a $10.00 administration fee for any paperwork requiring a doctor’s signature to be paid at time of pickup.

Understanding My Bills & Copays

• No copays are required for most preventive care services (or care provided to Medicaid-enrolled children)

• Many times parents have extra concerns about their child's health or behavior that requires extra time and is not part of a routine preventive care visit.

• For the convenience of children and families, and when schedules permit,

we try to address these added problems as part of your child's "check up" office visit.

• If your child happens to be sick during a well check and extra time is needed to evaluate for treatment we are required to bill an office visit.

• In this situation, as per guidelines developed by the American Academy of Pediatrics, we will bill for the added office visit time.

• Several insurance companies are now asking that we collect a co-pay from families when we address these extra problems in addition to the well child visit.

• If more convenient, we can also schedule a separate appointment to address these additional health concerns.

• Our goal is to deliver the very best quality care to your child and family comprehensive, convenient and fairly priced.

• Please bring any medications, prescription bottles, asthma devices and any other pertinent equipment with you to every visit to make the most out of it.

I have read and understand the Pediatric Healthcare Associates, DBA Caring Pediatric's Financial Policy. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for cost of collections. I certify the insurance information I have given is correct. I authorize release of any medical information to process a claim. I authorize payment to be made directly to Pediatric Healthcare Associates. I permit a copy of this authorization to be used in lieu of the original. I authorize the release of information to other medical providers that my children have been referred to. If I agree to be placed on a payment plan to collect an outstanding balance, I agree for Pediatric Healthcare Associates DBA Caring Pediatrics to charge the credit card I provided.

Child's Name:_____D.O.B:_____

Signature:_____Date_____

If you need assistance or have questions, please contact our billing office