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|  **ROXBURY PEDIATRICS** **KIMBERLY S. KLAUSNER, M.D. GUY EFRON, M.D.**  |
| PATIENT |  | SEX |  | BIRTHDATE |  |
| PARENT 1 |  **DOB** |
|  HOME ADDRESS |  |  |
|  |  CITY |  | STATE |  | ZIP |  |
|  HOME PHONE |  | CELL PHONE |  |
| PARENT 2 |  **DOB** |
| - List both addresses if parents living separately - |
|  HOME ADDRESS |  |
|  |  CITY |  | STATE |  | ZIP |  |
|  HOME PHONE |  | CELL PHONE |  |
| **PARENT 1’S SS#** |  | PARENT 1’S DRIVERS LIC# (include state) |  |
| **PARENT 2’S SS#** |  | PARENT 2’S DRIVERS LIC# (include state) |  |
| PARENT 1’S OCCUPATION |  | BUSINESS PHONE |  |
| EMPLOYERS ADDRESS |  |
| PARENT 2’S OCCUPATION |  | BUSINESS PHONE |  |
| EMPLOYERS ADDRESS |  |
| IS PATIENT COVERED BY INSURANCE? |  | NAME OF COMPANY |  |
| IF GROUP INSURANCE, NAME OF GROUP |  |
| REFERRED BY |  |
| EMERGENCY CONTACT |  | PHONE  |  |
|  |
| **ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE INFORMATION**I hereby authorize direct payment of medical benefits to Roxbury Pediatrics for services rendered. I understand that I am financially responsible for any balance not covered by my insurance and for payment regardless of insurance pending. I hereby authorize Roxbury Pediatrics to release any medical or incidental information that may be necessary to process my claim.Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**The HIPAA Privacy Rule establishes national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.Our **Notice of Privacy Practices** describes in greater detail how your health information may be used and disclosed, and how you can access your information. **□ I would like a copy of the Notice of Privacy Practices** **□** **I do not want a copy of the Notice of Privacy Practices**Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **AUTHORIZATION TO RENDER CARE**I hereby authorize Drs. Klausner, Efron, and Jumaily and the Staff of Roxbury Pediatrics to render any medical care necessary to my child. In the event that I am not available and no other legal guardian is available at the time my child is brought to the office, I authorize, in advance, that care may be rendered in my absence.Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  **ROXBURY PEDIATRICS** **KIMBERLY S. KLAUSNER, M.D. GUY EFRON, M.D.**  |

Dear Parent:

**Please sign below where there is a blank line** to acknowledge that you have read and understand our office policies regarding billing and payments.

* For patients with no insurance coverage or with insurance where we are not a contracted provider, payment is due at time of service. We accept cash, checks, Visa, and MasterCard. \*We do not accept the discounted rates of providers with whom we are not contracted.
* If we are a participating provider with your insurance plan, we will bill your insurance carrier for all covered services. We are currently providers of *Blue Cross, Blue Shield, Cigna, & Aetna PPOs* only. You are required to pay for all co-payments at the time of your visit.
* For amounts due after the insurance has processed the claim (such as unmet deductibles, co-insurance, or non-covered services), we will send you three consecutive statements at 30 day intervals.
* You have 30 days after the third statement is sent to pay in full the balance indicated on the statement. **If payment is not received in full**, you will receive a notification and your account will be forwarded to a collection agency for further action. A **30%** collection fee will be applied to the bill and your family will be discharged from the practice.
* We value your time and expect you to value ours. Any appointment missed or cancelled without 24-hour notice will be subject to a $50 missed appointment fee.

**It is the responsibility of the patient to notify our office of any change in insurance, mailing address, or contact information.**

*Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to this office.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child name Child name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child name Child name

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|  **ROXBURY PEDIATRICS** **KIMBERLY S. KLAUSNER, M.D. GUY EFRON, M.D.**  |

**Consent to Email and/or Text Message for Healthcare Communications**

Dear Parent:

We will soon have the ability to email and/or text you, reminding you of your appointments and other healthcare related communications.

Parents and patients in our practice may be contacted via email and/or text messaging to remind them of an appointment, to obtain feedback on their experience with our healthcare team, and to provide general health reminders/information.

If you would like to receive this feature in the future, please read the consent below and sign.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Roxbury Pediatrics.

**\_\_\_\_\_ (Parent initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

**(\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_ (Patient initials)** I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is

**E-mail Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that this request to receive emails and/or text messages may apply to all

future appointment reminders/feedback/health information unless I request a change in

writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child name Child name

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Child name Child name