New Patient Packet

A Welcome...

Welcome to our practice. We are board certified specialists in the provision of health care to infants, children, and adolescents. Everyone in this practice operates as a team member. As such, we act as advocates on your child's behalf. By providing on-going primary care for your child through our group, you are ensuring the best care possible. We look forward to participating in your child's health care. To better serve you, all visits are by appointment only. Please be on time in order to help keep us on schedule. If you are late, you may be asked to reschedule. We require 24-hours' notice of cancellation of appointments. There will be a service charge for missed appointments without proper notice. When calling our office, be sure to provide the name of your child and the type of visit needed. Please have the scheduler repeat to you all of the appointment information at the end of your conversation to confirm that it is correct. If you have more than one child that needs to be seen, let the scheduler know so that an appropriate amount of time is allowed. If your child is sick, we ask that you call as early as possible in the morning for an appointment. Appointments can be made or canceled after 7:15 a.m. Please try to make your next checkup and/or follow-up appointment while you are still in the office.

Telephone Calls...

If you are calling with a true medical emergency, please call 911. We have centralized scheduling; all appointments can be made by calling (804) 320-1353 and then selecting option 2. Daily sick appointments are made after 7:15 a.m. If you would like to reach a doctor, or need medical advice, please leave a message on the medical advice line. We will need the following information when you leave any message: the child's name, date of birth, nature of your call and a telephone number where you can be reached. All calls are returned in order of medical necessity.

Referrals...

It is your responsibility to know specifics of your insurance policy. Please be sure to take proper steps when seeking care outside of our office. We require 72-hours' notice when acquiring a referral or authorization number. Your insurance company does not allow us to back date any referral or pre-certification.

Emergencies...

For all true medical emergencies please call 911. During our office hours, if your call is urgent, please state the nature of your call immediately and you will be connected with our medical advice staff. If you have an emergency situation after hours, in the evening, on a weekend or on a holiday, a nurse may be reached either by calling (804) 320-1353 or (804) 739-8166. You will hear a recorded message with instructions on how to contact the on-call nurse. We do ask that after hours' calls are limited to **emergency and urgent care situations only**. The nurse will return your call as soon as possible. **All after hours in-office visits are rendered at our Chippenham/ Old Jahnke Road Office location only.**

LANGUAGE LINE: Commonwealth Pediatrics offers the use of language phone line for those who speak a language other than English. We also offer interpreters for the deaf. (interpreter visits require a two-day advance notice.)

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

HIPAA Consent Form

(Health Insurance Portability and Accountability Act of 1995)

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our NPP before signing this consent. As provided in our NPP, the terms or our NPP may change, in accordance with changes in Federal regulations. A current copy is attached to this form and may also be viewed by visiting our website, www.commonwealthpeds.com.

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

If you have any questions, you may contact our Privacy Officer, Mr. Richard Meador at (804) 320-1353 ext. 110.

Print Name: _____ Signature: _____

Child Name: _____ Date: _____

Child Name: _____ Date: _____

Child Name: _____ Date: _____

Notice of Deemed Consent

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

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_____

Parent or Patient/Legal Guardian Name

_____

Parent or Patient/Legal Guardian Signature

_____

Date

Assignment of Benefits/Guarantorship of Account

We must emphasize that as medical care providers, our relationship is with your child and not your insurance company. While the filing of claims is a courtesy that we extend to you, you are responsible from the date of service is rendered. If we do not participate with your insurance company, you are responsible for all fees at the time of service and must file for reimbursement from your insurance company. For your convenience we accept cash, check, and credit (American Express, Discover, MasterCard, and Visa). **Commonwealth Pediatrics will hold the person signing this form fully financially responsible for all balances due regardless of the insured party, unless; unless a signed court order is provided proving financial responsibility lies elsewhere.**

We will provide you with any information you require to assist you with your claim. We look to the party receiving the services for payment and cannot be expected to wait for the conclusion of court cases or insurance disputes. We realize that temporary financial problems may affect timely payment of your account. We encourage you to contact us promptly prior to your office visit for assistance in management of your account if any problems arise.

Should a check be returned to us for insufficient funds a $25.00 service charge will be applied to your account. Balances older than 60 days may be subject to a hold on account prohibiting certain types of appointments from being scheduled unless the balance is resolved or arrangements are established. If collection attempts by our office on your account prove to be unsuccessful, then you will be dismissed from the practice and your account will be turned over to and outside source that **will** report to the credit bureau. Chagres may also arise from broken appointments, especially those within 24-hours' notice.

We will gladly discuss charges prior to your office visit and any question relating to your insurance. Please realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
- Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area referred to by insurance companies as **UCR-usual, customary, and reasonable.**
- Not all services are a covered benefit in all contracts. It is your responsibility to know what services are covered by your policy. Please contact your insurance company to go over the medical coverage for your child/children. This includes how many well child checks (check-ups) your child is allowed per year (birth to 12 months, 2-3 years, and annual visits after 5 years). Check with the insurance company to make sure that vaccinations are a covered benefit with their policy. If the child goes over the amount of allowed well child check-ups or receives vaccinations that are not considered a covered benefit, we will expect payment in full for these services. Should your insurance require services to be rendered by another provider it is your responsibility to notify us of the provider and facility used (e.g. lab procedures, x-ray, and durable medical equipment).

ADDITIONAL CHARGES DURING WELL CHILD CHECK-UPS: Sometimes a child is ill on the day his/her physical is scheduled. When this happens, our physicians recommend that you bring your child in to be seen and treated for the illness, and reschedule the check-up for a date and time when your child is feeling better.

Sometimes, if your child has a simple illness such as an earache, sore throat, or fever, treatment for the illness and the check-up can occur at the same visit. Please be aware that these are considered two separate visits and are required to be charged as such. This may result in an additional copay or application of your deductible for a visit that would otherwise have been considered preventative. Please notify the receptionist of your child's illness and of your choice to be seen for both visits together or to reschedule the check-up portion. Thank you for your cooperation.

By my signature, I attest that I have read and understood the above policy.

_____

Parent/Guardian/Guarantor Signature

_____ _____

Relationship to Patient Date

Registration Form

Please fill out the form completely and include all children on form

1st Child's Name: _____ Date Of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Primary Language: _____

2nd Child's Name: _____ Date Of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Primary Language: _____

3rd Child's Name: _____ Date Of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Parent/Guardian Name: _____ Date Of Birth: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Relationship To Patient: _____

Parent/Guardian Name: _____ Date Of Birth: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Relationship To Patient: _____

Do you consent to send/receive health information regarding your child via our secure patient portal? *(please circle one)* Yes No

If yes, please provide the email address below that you would like linked to your account _____

***All communication containing Protected Health Information (PHI) should be transmitted to or from Commonwealth Pediatrics via our secure patient portal. Any communication not transmitted to Commonwealth Pediatrics through the portal poses a risk of being accessed inappropriately. To protect patient privacy, Commonwealth Pediatrics will not respond to any communication containing phi not submitted through our secure portal.*

Permission To Disclose Protected Health Information (PHI)

Patient(s) Name:_______________________________ Date of Birth: ______________

Name _______________________________ Date of Birth:______________

Name:_______________________________ Date of Birth:______________

Commonwealth Pediatrics is dedicated to protecting the privacy of our patients. Except where required by law, Commonwealth Pediatrics will **NOT** authorize treatment, disclose, or discuss any information regarding your child's health or financial status with anyone other than the parent or legal guardian, unless otherwise listed in the chart below. ***Please consider adding certain people such as grandparents, aunts, uncles, siblings over the age of 18, babysitters, or other care providers that may need to seek treatment or advice in your absence.***

Name	Relationship To Patient	Phone	Permission To Do The Following: *(check all that apply)*
		______________ *OK to leave detailed message?* ❏ *YES* ❏ *NO*	❏ Bring in for an appointment ❏ Seek medical advice ❏ Obtain lab/procedure results ❏ Pick up medication ❏ Discuss financial/insurance info
		______________ *OK to leave detailed message?* ❏ *YES* ❏ *NO*	❏ Bring in for an appointment ❏ Seek medical advice ❏ Obtain lab/procedure results ❏ Pick up medication ❏ Discuss financial/insurance info
		______________ *OK to leave detailed message?* ❏ *YES* ❏ *NO*	❏ Bring in for an appointment ❏ Seek medical advice ❏ Obtain lab/procedure results ❏ Pick up medication ❏ Discuss financial/insurance info

As a parent or legal guardian do you consent to receive a detailed message regarding your child's care or account in the event a member of our staff is unable to reach you? (please check one) ❏ *YES* ❏ *NO*

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

By signing below, I give permission for the person(s) listed in the table to receive the indicated protected health information about my child. I understand that this form is legally binding, and I have the right to refuse to sign this authorization and my child's treatment will not be conditioned on signing. The information is released at the parent/legal guardian, or at the time the child reaches 18 years of age.

Signature of Parent/Guardian:_______________________________ Date: ______________________

Printed Name: _______________________________ Relationship to Patient: ______________

PLEASE READ EACH OF THE ITEMS BELOW BEFORE SIGNING.
WITHOUT YOUR SIGNATURE, WE CANNOT SEE YOUR CHILDREN.

I **AUTHORIZE** Commonwealth Pediatrics to render medical care to my child/children. I authorize payment from my insurance carrier (if applicable) to Commonwealth Pediatrics for incurred charges. I also authorize release of medical information to my insurance carrier.

I **UNDERSTAND AND AGREE** that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information above and have completed the above answers; I certify that this information is true and correct to the best of my knowledge. I will notify you immediately of any change in the above information.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____