Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

Patient Registration Demographic Form

Patient Information:

Last Name _____ First Name _____ MI _____
D.O.B _____/_____/_____ Gender _____ Social Security # _____-_____-_____
Primary Language _____

(please circle)
Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined to specify
Race: White / American Indian or Alaskan / Asian / Black or African American / Hawaiian or Pacific Islander / Declined to specify

Preferred Primary Doctor: Dr. Michele Hensley / Dr. Jennifer Miller / Dr. Michelle Golla

Patient Address:
Physical Address _____
Mailing Address/PO Box (if applicable) _____
City _____ County _____
State_____ Zip Code _____

Who lives in the household (please list by name and relation)?
_____

Patient Insurance:
Primary Policy: Policy Holder Name _____
Policy Holder Birth Date _____/_____/_____ Policy Holder Gender _____
Policy Holder SS# _____ Relation to patient _____
Insurance Carrier _____
ID#_____ Group # _____
Policy Effective Date _____

Secondary Policy: Policy Holder Name _____
Policy Holder Birth Date _____/_____/_____ Policy Holder Gender _____
Policy Holder SS# _____ Relation to patient _____
Insurance Carrier _____
ID#_____ Group # _____
Policy Effective Date _____

Contact 1 – Relationship to Patient: Mother / Father / Other _____
Last Name _____ First Name _____ MI _____
Lives with patient? Yes / No Maiden Name (if applicable) _____
SS # _____ Date of Birth _____/_____/_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Work Phone (_____) _____-_____ Email _____
Employer_____ Occupation _____
Address (if different than Patient Address) _____

Contact 2* – Relationship to Patient: Mother / Father / Other _____
Last Name _____ First Name _____ MI _____
Lives with patient? Yes / No Maiden Name (if applicable) _____
SS # _____ Date of Birth _____/_____/_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Work Phone (_____) _____-_____ Email _____
Employer_____ Occupation _____
Address (if different than Patient Address) _____

How would you ideally prefer to be contacted regarding (please circle):

Medical Issues: *Home phone / Work phone / Cell phone*
Appointment Reminders: *Home phone / Cell phone / email / text to cell phone*
Recall Notices: *Mailing address / Home phone / Work phone / Cell phone / e-mail / Text*
General Practice Notices: *Mailing address / Home phone / Cell phone / e-mail / Text*
Patient Portal Notifications: *Text to cell phone / e-mail*
*If Contact 2 will need to be notified *in addition to* Contact 1, please list contact preferences -
_____

Additional Contact Questions:

Who should receive billing statements _____
Marital Status of Parent(s) Married / Single / Divorced / Widowed / Separated
Patient/Child Cell Phone (_____) _____-_____ (if applicable, otherwise leave blank)

Emergency Contacts other than parents:

1. Name_____ Relationship _____
   Phone (_____) _____-_____
2. Name_____ Relationship _____
   Phone (_____) _____-_____

If parents are divorced, or separated, or if there are any custody issues, please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction:

_____

****If you desire for any person to be assigned restricted access to medical information – please request a Restriction of Disclosure form at the front desk****

Form completed by:

Last Name _____ First Name _____

Relationship to Patient _____

Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

Pediatric Associates of Lancaster, Inc.
Office and Financial Policy

Thank you for choosing Pediatric Associates of Lancaster for your medical care. We are committed to providing you with the highest quality medical care possible in a cost-effective manner. We are happy to discuss with you any questions you may have concerning your account. Our goal is to provide and maintain a good physician-patient relationship. Informing you in advance of our policies allows for a balanced flow of communication for all.

Please read each section carefully and sign where indicated to acknowledge your understanding. If you have any questions, please feel free to ask for clarification from our staff.

Things to bring to each appointment:

- Health Insurance Card(s) – be sure to bring all active and applicable insurance cards
- Driver's license
- Method of payment (we accept, cash/check/credit card payments)

Appointments:

- We value the time we have set aside to see and treat your child. If you require cancelling your appointment, please notify our office immediately so that we may offer the appointment slot to another patient.
- If you/your child/children miss 2 appointments without giving prior notice, you will receive a letter of warning. If there is a 3rd missed appointment without prior notification, you will be asked to leave the practice and find care elsewhere.
- If you are more than 15 minutes late for an appointment without notifying the office, it may be necessary to re-schedule or cancel the appointment.
- We strive to minimize wait times, but emergencies do occur that may take priority over the scheduled appointments, and in these instances, we appreciate your patience and understanding.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals before your scheduled appointment (failure to confirm this information may result in your responsibility for any/all charges).
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status, and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Evening, Weekend and Holiday Differential:

- Evening, weekend, and holiday office hours are services that we provide for the convenience of our patients.
- Due to additional cost for staffing and office-related expenses during these times, you will be charged a differential for this availability of care. We will bill your insurance company for the differential, however not all insurance plans cover this charge. Depending on your level of coverage – you may be responsible for payment of this additional fee.
- Please be sure to schedule your appointment(s) during our regular office hours, if you do not want to be responsible for the differential.

Insurance Plan:

- It is your responsibility to keep our office updated with all your current/correct insurance information. **If the insurance information you provide to our office is incorrect – you will be responsible for payment and for submission of the charges to the correct plan for reimbursement.**
- Your insurance carrier may require your primary care physician to be on file and/or to appear on your insurance card. Please ensure that you have updated your insurance company with our office information as your child's primary care physician.
- It is your responsibility to understand your insurance benefits with regards to covered services and participating laboratories. There

may be limitations on annual well care, sports physicals, hearing and vision screenings, etc. You are responsible for verification of insurance benefits and knowledge of your financial responsibility for services provided by our office for your child.

- According to your insurance plan, you are responsible for all co-payments, deductibles, coinsurance, and non-covered services.
- If your insurance carrier requests other information from you, such as evidence of coordination of benefits, they will not reimburse our office until you provide the information. If you fail to comply in a timely fashion, you will be responsible for the charges.
- It is your responsibility to know if a written referral or authorization is required to see a specialist, whether pre-authorization is required prior to a procedure (example: MRI or CT scan), and what/how services are covered.

Your relationship with your insurance carrier:

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- Insurance carriers require that newborn infants are enrolled within 30 days of birth. If you fail to enroll your infant within 30 days of birth, the child will not have insurance coverage and you will be responsible for any charges.

Payment at time of service:

- Payment (co-payment, personal balance payment, etc.) for our services is due at the check-in – regardless of who accompanies the patient to the office, if the patient is of driving age and arrives to the appointment alone, and regardless of any judicial proceedings or judicial decrees. Failure to produce required payment at check-in may result in your appointment being rescheduled.
- We accept cash, check, credit and debit cards.
- If you receive more than one type of service on the same day, or during the same visit, you may be responsible for more than one co-payment.
- If there is a personal balance due on your account that requires payment – we will ask for a full, or partial, payment towards that balance at check-in.

Financial Responsibility:

- Patient personal balance invoices are compiled and mailed once your insurance carrier has processed your claim. Your payment is due immediately upon receipt of your invoice from our office.
- We offer an automatic payment program for balances to be paid over time. We require a minimum payment per month based on your balance to ensure timely collection.

Self-Pay Patients:

- We offer a reasonable discount for our cash paying patients with no insurance coverage. We will give you an estimate of what will be due at the time of service and/or payment towards a personal balance due at the time of service, if applicable.

Medicare/Medicaid Patients:

- Please make sure to have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan.
- Please ensure that your enrollment/id card is current before your appointment to ensure the correct agency is billed for your service(s).

Minor Patients:

- The parents(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor, as well as payment in full for services provided.
- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parents that are not the patient, unless otherwise documented.
- *Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient.*

Auto Accidents/Workers' Compensation:

- Motor Vehicle Accidents (MVAs) will be filed with your auto insurance company as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in your responsibility to pay.
- Our office will send appropriate workers' compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full, from you, within 30 days of receipt of our bill.

Lab/Hospital Charges:

- Any services provided by a lab or hospital is a contract between you and the lab or hospital. Any dispute with these outside facilities is your responsibility and not that of our office.
- It is your responsibility to know which procedures your insurance company will or will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Referrals:

- Advanced notice is needed for all non-emergency referrals. Please allow 3-5 business days for processing.

- It is your responsibility to know if a selected specialist participates in your plan.

Collections and Outstanding Personal Balances:

- If you are unable to pay an outstanding personal balance in a single payment, we will be pleased to work with you on a payment plan. We strongly recommend a good faith down payment (example: 25% of balance) along with enrollment in an automatic payment plan to ensure that the balance will be paid in a timely manner. A minimum of $20 per payment is required if paying with our automatic payment plan or by credit card payment. Any changes to an agreed payment plan will require ample notice and agreeance from our billing office.
- Please contact our billing office to review and establish options for payment on personal balances with our office.
- If no payment plan has been established and no payment has been received past 60 days from date of first invoice – we may submit your account to our collection agency for collection of funds.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

Insufficient Funds:

- You are responsible for any bank fees associated with failed payments due to insufficient funds.

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active, or past due, personal balances are paid in full.
- Refunds less than $10.01 will not be issued, unless requested, and will be credited to your account at our practice.

Prescription Refills:

- For medication refills, we require a 48-hour notice, during regular business hours. Please plan accordingly.

Transfer of Records:

- If you transfer to another physician, we will provide a copy of your immunization record and a summary of your visits to your new physician, free of charge, as a courtesy to you. We require a 48-hour notice.
- We provide records of your child's visits (including consultation from specialists) for services provided at our offices only. For any previous records, you must request the directly from your previous doctor(s).

Office and Financial Policy Consent

By signing this document, I, _____, have fully read and understand the office and financial policy of Pediatric Associates of Lancaster, Inc. I hereby consent to allow Pediatric Associate of Lancaster, Inc. to contact me via: (check all that apply)

___ Home Phone: (_____) _____-

___ Work Phone: (_____) _____-

___ Cell Phone: (_____) _____-

___ Email: _____@ _____

I understand and consent to Pediatric Associates of Lancaster, Inc. to use an automatic dialer to contact me and/or leave messages regarding the patient. I will cooperate with the billing department of Pediatric Associates of Lancaster, Inc. to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. If the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment of all services rendered to that patient herein.

_____ _____/_____/_____

Printed name of patient/mother/guardian Month Day Year

_____

Signature of patient/mother/guardian

_____ _____/_____/_____

Printed name of father/parent/guardian – if applicable Month Day Year

_____

Signature of father/parent/guardian – if applicable

Please return this signed policy to the front desk. A copy will be provided to you upon request

Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by (please print): _____

This consent applies to (name of child): _____

Signature: _____ Date: _____

PEDIATRIC ASSOCIATES OF LANCASTER
LET'S GROW STRONG TOGETHER

Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388

Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

New Patient Questionnaire

CHILD'S NAME _____ DATE OF BIRTH _____

PREVIOUS PHYSICIAN _____ TODAY'S DATE _____

LAST SEEN _____

PREGNANCY:

1) Mother's age @ birth of child _____
2) Any illness during pregnancy? No Yes
   _____
3) Take any medications except vits/iron? No Yes
   What: _____
   _____

LABOR:

1) Vaginal or C-section
2) Problems with labor? No Yes
   _____
   _____

NEWBORN:

1) Was baby on time? No Yes
2) Birth weight _____
3) Circle any problems:
   Blueness Breathing Jaundice Infection Eating
4) Where was baby born?
   _____

PAST MEDICAL HISTORY:

1) Allergies to medication? No Yes
   If so, what? _____
   _____
2) Hospitalization? No Yes
   If so, what? _____
   _____
3) Surgery? No Yes
   If so, for what? _____
   _____
4) Chronic medical problems? No Yes
   _____
   _____
5) Serious injury? No Yes
   _____
   _____
6) Routine Medications? No Yes
   _____
   _____
7) Immunizations up-to-date? No Yes

FAMILY HISTORY:

	Age	Health Problem
1) Child's Father's Name		
Child's Mother's Name		
Child's Brother/Sister		

1) Circle any disease in immediate family member (parent, grand-parent, brothers, sisters, etc):

Anemia Allergy Diabetes Asthma High Blood Pressure
Heart trouble Tuberculosis Mental Illness Drug Usage
Alcohol problems STD Cancer AIDS Epilepsy
Bleeding problems High Cholesterol Heart disease under 50
ADHD

REVIEW OF SYSTEMS:

1) Does your child have:

Trouble seeing	No	Yes
Crossed eyes	No	Yes
Frequent ear infections	No	Yes
Trouble Hearing	No	Yes
Heart Murmur	No	Yes
Chronic Cough	No	Yes
Frequent abdominal pain	No	Yes
Frequent urinary tract infection	No	Yes
Other problems?	No	Yes

_____
_____

SAFETY: (circle)

1) Do you live in a: house apartment mobile home
   other _____
2) Are there smokers in the house? No Yes
3) Is there a smoke alarm on each floor? No Yes
4) Are there any problems with the condition of your home:
   (peeling paint, insects, rates/mice) No Yes
5) How old is your home? _____

PEDIATRIC ASSOCIATES OF LANCASTER
LET'S GROW STRONG TOGETHER

Welcome to our Patient Portal!

We are pleased you are interested in our Patient Portal!

Enrollment in the Patient Portal will allow you to access the following features to help gain better access to your child's information and coordination with our Doctors and staff:

View:

- Immunizations records
- Allergies
- Growth Charts
- Summary of visits (well and sick)
- Prescribed Medications
- Lab Results

Request:

- Well child appointments
- Refill of medications
- Copy of school forms/sports physicals/etc.

Access to:

- Office Policies and Forms

Enrollment in our Patient Portal is easy!
Please Complete the information below and
follow the directions for quick and easy enrollment.

- Go to our portal website **https://portal.palsmds.com**
- Sign in with your email address and temporary password (see below)
- Verify your account information and make any changes necessary
- Enjoy and explore all the options available to you on our Patient Portal!
- Please call our office with any questions regarding enrollment or navigating the Patient Portal

Parent Name: _____ **Date:** _____

Patient Name: _____

Your email address: _____

Your temporary password is: _____

Your security question ANSWER is: _____

Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * 740-687-6386 phone * 740-687-1388 fax
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP
www.palsmds.com