Pediatric Associates of Lancaster

Patient Registration Demographics

Last Name:_____ First Name:_____MI:_____
D.O.B _____/_____/_____ Sex:_____
Primary Language:_____
Ethnicity: *Hispanic/Non-Hispanic/Unknown*
Race: *Asian/Black/Hawaiian/White/American Indian*

Mailing Address:
Street or PO Box_____
City _____
State_____
Zip Code _____

Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____ (for *Mother/Father*)
Cell Phone: (_____) _____-_____ (for *Mother/Father*)

Who lives at this household? _____

Are parents: *Married/Single/Divorced/Widowed/Separated*

Insurance:
Primary Policy: Policy Holder's Name:_____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Policy Holder SSN:_____ Relation to patient:_____
Insurance Carrier:_____
ID#_____ Group # _____
Policy Effective Date:_____

Secondary Policy: Policy Holder's Name:_____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Policy Holder SSN:_____ Relation to patient:_____
Insurance Carrier:_____
ID#_____ Group # _____
Policy Effective Date:_____

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Mother's Information (or Contact 1)

Name:_____ Lives with patient? Yes / No
Social Security Number:_____ Date of Birth: _____/_____/_____
Work Phone (___) ____-_____ Cell Phone: (___) ____-_____
Home email:_____
Employer: _____ Occupation: _____

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

Medical Issues: Home phone/ Work phone/ Cell phone/ email
Appointment Reminders: Home phone/ Cell phone/ email
Recall Notices: Home address/ Home phone/ Work phone/ Cell phone/ email
Billing Statements: Home address/ email
General Practice Notices: Home address/ Home phone/ Cell phone/ email
Patient Portal Notifications: Cell phone/ email

Father's Information (or Contact 2)

Name:_____ Lives with patient? Yes / No
Social Security Number:_____ Date of Birth: _____/_____/_____
Work Phone (___) ____-_____ Cell Phone: (___) ____-_____
Home email:_____
Employer: _____ Occupation: _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment reminders, recall notices, billing statements, practice notices and patient portal notifications please list their preferences here:_____
_____

Additional Contact Questions:
*Who should receive billing statements?*_____
May all contacts have access to the patient's records electronically? Yes / No

If parents are divorces or separated 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:*_____
Emergency Contacts <u>other than parents:</u> (please provide name and relationship)
1. _____ Phone: _____
2. _____ Phone: _____

PEDIATRIC ASSOCIATES OF LANCASTER

1550 Sheridan Drive • Suite 102 • Lancaster, Ohio 43130-1303

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, grandparent, 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, INC.
ROBIN L. RHODES MD, FAAP
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Lancaster, Ohio 43130
(740) 687-6386
Fax (740) 687-1388

Office and Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our policies allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, please ask.

Appointments

1) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, please notify us so that we may offer the appointment slot to another patient.
2) If you are more than 15 minutes late for your appointment without notifying us, it may be necessary to reschedule or cancel the appointment. We will do our best to see you, but it may not always be possible.
3) We strive to minimize wait time; however, emergencies do occur and must take priority over a scheduled visit. Of course we would do the same for you in an emergency, and we appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company to learn whether the visit will be covered as a healthy (well-child) visit and if any scheduled immunizations will be covered. If immunizations are not covered, you may obtain them at your local health department for a reduced cost.

Initial:_____

Insurance Plans

1) It is your responsibility to keep us updated with all of your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment for the visit and for submission of the charges to the correct plan for reimbursement.**
2) As your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for our charges.
3) It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories. Not all plans cover annual healthy (well) physicals, sports physicals, hearing and vision screenings, or other procedures. If these are not covered, you will be responsible for payment. For children younger than 2 years, your insurance may limit the number of covered well visits per year. If you exceed the number of visits, your insurance company will not pay and you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure (such as MRI or CT scan), and what services are covered.

Initial:_____

Referrals

1) Advance notice is needed for all non-emergency referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, the physicians must approve referrals before they are issued and we must have a current insurance card on file.

Initial:_____

Forms

1) There is no charge for school, daycare, camp or sports forms we complete and/or copy at the time of your child's visit. However, we reserve the right to charge a $5 fee for replacing or filling out additional forms that are not presented at the time of the visit. Please allow 3 days for completion of forms.

Initial:_____

(Over)

Financial Responsibility

1) Payment for our services is due at the time the service is provided, *regardless of who brings the child to our office and regardless of any judicial proceedings that may be in progress or judicial decrees.*

2) If you do not have any health insurance coverage, we offer a discount for full payment received on the day services are provided.

3) We accept cash, checks, Visa, MasterCard, and Discover credit and debit cards.

4) According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances, and non-covered services.

5) **You are required to present your current insurance card(s) at every visit.** We require a photocopy of your current insurance information.

6) 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.

7) If your insurance carrier requests other information such as evidence of coordination of benefits, they will not reimburse us until you provide it. If you fail to comply in a timely fashion, you will be responsible for the charges.

8) Patient balances are billed after receipt of your insurance plan's explanation of benefits (EOB). Your payment is due upon receipt of our statement.

9) If you are unable to pay any outstanding balance in a single payment, we will be pleased to work with you on a payment plan. Once we agree upon a payment plan, please notify us if you are unable to make a payment or if you need to change the arrangement. In cases of nonpayment and failure to communicate with us, we may submit your account, along with a 40% collection fee, to our collection agency.

10) Prior to a physical or well child visit being scheduled, prior balances must be paid in full unless a payment plan is in place and is in good standing.

11) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.

12) You are responsible for bank fees associated with checks returned for insufficient funds.

Initial: _____

Prescription Refills

1) For medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly.

Initial: _____

Transfer of Records

1) 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 48 hours notice.

2) We provide records of your child's visits (including consultations from specialists) provided here at Pediatric Associates of Lancaster only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

I have read and understand this Office and Financial Policy and I accept responsibility for any payment that becomes due as described herein.

Patient Name_____ **Date** _____

Guardian/Mother's Name _____ **Signature** _____

Father's Name _____ **Signature** _____

We will be happy to provide you with a copy of your signed Office and Financial Policy for your records.

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Office and Financial Policy

After Hours Services
EVENING * WEEKEND * HOLIDAY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our policies allows for a good flow of communication and enables us to achieve our goal. If you have any questions, please ask.

Services during these times are for the convenience of our patients and will be charged a differential to cover the additional cost of staff and office-related expenses. We will bill your insurance company, however, not all insurance plans cover this charge. If your insurance determines the charge is an allowed amount, but does not cover the fee, you will be responsible for payment of the allowed amount.

Please be sure to schedule your appointments during our regular office hours, if you do not want to be responsible for the differential.

1) It is your responsibility to keep us updated with all of your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment for the visit and for submission of the charges to the correct plan for reimbursement.**
1) It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories. Not all plans cover every procedure or service. If a procedure or service is not covered, you will be responsible for payment.
2) According to your insurance plan, you are responsible for all co-payments, deductibles, coinsurances, and non-covered services.
3) Payment for our services is due at the time the service is provided, *regardless of who brings the child to our office.* We accept cash, checks, Visa, MasterCard, and Discover credit and debit cards.
4) If you do not have any health insurance coverage, we offer a discount for full payment received on the day services are provided.
5) **You are required to present your current insurance card(s) at every visit.** We require a photocopy of your current insurance information.
6) 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.
7) If your insurance carrier requests other information such as evidence of coordination of benefits, they will not reimburse us until you provide it. If you fail to comply in a timely fashion, you will be responsible for the charges.
8) Patient balances are billed after receipt of your insurance plan's explanation of benefits (EOB). Your payment is due upon receipt of our statement.
9) If you are unable to pay any outstanding balance in a single payment, we will be pleased to work with you on a payment plan. Once we agree upon a payment plan, please notify us if you are unable to make a payment or if you need to change the arrangement. In cases of nonpayment and failure to communicate with us, we may submit your account, along with a 40% collection fee, to our collection agency.
10) You are responsible for bank fees associated with checks returned for insufficient funds.

I have read and understand this Office and Financial Policy and I accept responsibility for any payment that becomes due as described herein.

Patient Name_____ **Date** _____

Responsible Party Member's Name _____

Responsible Party Member's Signature _____

We will be happy to provide you with a copy of your signed Office and Financial Policy for your records.

PEDIATRIC ASSOCIATES OF LANCASTER, INC.

Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, Pediatric Associates of Lancaster, Inc. may use and disclose protected health information (PHI) about me or my child to facilitate treatment, payment and healthcare operations (TPO.)

With my consent, Pediatric Associates of Lancaster, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to all items that assist the practice in implementing TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, Pediatric Associates of Lancaster, Inc. may mail to my home or other designated location any items that assist the practice in implementing TPO, such as appointment reminder cards and patient statements, provided they are marked "Personal and Confidential."

With my consent, Pediatric Associates of Lancaster, Inc. may e-mail my appointment reminder cards and patient statements.

I have the right to request that Pediatric Associates of Lancaster, Inc. restrict how it uses or discloses my PHI in the implementation of TPO. However, the practice is not required to agree to my requested restrictions. If the practice does agree, however, it is bound by this agreement.

I have the right to review the Pediatric Associates of Lancaster Inc. Practice Privacy Notice prior to signing this consent.

Pediatric Associates of Lancaster Inc. reserves the right to revise its Practice Privacy Notice at any time.

A current Pediatric Associates of Lancaster Inc. Practice Privacy Notice may be obtained by forwarding a written request to: Privacy Officer, at Pediatric Associates of Lancaster, Inc, 1550 Sheridan Drive, Suite 102, LANCASTER OH 43130.

By signing this form, I am consenting to Pediatric Associates of Lancaster, Inc.'s use and disclosure of my PHI to implement TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of Lancaster, Inc. may decline to provide treatment to me or my child.

_____ _____

Signature of patient, parent or legal guardian **Print** name of patient, parent or legal guardian

_____ _____

Name(s) of Patient(s) - List names of **all** children we see Date