PARK PEDIATRICS

Takoma Park
7610 Carroll Ave
Suite #400
Takoma Park, MD, 20912
Phone: (301) 891-6141
Fax: (301) 891-6841

Gaithersburg
501 North Frederick Ave
Suite #320
Gaithersburg, MD, 20877
Phone: (240) 801-4903
Fax: (240) 801-4905

Greenbelt
7500 Hanover Parkway
Suite #204
Greenbelt, MD 20770
Phone: (301) 232-3638
Fax: (240) 241-4837

REGISTRATION FORM

Name of person filling form_____ Relationship to child*_____

*If you are not child's parent or legal guardian please inform parent they must be present to sign legal documents.

A. PATIENT INFORMATION (Use name on birth certificate or insurance)

Child's Last name _____ Date of birth _____/_____/____

Child's First name_____ Gender (Circle one) GIRL/BOY/Unknown

Child's Middle name_____ Social Security Number(SSN)_____

Address _____ _____

_____APT #_____ Any custody issues? YES/NO if yes, explain

City_____ _____

Codigo Postal_____ State_____ _____

Race (s) or ethnic background (s)_____ Language_____

B. CONTAC INFORMATION

Phone #1_____(Circle one) Cell/Home/Work ☐Mom ☐Dad ☐Other_____

Phone #2_____(Circle one) Cell/Home/Work ☐ Mom ☐Dad ☐Other_____

Phone #3_____(Circle one) Cell/Home/Work ☐ Mom ☐Dad ☐Other_____

♦ PARENT /GUARDIAN #1 Information

Last Name_____ Relationship to child_____

First Name_____ Legal guardian? YES____ NO___

Address (If different than child's)_____ Email_____

_____ Phone (if different from above)_____

Employer_____ Full-Time Student? YES___ NO____

DOB_____ SSN_____ Financially responsible for child? YES___ NO____

Authorized to bring patient to office, discuss medical information and make medical decisions? *YES___ NO____*

♦ PARENT /GUARDIAN #2 Information

Last Name_____ Relationship to child_____

First Name_____ Legal guardian? YES____ NO___

Address (If different than child's)_____ Email_____

_____ Phone (if different from above)_____

Employer_____ Full-Time Student? YES___ NO____

DOB_____ SSN_____ Financially responsible for child? YES___ NO____

Authorized to bring patient to office, discuss medical information and make medical decisions? *YES___ NO____*

♦ PARENT /GUARDIAN #3 or Emergency Contact

Last Name_____ Relationship to child_____

First Name_____ Legal guardian? YES____ NO___

Address (If different than child's)_____ Email_____

_____ Phone (if different from above)_____

Employer_____ Full-Time Student? YES___ NO____

DOB_____ SSN_____ Financially responsible for child? YES___ NO____

Authorized to bring patient to office, discuss medical information and make medical decisions? *YES___ NO____*

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♦ FINANCIAL GUARANTOR (Person primarily responsible for finances) No other parent or legal guardian.____

Last Name_____ Relationship to child_____

First Name_____ Legal guardian? YES____ NO___

Address (If different than child's)_____ Email_____

_____ Phone (if different from above)_____

Employer_____ Full-Time Student? YES___ NO____

DOB_____ SSN_____ Financially responsible for child? YES___ NO____

Authorized to bring patient to office, discuss medical information and make medical decisions? *YES___ NO____*

C. INSURANCE

For Newborns or babies less than 28 days. If you are adding your child to your insurance plan, newborns are covered under mother up to the first 30 days of life.

Does mother have MEDICAID? YES/NO MEDICAID Number (Red and white card)_____

Mother's Insurance Name_____ Subscriber Number_____

Is your child uninsured? YES/NO Have you started Medicaid application process for child? YES/NO

Does your child has Medicaid? YES/NO* Medicaid Number (red and white card)_____

*If NO, go to Section C1

Child's Insurance Company_____Subscriber #_____

Is your child covered by any other insurance (private insurance through a job, parent or spouse, etc)? YES/NO

! PLEASE NOTE According to Maryland Medicaid: "If you have other medical insurance coverage, that insurance must pay first for covered services before Medicaid will pay". Whether or not you report any other insurance, Medicaid is able to discover if a child is covered by other insurance. In this event, they will refuse to pay until other insurance has been billed and/or will retract payment for previous visits until other insurance is billed. If you fail to report any other insurance you are responsible for your child's balance.

C1.PRIVATE INSURANCE (if no other insurance, go to section D.)_____

Private Insurance Name_____ Subscriber #_____

Subscriber Name

(Person who enrolled into health plan) _____ Group #_____

Subscriber Date of Birth_____/_____/_____ Subscriber SSN_____

Insurance Claims Address_____ Insurance Phone Number_____

_____ Employer Phone Number_____

Other Insurance Name_____ Subscriber #_____

Subscriber Name

(Person who enrolled into health plan) _____ Group #_____

Subscriber Date of Birth_____/_____/_____ Subscriber SSN_____

Insurance Claims Address_____ Insurance Phone Number_____

_____ Employer Phone Number_____

D. PREFERRED PHARMACY_____

Pharmacy Name_____ Pharmacy Phone Number_____

Address_____ City/State_____

E. CONSENT & AGREEMENT_____

I hereby consent to the use and disclosure of my child's Private Health Information (PHI) and Individually Identifiable Health Information (IIHI) for payment, treatment and other healthcare operations, according to the Health Insurance Accountability and Portability Act of 1996, effective April 14, 2003. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED AND/OR DEEMED "PATIENT RESPONSIBILITY" BY MY HEALTH INSURANCE AND AGREE TO PAY THE BALANCE OWED BY ME.**

Parent/Guardian Signature_____ Today's Date_____

Parent/Guardian Name_____

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Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name: | **Date of Birth:** | **Sex: (circle)** Male Female

Form Completed By: | **Today's Date** | **Relationship:** _____

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐ **Alcohol/Drug Abuse?** No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section Birth
Weight _____ **Discharge Weight** _____ **Did baby receive Hepatitis B vaccine?** No ☐ Yes ☐ **Date of Hepatitis B immunization:** _____ **Newborn Hearing Screen?** No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household? _____
How many? _____
☐ **Rent?** ☐ **Own?** ☐ **Shelter?**
Who cares for child? _____ **Date of Birth?**
Mother _____
Father _____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____ **Dates:** _____
Other Languages? _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:
Who?

Allergies (List) _____	No ☐	Yes ☐ _____
Asthma	No ☐	Yes ☐ _____
TB/Lung Disease	No ☐	Yes ☐ _____
HIV/AIDS	No ☐	Yes ☐ _____
Suicide Attempts	No ☐	Yes ☐ _____
Heart Disease	No ☐	Yes ☐ _____
High Blood Pressure/Stroke	No ☐	Yes ☐ _____
High Cholesterol	No ☐	Yes ☐ _____
Blood Disorders/Sickle Cell	No ☐	Yes ☐ _____
Diabetes	No ☐	Yes ☐ _____
Seizures	No ☐	Yes ☐ _____
Mental Illness	No ☐	Yes ☐ _____
Cancer	No ☐	Yes ☐ _____
Birth Defects	No ☐	Yes ☐ _____
Hearing Loss	No ☐	Yes ☐ _____
Speech Problems	No ☐	Yes ☐ _____
Kidney Disease	No ☐	Yes ☐ _____
Alcohol/Drug Abuse	No ☐	Yes ☐ _____
Hepatitis/Liver Disease		
Thyroid Disease	No ☐	Yes ☐ _____
Learning Problems/Attention	No ☐	Yes ☐ _____
Deficit Disorder	No ☐	Yes ☐ _____
Family Violence	No ☐	Yes ☐ _____

Other: _____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) _____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐

Current Medication(s): (*List*) _____

Reviewed by: | **Date of Review:**

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FINANCIAL POLICY & WAIVER

Your healthcare is extremely important to us. We are committed to providing you with the highest quality medical care possible in a cost effective manner. We are pleased to discuss with you any questions you may having concerning a bill.

PAYMENT AT TIME OF SERVICE

- Payment (copayments, coinsurance, and deductibles, etc.) in full is due at the time of service. If you do not have insurance, please come prepared to pay for your visit in full.
- As a courtesy to our patients, we accept *cash*, *Visa*, *MasterCard*, *American Express*, *money order*, and *personal checks*.
- We do not accept checks over $20 or *Discover* cards.
- Failure to pay balances may result in discharge from the practice.

LET US KNOW OF ANY CHANGES

- Always bring your current health insurance card information to ***every*** office visit.
- Please notify us at the time of check-in of any changes in insurance, address, phone number, preferred pharmacy, etc.
- ***If the insurance company that you designate is incorrect, you will be responsible for the balance.***
- Your insurance policy is a contract between you and your insurance company. If you have any questions regarding coverage for services, please contact your insurance company.

MEDICAID

- ***If you have Medicaid and do not disclose any other insurance coverage, Medicaid has the right to reject payment. You will then become financially responsible for the visit.***
- If your child is listed under any other insurance policy, by federal law, that policy is considered the primary insurance and must be billed first. Medicaid is considered secondary insurance and will only be billed after the primary insurance has processed the claim.

SECONDARY INSURANCE *Additional insurance that may pay some medical charges not covered by primary insurance*

- "Birthday Rule" – In cases where a child is covered by two private insurance policies, the health plan of the parent/legal guardian whose birth month comes first in the calendar year is designated as the primary insurance, according to the National Association of Insurance Commissioners.

FEES **Your insurance will **NOT** cover any of these administrative fees*

- If your check is returned as a result of insufficient funds, you are responsible for the returned check fees.
- There will be a fee of $35 for any returned checks.
- If you are more than 15 minutes late for an appointment, you will be marked as a *No Show*. Failure to arrive on time for your appointment will result in a $25 fee.*
- 24 hours' notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $25 *No Show* fee.*
- All copayments are due at the time of service. Any copayment not received at the time of service will result in a $10 processing fee.
- Forms needed to be filled out by the physician will result in a $5 charge. Copies of medical records will result in a $15 charge.*
- Forms will be completed in 4-5 business days from the day they are submitted. Please allow to 2 weeks for medical records.

MINOR PATIENTS

- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient or authorized adult.
- Both parent(s)/legal guardian(s) are responsible for payment for services rendered to the minor patient.

COLLECTIONS & OUTSTANDING BALANCES

- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to a collection agency or attorney may be subject to a collection fee of 35% in addition to the total balance due.

PAYMENT PLANS

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice. Please note that a ***$25 non-refundable administration fee will be charged to enroll into payment plans***.
- Please allow 7 mail days after mailing your payment for each payment to be received and posted by our practice.

Please sign below to acknowledge that you have read and understand Takoma Park Pediatrics' financial policies and agree to be bound by its terms. Takoma Park Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Name _____
(please print legibly)

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PARK PEDIATRICS
Single Consent to View, Request and Share Medical Information with Children's IQ Network Providers and Other Providers Treating my Child.

INTRODUCTION

TAKOMA PARK PEDIATRICS, has elected to participate in the Children's National Medical Center's IQ Network as part of our commimtment to improve the quality and the coordination of medical care for the children we serve. This innovative program is the first in the country to provide real-time coordination of care via an electronic medical record between your child's primary care pediatrician at Takoma Park Pediatrics and one of the country's leading children's hospitals.

Additionally, we need your permission to request any medical information from any medical facility or provider that has treated your child to ensure continuity of care at Takoma Park Pediatrics. For example, if you bring your child to our office for follow-up for an emergency room visit, we can quickly send a request to the hospital's emergency department for those records with your signature on file.

This SINGLE CONSENT will allow us to quickly access critical information about your child from his/her medical record before beginning treatment. This should dramatically reduce the chance of medical errors including adverse drug interactions or allergic reactions.

Any of your child's protected health information that is shared or received with CIQN providers is encrypted (encoded) **an can be accessed only by health care proviers who are caring for your child and have a need to know.**

As TAKOMA PARK PEDIATRICS is a pat of the Children's IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider withing the IQ Network and will allow TAKOMA PARK PEDIATRICS to request necessary medical records from other providers whom you have elected to be involved in the tratment of your child. You do have the option to opt out of SINGLE CONSENT. If you choose to opt out, you will need to sign a separate consent form each and every time your child needs to be seen by another member of the Children's IQ Network other than those at TAKOMA PARK PEDIATRICS or anytime any medical records from another provider are needed to treat your child.

****

PATIENT RIGHTS: I have received a copy of the Children's IQ Network (CIQN) Information Sheet. I understand that patient information will still be store electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I understand that any medical records needed for the care and treatment of my child will be requested as needed from other providers that have treated my child. I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

PROTECTED DISCLOSURE OF INFORMATION: I understand that Children's and Takoma Park Pediatrics comply will all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's and Takoma Park Pediatrics can use private health information for treatment of my child as defined in the Notice of Private Practices. I agree to Children's use of de-identified health information about my child for appropriately reviewed and approved research and quality improvement activities.

Patient Name_____ Date of Birth_____

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Maryland
Vaccines for Children (VFC) Program
Patient Eligibility Screening Record.

The provider **is not** required to verify responses by the parent, guardian, or individual of record.

Date:_____

Child:_____
Last Name First Name MI

Date of Birth:_____

Parent/Guardian/
Individual or Record:_____
Last Name First Name MI

Health Care Provider:_____

The provider's office must keep this form for each child (birth through 18 years of age) who receives immunizations through the Vaccines for Children (VFC) Program in Maryland in the patient's permanent medical record for six years. The health care provider or the parent, guardian, or individual of record may complete this form, and should complete a new form if the child's status changes. The provider may use this record for all subsequent visits as long as there is no change in the child's eligibility status.

This child qualifies for vaccination through the Maryland VFC Program because he/she (please check only one box):

(a) Is covered by or Enrolled in Medical Assistance ☐ or

(b) Does not have health insurance ☐ or

(c) is Native American (American Indian) or Alaskan Native ☐ or

(d) Has health insurance that does not cover (pay for) vaccines ☐ or

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PARK PEDIATRICS
ACKNOWLEDGMENT OF PRIVACY PRACTICES

Abbreviated

This is a summary of Notice of Privacy Practice. Read full version to sign acknowledgment.

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Individually Identifiable Health Information (IIHI).

I understand that this information can and may be used for:

- Treatment
- Payment for treatment or services
- Healthcare operations
- Appointment/Follow-up calls
- Coordinating healthcare care among individuals involved in your or your child(ren)'s care

I understand that my or my child's PHI may be disclosed to outside individuals if:

- Required by court order, law enforcement, and/or public health organizations
- Assisting to prevent or control disease, injury or disability in matters of public health
- Assisting to avert a serious threat to the health or safety of you, or any other person or the public
- Assisting funeral directors, medical examiners or coroners in the event of death
- Assisting in organ/tissue donations if your child is an organ donor
- For approved research purposes; patient identification will only be released with your permission
- Required by federal officials in matters of national security
- Recommending possible treatment alternatives
- Complying with Workers' Compensation cases

I understand that I have the right to:

- Request a restriction on the use and disclosure of my or my child's health record
- Request to inspect or obtain a copy of child's health record
- Request to correct or amend information in child's health record
- Request confidential communications
- Receive a paper copy of this notice

Park Pediatrics will not receive payment or other compensation from a third party in exchange for using or disclosing the *Notice of Privacy Practices*.

I do not have to sign this authorization in order to receive treatment from Park Pediatrics. I acknowledge that I have the right to refuse to sign this authorization notice. **I have read the full version of *Notice of Privacy Practices.*** When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Park Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Park Pediatrics at: Park Pediatrics, 7610 Carroll Avenue, Suite 400, Takoma Park, MD 20912.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

For Office Use Only:

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below.

Date _____ Initials _____ Reason

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After Hour Waiver Commercial Insurance Only

Dear Valued Parents/Guardians,

Park Pediatrics is committed to providing quality care. We have been proudly providing after hours care during extended morning, evening and weekend hours as a courtesy to our patients. Due to the added cost of keeping our office open for extended hours, we have relied on insurance companies to cover the cost of the service, which offers convenience to the patients and saves the insurance companies from paying for expensive emergency room visits. However, some insurance companies are refusing to pay for this service or are applying these charges to patient's responsibility.

We at Park Pediatrics want to continue to provide quality care to our patients by being able to provide these extended hours services. In an effort to continue providing these services, and to avoid cost-shifting from one group of patients to another we are implementing a $15.00 flat charge for this after hour's service. This charge will only apply if your insurance denies or does not pay for these services. The charge is separate and in addition to any copays, co-insurance or deductibles that you may be responsible for.

If you would like to be seen in our offices during these extended mornings, evenings and weekend hours, please sign the waiver below. If you choose not to be charged for these services please choose to visit us during our regular office hours Monday-Friday between 9am-5pm by checking availability.

Patient's Name: _____
Date of Birth: _____

I, (Parent/Guardian) have read and understand Park Pediatrics policy on after hours care billing. I authorize Park Pediatrics to see my child for care during their extended hours. I understand and acknowledge that I will be charged a $15.00 flat charge for these services in the event that my insurance denies or does not cover for these charges. I also understand that these charges are separate and in addition to any copays, co-insurance, or deductibles that I may be responsible for.

_____ Date: _____
Signature of Parent or Guardian

_____
Name of Parent or Guardian

** Thank you for choosing Park Pediatrics as your child's primary health care provider.*

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Newborn Financial Policy

I understand that it is MY responsibility to add my newborn to my insurance plan, or to apply for a new insurance plan for my newborn, within 30 days from the date of birth. Park Pediatrics will defer payment on newborn office visits until one month of age for patients in the process of obtaining insurance. Self-pay patients without plans to obtain insurance are expected to pay at each visit.

I understand that as a convenience to me, Park Pediatrics is willing to hold claims until the baby has been added to my plan. Claims will be submitted once the insurance has been verified under the baby's name within one month.

If I fail to add the baby to my insurance plan, I acknowledge that I will owe the full amount billed for all the services rendered.

I agree that upon Park Pediatrics receiving notification that the baby was not added to my insurance plan within 30 days, I will be fully responsible for the statement issued by Park Pediatrics.

If your insurance plan retro-activates the policy effective from your baby's birth date, please notify our **billing team @ 301-891-6141 Ext: 5**, so that we may have all claims from birth submitted to the insurance plan that you provide. Once these claims are fully paid by the insurance company including any patient responsibility portions such as co pays / deductibles, we will submit a refund for any patient payment you have made for those visits.

Patient Name: D.O.B:

Parent/ Guardian Name & Signature: Date:

Phone Number: