PENGUIN PEDIATRICS

44095 PIPELINE PLAZA SUITE 410 ASHBURN VA 20147
24600 MILLSTREAM DRIVE SUITE 460 STONE RIDGE VA 20105
PHONE 571-223-2229 FAX 855-830-1726

New Patient Registration

Welcome to Penguin Pediatrics, we are excited to have you!

In order to establish care at our practice, please follow the below steps. Once you have completed everything on the check list, you will be an established patient and can request any appointment you require through the Patient Portal. *

Check List:

1. If you haven't already, please click here to Pre-register to our patient portal.

2. **Email below information to info@penguinpediatrics.com to expedite the process of scheduling your child's initial visit:**
    a. Photocopy of Insurance card (Front/Back)

3. **Bring the information list below to expedite the onboarding process during your child's initial visit:**
    a. Complete all sections in this form after entering the required fields, sign and bring a copy
    b. Insurance card
    c. Parent's photo IDs (preferably both Parent IDs)
    d. Vaccination records, if you do not have the vaccination records, you will need to retrieve them from the previous doctor's office as we require them for any well child visit

Commonly Accepted Insurances:

- Aetna
- All Savers Insurance
- Anthem BCBS
- Assurant Health
- Care First
- Cigna
- Golden Rule Insurance
- Humana
- Innovation Health
- Meritain Health
- Oxford Health
- Tricare
- Trust Mark Small Business
- UMR
- United Healthcare
- United Healthcare Integrated Services

* **Urgent** appointment requests can be made by phone at (571)223-2229

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Child's Name*: _____

Date of Birth*: ____/____/____ Sex*: M ☐ F ☐ (Please check one)

Primary Phone*: (____) _____ - _____

SSN*: ____ ____ ____

Mother's Name*: _____ Cell Phone*: (____) ____ - ____

Date of Birth*: ____/____/____ SSN*: ____ - ____ - ____

Home Address*: _____

City/State/Zip*: _____

Email: _____

Father's Name*: _____ Cell Phone*: (____) ____ - ____

Date of Birth*: ____/____/____ SSN: ____ - ____ - ____

Home Address*: _____

City/State/Zip*: _____

Email*: _____

By signing below, I certify that the above information is accurate to the best of my knowledge. I verify that all information has been filled out in its entirety. Changes to the above information will be made immediately. This information will be updated one year from the date noted below. I Certify that I have read and understood Penguin Pediatrics Financial Policies & Waiver, Notice of Privacy Practices, Insurance Authorization to Pay Benefits to Physician, Authorization to Discuss Test Results and agree to be bound by its terms. Penguin Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary. This authorization Shall be from this date forward unless, written request to revoke is received.

Signature* _____ Date* _____

Print Name _____

Relationship to patient _____

When was the Child's last physical done? _____

What pharmacy are you currently using? _____

CONSENT FOR MEDICAL CARE

The following person(s) have permission to authorize medical treatment if I am not available to give my consent.

1. Name* Relationship*

Phone*:

2. Name Relationship

Phone:

I understand that it is the parent/guardian's responsibility to notify Penguin Pediatrics PLLC of any changes to this list of authorized caregivers in writing.

AUTHORIZATION TO DISCUSS TEST RESULTS

Purpose of Request: I authorize Penguin Pediatrics to provide the protected health information of the child mentioned above in this form to the personal representative. As my representative, Penguin Pediatrics can discuss requested information mentioned below about my child/children's health information.

I understand it is my responsibility to have the ordered tests done and have been explained the importance and reasoning for the testing. This agreement remains in full effect until rescinded in writing by parent/legal guardian.

By signing below, you give the authorization to discuss the following information with above designated persons

- I authorize the practice to disclose all my child/children's protected health information
- Normal (Blood, X-Rays, M-Rays, Prescriptions) Tests
- Abnormal (Blood, X-Rays, M-Rays, Prescriptions) Tests
- Both Abnormal and Normal Tests
- School related concerns

By signing this agreement, I acknowledge it is my responsibility to inform Penguin Pediatrics PLLC of any change in information.

Signature* Date*

Print Name

Relationship to patient:

INSURANCE INFORMATION

Responsible Party* _____

Relationship to patient: (Please check one) Mother ☐ Father ☐ Guardian ☐

Primary Insurance Name* _____

Subscriber/ Policy Holder Name _____

ID#* _____

Group#* _____

Insurance Address* _____

City State Zip* _____

Secondary Insurance Name _____

Subscriber/ Policy Holder Name _____

ID# _____

Group# _____

Insurance Address _____

City State Zip _____

AUTHORIZATION PAY BENEFITS OF PHYSICIAN:

I certify that I, and/or my dependents have insurance coverage with_____ (insurance name) and assign directly to Penguin Pediatrics PLLC all insurance benefits, if any otherwise payable to me for services rendered. I hereby authorize the undersigned physician to release and medical information necessary to process these claims. I authorize the use of my signature on all insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. I hereby authorize payments directly to Penguin pediatrics PLLC. I understand that I am financially responsible for the charges not covered nu this authorization or charges not covered by my insurance carrier/third party payers. This consent is valid until the patient is under care of Penguin Pediatrics.

Signature* _____ Date* _____

Print Name _____

PENGUIN PEDIATRICS 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 have concerned a bill.

INSURANCE ASSIGNMENT POLICY AND AGREEMENT

We will do our best to accurately verify and file your insurance for services and/or materials, however, benefits quoted by your insurance carrier are not a guarantee of payment. All current insurance and secondary insurance must be provided at the time of service. You are also responsible for any, and all co-insurance, deductibles and non-covered services on the day service is rendered.

NON-COVERED SERVICES

Should your insurance deny any service or material for any reason, you will be responsible for full payment to us. You may pursue any reimbursement you deem payable directly from your insurance company.

Insurance coverage varies depending on individual plans and contracts, but we have found that some plans do not cover the following: iScreen (photo-screen): recommended by AAP from 9 months to 4 years, Vision Check, Hearing Screen, Urinalysis, Fluoride, Hemoglobin, rapid flu test, rapid strep test, wart treatment, dressing/wound care, and ear wax removal and "after hour surcharge" for services rendered to sick patients after 6pm, holidays and weekends.

PAYMENT AT TIME OF SERVICE

- Payment (co-payments, coinsurance. and deductibles, etc.) in full is due at the time of service and within 30 days of receiving the statements by email. Patients are advised to login to the patient portal to make payments. Failure to make payments on time will result in an additional charge of $10 per month applied 30 days after statement is generated. Any unpaid balances past due 90 days from the statement date will be sent to collections with additional charge of 30% of the original bill. 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 with added convenience of payment through patient portal.
- Failure to pay balances may result in discharge from the practice.

LET US KNOW OF ANY CHANGES

- *Always bring your current health insurance card 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" - ln 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 of $35.
- 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-hour notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $25 No Show fee. *
- All co-payments are due at the time of service. Any co-payment 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 $10 charge. Copies of medical records will result in a $25 charge. *
- Forms will be completed in 4-5 business days from the day they are submitted. Please allow up to 2 weeks for medical records.

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 **(info@penguinbilling.com)** to work out a payment plan with our practice. Please note that a $25 nonrefundable administration fee will be charged to enroll into payment plans.
- Please allow 7 business days after mailing your payment for each payment to be received and posted by our practice.

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.

IMMUNIZATION POLICIES

- We strictly follow the immunization schedule recommended by the American Academy of Pediatrics. In the best interest of our patients, we cannot deviate from AAP schedule. This is to help limit exposure of communicable diseases to patients waiting in our office that may be too young to receive vaccines.
- The child must receive each of the following vaccines by 24months of age and thereafter:
    - 3 doses of DTaP, Hib, and PCV13 (Prevnar) within the first 6 months and total 4 doses by 24 months. DTaP 5th dose at 4-5yrs of age and Tdap at 11 years of age.
    - 3 doses of Polio IPV Vaccine by 2 years of and 4th dose at the age of 4-5 years.
    - 3 doses of Hepatitis HepB Vaccine in the first 12 months.
    - MMR at 12 months and booster dose at 4-5years of age
    - Varicella by 15 months and booster dose at 4-5 years of age
    - Meningococcal Vaccine (Menveo) at 10-11 years of age and booster 16 years of age
    - Meningococcal B Vaccine 2 doses 1 month apart between 16 to 18 years of age
    - Gardasil (HPV Vaccine) 2 doses given 6 months apart between 10 to 15 years of age (optional)

- If these immunizations are delayed in an attempt, to avoid vaccinating your child, we reserve the right to dismiss your child from our practice.

AUTHORIZATION TO DISCUSS TEST RESULTS

- I authorize Penguin Pediatrics to provide the protected health information of my child as my personal representative.
- I understand it is my responsibility to have the ordered tests done and have been explained the importance and reasoning for the testing.
- I authorize the practice to disclose all of my child/children's protected health information
    - Normal and Abnormal (Blood results, X-Rays) test results and Prescriptions
    - School related concerns
    - Communicate with the staff and doctor using phone calls, text, or WhatsApp messages and email.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

- I certify that I, and/or my dependents have insurance coverage and benefits assigned directly to Penguin Pediatrics PLLC, if any otherwise payable to me for services rendered. I hereby authorize the undersigned physician to release medical information necessary to process these claims. I authorize the use of my signature on all insurance company(ies) provided and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. I hereby authorize payments directly to Penguin pediatrics PLLC. I understand that I am financially responsible for the charges not covered by my insurance carrier/third party payers. This consent is valid until the patient is under care of Penguin Pediatrics.
- By signing this form, you are giving us the authorization to keep your credit card/ HSA card (mandatory) in our secure system and charge the account with outstanding balances less than $200.

Acknowledge that you have read and understand Penguin Pediatrics financial policies and agree to be bound by its terms. Penguin Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary. This authorization Shall be from this date forward, unless written request to revoke is received.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD(REN) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Penguin Pediatrics, including staff, physicians, and other health care providers on our staff, use and share health information about you or your child(ren) for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We are committed to protecting health information about you or your child(ren). You or your child's health information is contained in a medical record that is the physical property of Penguin Pediatrics.

HOW WE MAY USE YOUR HEALTH INFORMATION

FOR TREATMENT. We may use your or your child's health information to provide, coordinate or manage medical treatment or related services. Information obtained by a medical assistant, physician, or other member of the healthcare team will be recorded in the medical record and used to determine the course of treatment that will work best for you or your child.

FOR PAYMENT. We may use and disclose health information to bill and collect payment for treatment and services that are received. For example, a bill may be sent to you or to your insurance company. The bill will contain information that identifies you or your child(ren), as well as the diagnosis, procedures and supplies used in the course of treatment.

FOR HEALTH CARE OPERATIONS. We may use and disclose health information about you or your child(ren) for office operations. For example, you or your child's health information may be disclosed to other staff members to:

- Evaluate the performance of our staff
- Assess the quality of care
- Learn how to improve our facilities and services; and
- Determine how we can make improvements in the care and services we provide

APPOINTMENTS/FOLLOW-UP CALLS. We may use your or your child's information to contact you as a reminder that you have an appointment for treatment or to follow-up regarding medical care.

INDIVIDUALS INVOLVED IN YOUR CARE. We may share information with a family member or other person identified by you or who is involved in your or your child's care or payment related to that care. We may tell a family member or friend about you or your child's condition. If you do not want that information released to those involved in the care, see instructions for requesting a restriction under **YOUR HEALTH INFORMATION RIGHTS.**

HOW WE MAY DISCLOSE YOUR OR YOUR CHILD(REN)'S HEALTH INFORMATION OUTSIDE OF PENGUIN PEDIATRICS

REQUIRED BY LAW/PUBLIC HEALTH. We may disclose information about you or your child(ren) when required to do so by federal, state, or local laws. For example, we may disclose information for the following purposes:

To respond to a court order, subpoena, or deposition.

- To assist law enforcement officials in their duties to locate a suspect, fugitive, or missing person.
- To report information related to victims of child abuse or neglect.
- To report reactions to medication or recalls of products.
- To federal and state agencies for oversight activities authorized by law such as investigation, inspections, audits. surveys and licensing. (Examples may include organizations that ensure the quality/safety of the care we provide).

HEALTH RISKS. You or your child's health information may be released for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability. We may disclose your or your child's health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

HEALTH AND SAFETY. We may disclose health information about you or your child(ren) to avert a serious threat to the health or safety of you, any other person or the public. Any disclosure would only be to someone able to help prevent the threat.

DECEASED. Health information may be disclosed to funeral directors, medical examiners, or coroners to enable them to carry out their lawful duties.

ORGAN/TISSUE DONATION. If you or your child(ren) are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

RESEARCH. We may disclose information for research purposes when Penguin Pediatrics has reviewed and approved the research proposal. Medical record information that identities you or your child (children) will only be used when given permission for us to do so. Additionally, when given permission, RPA may contact you regarding research purposes.

NATIONAL SECURITY. We may disclose your or your child's health information to federal officials for intelligence, counterintelligence, and national security activities authorized by law.

TREATMENT ALTERNATIVES. We may use and disclose health information to tell you about or recommend possible treatment options or other health-related benefits and services that may be of interest to you.

WORKERS' COMPENSATION. Your or your child's health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

YOUR HEALTH INFORMATION RIGHTS

In accordance with federal regulations and Penguin Pediatrics policies and procedures, you have the right to:

- Request a restriction on certain uses and disclosures of your or your child's health information. ***** We will make every effort to honor your request. However, in some situations, we may be required by law to share the health information. As an example, tuberculosis (TB) results are required by law to be reported to the Health Department. Penguin Pediatrics is not required to agree to all requested restrictions.
- Request to inspect and/or obtain a copy of your or your child's health record. ****** You have the right to request to inspect and/or obtain a copy of the health information and billing records. We may charge a fee for the costs associated with copying and/or mailing the information.
- Request to correct/amend information in your or your child's health record. ****** If you feel that health information, we have is incorrect or incomplete, you may ask us to correct/amend the information. If the health information is determined to be incorrect or incomplete, we will revise the record.
- Request confidential communications. You have the right to request that we communicate with you about health information in a particular manner or at a location other than your permanent address. For example, you may ask that we contact you by mail rather than by telephone, or at work rather than at home. It is your responsibility to make sure that we have your correct address and contact information.
- Receive a paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time.

***** In order to request a restriction on how your or your child's health information is used or to request confidential communication, you must complete a "Restriction of Health Information Request Form".

****** In order to request a copy, an inspection, a correction/amendment, or a listing of disclosures you must submit a request in writing to the Medical Records Department.

OBLIGATIONS OF PENGUIN PEDIATRICS

We are committed to:

- Make sure that medical information that identifies you, your child(ren) is kept private.
- Provide you with this notice of our legal duties and privacy practices with respect to you or your child's health information.
- Follow the terms of this notice.
- Notify you, after management's review, if we are unable to agree to a requested restriction on how health information is used or disclosed.
- Accommodate reasonable requests for communications of health information particular manner or to a location other than your permanent address.
- Obtain your written authorization to disclose health information for reasons other than those listed above and permitted.

Penguin Pediatrics reserves the right to change the terms of this notice and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by posting them in our office, posting them on our website at www.penguinpediatrics.com and upon your request; we will provide you with a copy of the most recent copy of our Notice of Privacy Practices.

CONTACT INFORMATION

You may file a complaint to Penguin Pediatrics or to the United States Secretary of the Department of Health and Human Services if you believe your or your child's privacy rights have been violated, you will not be penalized for filing a complaint, If you have any complaints or questions about information in this document, you may contact:

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

Penguin 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 Penguin 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 redisclosure 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 Penguin Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Penguin Pediatrics at:

Penguin Pediatrics PLLC
(571) 223-2229

44095 Pipeline Plaza, Ste. 410
Ashburn, VA 20147

24600 Millstream Drive, Ste. 460
Stone Ridge, VA 20105

Please sign below to acknowledge that you have read and understood Penguin Pediatrics Financial Policies & Waiver, Notice of Privacy Practices, Insurance Authorization to Pay Benefits to Physician, Authorization to Discuss Test Results and agree to be bound by its terms. Penguin Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary. This authorization Shall be from this date forward unless, written request to revoke is received.

Patient/Guardian*: _____

Signature*: _____

Date*: _____

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PHONE 571-223-2229 FAX 855-830-1726

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name*) Birth date* (Month/Day/Year)

(Street address*) Social security number

(City, state, zip code*) Phone (Home)

(Parent/Guardian if Patient <18 years) Chart #

At the request of the individual, I_____, do hereby authorize_____to release:
(Patient's Name) *(Name of Previous Provider)*

Name of Facility*: _____ **Fax Number*:** _____
(Name of Previous Facility/Organization) *(Previous Provider Fax Number)*

SERVICE DATES OF _____

_____ WELL CHILD VISITS	_____ PATWLAB REPORTS	_____ IMMUNIZATIONS ONLY
_____ SICK CHILD VISITS	_____ RADIOLOGY REPORTS	_____ LAST 3 YEARS
_____ ALL OFFICE VISITS	_____ ENTIRE CHART	_____ OTHER

INFORMATION RELEASED TO:

PENGUIN PEDIATRICS PLLC

24600 MILLSTREAM DRIVE SUITE 460

STONE RIDGE VA 20105

PURPOSE OF DISCLOSURE*:_____ REFERRAL TO SPECIALIST _____ LEAVING PRACTICE _____ RELOCATION/MOVING

OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you:_____
I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Date

Personal Representative of patient's estate Power of Attorney Must Be Attached

MEDICAL INFORMATON RELEASE

ROI SPECIALIST DATE