ADETEJU OGUNRINDE, M.D.,F.A.A.P., CHILDREN'S HEALTHCARE CENTER. P.C.

605 Post Office Road, Suite 102, Waldorf, Maryland 20602.
Phone: (301) 374-2666, Fax: {301} 374-2662

PATIENT REGISTRATION

DATE_____/____/20_____ Updated: Jan 2022.

PERSONAL DATA

PATIENT'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

SIBLING'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

SIBLING'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

HOME ADDRESS:_____

HOME PHONE NO: (_____)_____-_____ PATIENT SS. #_____-____-_____

MOTHER'S NAME_____ DOB___/____/_____ SS.#_____-____-_____
LAST NAME FIRST NAME INITIAL

FATHER'S NAME_____DOB__/____/_____ SS.# ____-____-_____
LAST NAME FIRST NAME INITIAL

MOTHERS'S CELL # _____ **EMAIL_____OCCUPATION_____
Please: TEXT _____ or EMAIL_____me for appointment reminder.
**Use this email to access Portal account for your lab results and vaccine record-ask us for temporary password.

FATHER'S CELL # _____ EMAIL_____OCCUPATION_____
Please: TEXT__ or EMAIL__ me for appointment reminder. (Only one portal account per family)

NAMES OF OTHER ADULT(S)
AUTHORIZED TO ACCOMPANY CHILD_____RELATIONSHIP_____CELL#_____

INSURANCE BILLING INFORMATION

PRIMARY INSURANCE: _____ SECOND INSURANCE_____NEED COB if sec ins.

*SUBSCRIBER'S NAME 1ST INS*_____ *SUBSCRIBER'S NAME 2ND INS*_____

SUBSCRIBER DATE OF BIRTH:_____ SUBSCRIBER DATE OF BIRTH: _____

EFFECTIVE DATE 1ST INSURANCE_____/_____/_____ EFFECTIVE DATE 2ST INSURANCE_____/_____/_____

I.D. #_____GROUP #_____ I.D# _____GROUP #_____

WE WILL BILL ALL INSURANCES GIVEN TO US PRIOR TO BILLING YOU EXCEPT FOR MEDICAID SECONDARIES. IF YOU HAVE MEDICAID AS SECONDARY, YOU WILL NOT BE BILLED. FAILURE TO DISCLOSE ALL INSURANCES MAY AFFECT YOUR CLAIM AND WE WILL CHARGE YOU $100 TO REPROCESS THE CLAIM IF YOUR PRIMARY INFORMS US OF YOUR SECONDARY INSURANCE. INITIAL HERE X_____+

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DR. OGUNRINDE FOR SERVICES RENDERED BY HER IN PERSON OR UNDER HER SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I ALSO WILL BE RESPONSIBLE FOR ALL PAYMENTS AND COLLECTION CHARGE FOR FAILING TO DISCLOSE MY SECONDARY INSURANCE OR MEDICAID COVERAGE TO THE OFFICE AT THE TIME OF SERVICE

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE DR. OGUNRINDE TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFITS IN ACCORDANCE WITH HIPPA REGULATIONS.

ACKNOWLEDGEMENT OF OFFICE POLICIES & PROCEDURES

I CERTIFY THAT INFORMATION WAS RECEIVED BY ME, REVIEWED AND UNDERSTOOD CONCERNING THE OFFICE POLICEIS AND PROCEDURES. I WILL COMPLY WITH THESE DIRECTIVES AS WRITTEN.

PARENT/GUARDIAN_____ SIGNATURE_____
PLEASE PRINT

Adeteju Ogunrinde, M.D.,F.A.A.P.,Children's Healthcare Center. P.C.

FINANCIAL POLICY

We are delighted you have chosen our practice for your child's medical care. We wish to have a relationship characterized by understanding and satisfaction while delivering the highest quality of care in a safe environment. If you have medical Insurance, we are here to help you receive the maximum allowable benefits. In order to achieve this goal we need your co -operation and understanding of our financial Policy.

COPAYMENTS AND DEDUCTIBLES:

Co-payments are to be paid at the time of service, Exceptions: Medicaid coverage!
We accept payment by cash, check, Visa or Master card. Please note there will be a $30.00 charge for all checks returned. Failure on our part to collect co-payment and deductibles from patients is considered a violation of contract and fraud. Please help us to uphold the law by making your co-payments at each visit and paying deductibles as billed.

CLAIM SUBMISSSION:

As a courtesy to you, we will submit your claim for services rendered by our practice to your insurance based on the information you have provided to us. It is your responsibility to make sure this office has your correct insurance information. Failure to disclose secondary insurance or Medicaid coverage may affect your claim payment. YOUR PRIMARY EVENTUALLY FINDS OUT ABOUT OTHER INSURANCES AND USUALLY RETRACT THEIR PAYMENT UNTILL COORDINATION IS DONE. WE WILL CHARGE YOUR ACCOUNT $100 FOR REPROCESSING YOUR CLAIM FOR WITHHOLDING SUCH IMPORTANT INFORMATIO FROM US IF THIS HAPPENS.
Your insurance is a contract between you, your employer and/or the insurance group. While we may provide services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
Unfortunately, we will be unable to schedule future appointments if arrangements for outstanding balances have not been made and/or no payments are being made on overdue balances.

NON COVERED SERVICES:

Not all services are covered by insurance; they vary from contract to contract. Some insurance arbitrarily consider some services NOT medically necessarily or experimental, however our primary goal at this practice is the "best preventive care for our patients" and in accordance to the standard of care recommended by American Board of Pediatrics. In the instance where your insurance refuses to pay, you will be responsible for these services. We will make every effort to ascertain coverage before treatment, however this does not guarantee payment, and unpaid balance will become your responsibility. For services that are not covered by insurance we require payment within thirty (30) days of bill statement unless prior arrangement has been made. In cases of financial hardship, we will also offer certain discounted services.

COVERAGE CHANGES

If your insurance changes, or you purchased additional coverage, please notify us immediately or at your visit so we may update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by an insurance that we do accept but you do not have the insurance card for us to ascertain your eligibility, payment is expected in full at time of service until we can verify your coverage.

MISSED APPOINTMENTS:

We require 24-hour notice for appointment cancellations. Please be aware there is a $30 non –cancellation fee for missing an appointment or for cancelling a well -child physical less than 24hours. This is because a missed appointment takes openings away from other sick children. These charges will be your responsibility and will NOT be billed to your insurance company. Those with Maryland Medicaid insurance would be reported to their mco/health department or be suspended from the practice after 2 missed appointments. Please help us serve you better by keeping your scheduled appointment.

NON PAYMENT

If your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full or make payment arrangement with us. Please note that if your account remains unpaid, we reserve the right to refer your account to a collection agency and all the accounts under your name will become inactive until paid. Account balances turned over to collection will accrue at the rate of 40% over the owed amount as collection fee. If your account is turned over to an attorney or pursued legally, you will be responsible for all reasonable attorneys' fee, filling fees and service fees.

Forms And Record Transfer:

We require a written request for all record requests. There is an applicable fee for all record transfer or request. Fees may be charged for some patient requested form completions, we will inform you prior to completion regarding the specific charge, and payments are due prior to performing such duty.

Assignment and Release

I hereby request that my authorized Medicaid or other insurance benefits submitted for payment by Children health Care center be paid directly to them for services rendered to me. I authorize them to release any information required to process submitted claims to my insurance company or if applicable Health Care Financing Administration or its agents. I also agree to be financially responsible for non-covered services, deductibles, and co-payment. I am aware that Children Healthcare would post all payments to my responsibility if my insurance or health benefit does not pay within ninety {90} days. I am also responsible for collection fees as well as attorney's fee if my account becomes delinquent as determined by this office.

Thank you for understanding our financial policy. Please let us know if you have additional questions.

We are here to help.

I have read and understood the above financial policy and assignment and non payment. I hereby authorize photocopies of this form to be used as valid as the original for all my children registered with this Children's Healthcare Center in Waldorf, Maryland.

PRINT NAME_____**SIGN HERE** _____**DATE**_____

NOTICE OF PRIVACY PRACTICES

Please read our copy of privacy practice posted on our website and in our waiting room. I have read a copy of the Notice of Privacy Practices for the office of Dr. Adeteju Ogunrinde and agree to abide by all disclosures and statements in the notice.

Parent Signature_____. **Date:**_____

EACH VISIT

Please bring a copy of your child's immunization record and insurance card with your picture ID to all visits.

Children's Healthcare Center

SICK VISIT, WELL VISIT OR BOTH?

SICK VISIT is an office visit for an acute problem or flare-up of a chronic problem. A sick visit could also be an office visit to follow-up on chronic problems.
WELL VISIT is an office visit for a routine physical exam or yearly health maintenance exam.
SICK/WELL VISIT is a combination visit of a routine physical exam where an acute or chronic issue is addressed as well. For example, if your child presented today for a well visit and he or she has an acute or chronic issue you would also like addressed, it is considered a combination visit and must be billed differently than just a well visit or just a sick visit.

WHY IS IT BILLED DIFFERENTLY?

The Sick/Well Visit is billed differently to account for the additional work, expertise and time required for a combination visit and involves additional documentation as well. For example, think about taking your vehicle in for an oil change (routine maintenance) and mentioning to the mechanic that your brakes are squeaking, and your windshield wipers are not working well. In addition to the oil change, you might require additional brake work if a problem has been found and replacement windshield wipers. Since additional services were provided, you would be charged more than just for the oil change.

HOW DOES THIS AFFECT ME?

Although many insurance companies acknowledge the Sick/Well Visit combination, some of them still requires the patient to pay co pay FOR THE SICK VISIT PORTION or have additional cost applied to his/her annual deductible.

ANNUAL PHYSICAL EXAMS

Annual physical exams target preventative care and are billed as such. Medication refills and/or other ailments, injuries or illnesses addressed during an annual physical exam are billed IN ADDITION to the annual physical. These charges may be passed on to the patient. Please check with your insurance company to confirm your coverage for all types of doctor visits.
We understand this can be confusing and if you have any questions or concerns after reviewing this document, please contact our office at 301-774-5800. (Ease Billing company)

_____ _____

PRINT PATIENT'S NAME **Patient/Parent Name & Signature**

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT'S FULL NAME: _____**Date of Birth:**_____

TO FACILITY NAME AND NUMBER: _____

I, _____ (parent or guardian) do hereby authorize **Children's HealthCare Center to** OBTAIN_____RELEASE_____
All RECORDS _____Specific Records ____ of all dates of records:

__ History and Physicals __ Consult Reports

__ Laboratory Reports __ Radiology Reports

__ Immunization Records __ Newborn Reports ____**MENTAL HEALTH REORDS**

PURPOSE OF RELEASE

__ Change of Doctor __ Personal __ Legal Investigation

__ Insurance __ Disability __ Continuation of Care __ School___

I authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to disclosure by the person or facility receiving it and would then no longer be protected by federal regulations.

Signature of parent or guardian (as above) Request Date

FOR RECORD RELEASE:
PLEASE NOTE ELECTRONIC MEDICAL RECORD is available on our patient portal at NO CHARGE; (https://childrenshcmd.com/Patient-Portal)
Under Health-General Article,
§4-304, Annotated Code of Maryland, health care providers are permitted to charge patients (or the patient's authorized representative) a fee for copying medical records. Our preparation fee is: $22.00, plus $0.83 per page plus first-class postage for printed copy OR for a flash drive format, the cost is $0.62 per page plus $10 for a flash drive and actual cost of postage. FOR ALL MEDICAID PATIENTS, STATE GUIDELINES APPLY.

Preparation Fee: $22.00
Number of pages/cost __ _____
Postage _____
Flash Drive _____
Total Amount _____ Record Prep: Signature(staff):_____Date_____Sent Date_____

(Policy Updated Jan 2022)

The following services are provided by this office at the request of the parent/patient. If performed, the following charges will apply and are due at time of form drop off. These charges are subject to change without notice. An up-to-date copy of this list will always be available to view in the office.

SERVICE	COST
Produce copy of Patient Chart, Medical Records:	$22 processing fee +.83 cents per page
Completion of form physicals for schools, camps, pre-school, daycare, university or other educational institution	$10
Completion of FMLA	$20
Returned check	$ 30
Missed Appointment • If you cancel your appointment within a 24 hour time frame there will be No Charge • If you did not show for your appointment, or cancel well visit within 24hours	$ 30 If you have Medicaid- You will not be charged but you may be terminated from our practice for not showing up for scheduled appointments. Please call us if you are unable to make any appointments or have difficulty with transportation.

Forms can be downloaded free via our web portal, please ask front desk for temporary password OR PIN if you need one, you can also see your child's visit, lab results and vaccine record and also email us for routine questions

https://childrenshcmd.com/Patient-Portal

We require 48-72hrs for form completions.