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The Children's Health Center

Patient Information

Patient's Name _____ Sex (M/F) _____ DOB _____/_____/_____
Address _____Phone (_____) _____-_____
City _____ State_____ Zip _____
Email address: _____
How did you hear about us? _____

Parent (Guardian) Information

Parent/Guardian 1 First Name _____Last Name _____
DOB _____/_____/_____ Cell Phone (_____) _____-_____
Occupation _____ Employer Name _____
Employer address _____ Work Phone (_____) _____-_____

Parent/Guardian 2 First Name _____ Last Name _____
DOB _____/_____/_____ Cell Phone (_____) _____-_____
Occupation _____ Employer Name _____
Employer address _____Work Phone (_____) _____-_____

Parent's Marital Status: _____

Primary Insurance (Person who holds insurance)

Insurance Company _____ ID# _____ Group #_____
Policy effective date _____/_____/_____ Copay amount $_____
Insured's Name _____Social Security #: _____-_____-_____ DOB ____/_____/_____
Driver's License Number: _____ Relationship to Patient _____

Secondary Insurance (If child has multiple insurance coverage)

Insurance Company _____ ID# _____ Group #_____
Policy effective date _____/_____/_____ Copay amount $_____
Insured's Name _____Social Security #: _____-_____-_____ DOB ____/_____/_____
Driver's License Number: _____ Relationship to Patient _____

Insurance assignment & Release of Information

- I authorize the release of my child's medical information necessary to process insurance claims. ● I authorize the release of payment of medical benefits to my child's provider. ● I understand that I am financially responsible for any deductibles, coinsurance fees, and charges for non-covered services. Unless, I am a member of an insurance organization that The Children's Health Center is a contracted provider, all charges are due at the time that services are rendered.
- I authorize The Children's Health Center to call me on my home/cell/ work number for collection purposes

_____ _____ Date: _____/_____/_____
Parent/Guardian Name Parent/Guardian Signature

The Children's Health Center

Patient Information Release

In accordance with the new Federal and HIPAA (Health Insurance Portability and Accountability Act) regulations, any medical information pertaining to you will only be disclosed to the person(s) indicated below. If they are not listed below, no information will be disclosed at any time. Thank you for your cooperation.

This is to certify that I, _____ parent of _____ authorize The Children's Health Center to disclose my child's medical information to the following person(s) only:

Name **Relationship**

_____
_____
_____
_____
_____

____ I DO NOT WISH to have any of my child's health related information released to anyone other than myself. (Please initial if this is your selection)

Signature: _____

Any changes of patients release information **MUST BE IN WRITING ONLY**.

941 St. Highway 35 North
Middletown, NJ 07748
732-264-6070

The Children's Health Center

Authorization for Obtaining Medical Record Information

Last Name: _____ First Name: _____

Date of Birth: ____ /____ /____ Telephone: (_____) _____-_____

Street Address: _____

City: _____ State: _____ Zip: _____

The Children's Health Center has my permission to obtain information contained in the medical records of the above named patient. (must be filled out in full to be requested)

Name of Previous Physician:

_____

Phone :(_____) _____-_____ Fax: (_____)_____-_____

I hereby authorize The Children's Health Center to obtain any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that The Children's Health Center cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at The Children's Health Center may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can, however, cancel this authorization in writing at any time, except to the extent that The Children's Health Center has relied upon it. For example, if I cancel it after The Children's Health Center has sent requested records, The Children's Health Center will not retrieve those records. Instructions for canceling this authorization are included in The Children's Health Center Notice of Privacy Practices.

I understand that The Children's Health Center will continue to provide care, even if I do not authorize this release.

Signature of Parent (unless 18 years of age or older): _____ **Date:** _____ /_____ /_____

941 St. Highway 35 North
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732-264-6070
732-264-6076

The Children's Health Center

Dear families,

In the interest of a good healthcare practice, it is desirable to establish a financial and office policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that goal. Insurance reimbursement is a contract between you, your employer, and the insurance carrier. **YOU** are responsible for payment of your account. **YOU** are responsible to be aware of your benefits and to contact your carrier directly when issues arise regarding timely payment of claims or denials. Insurance(s) are gladly billed as a courtesy to our patients when current cards are provided to us. We cannot accept responsibility for follow- up on your claims or for negotiating disputed claims, but our staff will assist you if needed.

The following policies must be agreed upon:

1. **Co-pays**
    a. All copays are due at the time of service. A $10 charge will be added to your account if we do not receive the payment at the time of service. Non-urgent care may be subject to rescheduling when co-pay is not paid. Please do not ask us to waive co-payments; it is considered a breach of the insurance contract and it can lead to denial of payment by the insurance company.
2. **No-show**
    a. We make it our responsibility to call/text you at least 24 hours prior to your appointment to confirm the appointment. If you do not cancel your appointment in a reasonable amount of time (i.e. 24 hours when scheduled in advance, or at least 2 hours prior when scheduled the same day) and simply fail to show up, the following will apply.
        i. 1st No-show: The patient will receive a phone call informing them that they missed their appointment, and another missed appointment will result in a $25 fee. A notation will also be made on the account.
        ii. 2nd and 3rd No-show: The patient will receive a letter informing them of the missed appointments and a $25 fee will be charged for each missed appointment.
        iii. 4th No-show: Letter will be sent advising that the patient finds another primary care physician within 30 days.
        iv. Patients who no-show a double appointment (bringing in 2 children at the same time), will be restricted from scheduling double appointments in the future.
3. **Balances**
    a. We run a zero balance office. All outstanding accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with us. All personal accounts past due more than 30 days from the date of billing will accrue a $10 monthly late fee. Accounts may be assigned to an outside

collection agency and reported to the credit bureaus if the personal balance is over 90 days old. A $100 or 40% of the balance collection fee will be assigned to your account if sent to an outside collection agency.

4. **Insurance Payment**
    a. If insurance payment is not received within 60 days of submission of the claim, you will be informed of your responsibility to contact the insurance company and ensure that payment in full is received promptly. It is your responsibility not ours that your insurance company pays on time.

5. We do **NOT** mail, email, or fax any prescriptions, completed forms, immunization records or excuse notes. These forms need to be picked up at our office in person or printed from the online parent portal.

6. **Returned Check**
    a. A $40 charge will be added to accounts for each check that is not honored by your bank. This is in addition to any fees that the bank charges us for your returned check. If a check is bounced, we will not accept checks for payment on your account.

7. **Responsible Party:** The parent or guardian who brings the child for their initial visit is responsible for payment. Independent of a divorce circumstance or custody agreement. Whoever signs the financial policy is the responsible party.

8. **Misunderstandings**
    a. It is our company policy to ensure the complete satisfaction of all our patients with the services and care that they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to promptly address and resolve the matter, provided it is brought to our attention in a timely, appropriate, cordial manner. You can expect that our staff will treat you with courtesy, professionalism, and respect and will strive to achieve mutual understanding.

Thank you for your cooperation. Please sign below to acknowledge that you have read and understand the above policies.

Patient Name: _____ Date: _____/_____/_____

Parent/Guardian Name: _____Signature: _____

Patient Name: _____

DOB: _____/_____/_____

Insurance coverage

YOUR INSURANCE COMPANY DECIDES IF YOU OWE A COPAY

Your insurance company determines whether or not you owe a copay. When you come into the office for a visit, your visit is charged and submitted to your insurance company. Your insurance company determines if you have a copay and the amount of the co-pay. Most insurance companies do not require a copay for preventive care visits however, some might require a copay.

Insurance companies are allowed to charge a copay to you for services that are **NOT** preventive. If non-preventative services are provided to a patient, we are legally required to report those services to your insurance company. If you receive a bill from the office for a co-pay for the same date as your well visit, then a non-preventative service was provided to you on that date and your insurance company determined that requirement.

Examples of services that may be provided on the day of your well visit that are **NOT** preventive services:

- Evaluation and treatment of an acute illness (ear infection, strep throat, uti, etc.) ● Evaluation and treatment of a chronic problem (eczema, asthma, allergies, etc.) ● Procedures that are not part of the routine well visit (removing impacted ear wax, draining an abscess, etc.)
- Any services that the insurance company says are not preventative

When both you and your insurance company pay for your health care expenses, it's called cost sharing. Deductibles, coinsurance, and co-pays are all examples of cost sharing. Understanding how they work will help you know how much you will pay.

- **Copay**: A fixed amount **YOU** pay for a health care service when you receive the service. The amount can vary based on the type of plan you have.
- **Deductible:** The amount **YOU** pay for health care services before your health insurance begins to pay
- **Coinsurance**: **YOUR** share of the costs of a health care service. It is usually figured as a percentage of the amount the insurance company will pay for the charged services

_____ _____

Parent/ Guardian Name Signature

Date: _____/_____/_____

New Patient Questionnaire

Patient name _____ **DOB** _____/_____/_____

Who lives at home?_____

Is the child in daycare? YES or NO

Is there a smoker in the home? YES or NO

Do you have any pets? YES or NO If "yes", what kind?_____

Pregnancy & Birth

Mother's age at child's birth: _____

Maternal illness during pregnancy or early labor? YES or NO If "yes", list:_____

Did she take medications other than vitamins? YES or NO If "yes", list: _____ Was the baby born <37 or >41 weeks gestation? YES or NO If "yes", the baby was born at _____ weeks What type of delivery (please circle)? Vaginal or C-section What hospital? _____ Birth Weight: _____lbs _____oz Did the baby have trouble while in the hospital? YES or NO If "yes", list: _____ (jaundice, NICU, breathing difficulties, infection)

Vaccination Status (please circle): Up-to-date Delayed Not Immunized

If delayed or not immunized please explain: _____

Past Medical History (refers to child)

Has the child had any allergic reactions to medications, foods, insect stings, immunizations, other? YES or NO If "yes", please list: _____ Has the child had any overnight hospitalizations? YES or NO

If "yes", why and what age? _____

Has the child had any surgeries? YES or NO

If "yes", what kind and what age? _____

Has the child had any serious injuries? YES or NO

If "yes", what kind and what age? _____

Does the child take any medications regularly (other than cold medicines/pain relievers)? YES or NO

If "yes", which ones? _____

List any other medical problems your child has had that are not listed above or any specialist the child has seen previously:

_____

Check any medical problems your child has had:

● Asthma ● Urinary Tract Infection ● Pneumonia ● Frequent Strep Throat ● Frequent Ear Infections	● Anemia ● Heart Problems ● Vision/Hearing Problems ● Environmental Allergies ● Seizures	● School Problems ● Emotional/Behavioral Problems ● Speech Problems ● Constipation ● Lyme Disease

Family History (please check): includes child's parents, siblings, grandparents, aunts, and uncles

● Asthma ● Hypertension ● Tuberculosis ● Sudden Unexplained Death ● Allergies	● Thyroid Disease ● Heart Disease ● Kidney Disease ● Genetic/Inherited Illness ● Liver Disease	● Diabetes ● High Cholesterol ● Mental Illness ● Seizures ● Cancer

If "yes" to any of the above boxes, please explain:

The Children's Health Center

Family Contacts

Patient Name: _____

Patient Date of Birth: _____

Please list any other children who are patients of our practice.

Patient Name: _____

Date of Birth : _____

Patient Name: _____

Date of Birth : _____

Patient Name: _____

Date of Birth : _____

Patient Name: _____

Date of Birth : _____

The Children's Health Center

Account Balances

Please list your email: _____

I acknowledge that I must use this email to create a patient portal account. Electronic statements can be sent through our patient portal. Please retrieve your pin from the front desk to register your child. Please note that a late fee of $10.00 monthly will be applied to any unpaid balances.

Patient Name: _____

Parent Name: _____

Signature: _____ Date: _____

Routine deductibles and/or coinsurance will be charged to the credit card on file as soon as your carrier provides an EOB (explanation of benefits) designating your financial responsibility for your claim. If the claim is denied, we will contact you to resolve the issue before collecting any amounts indicated as due or non-covered.

Name on card: _____

Credit Card Number: _____

Exp. date: _____ VISA MASTERCARD AMEX DISCOVER

Other: _____