

PATIENT REGISTRATION

ELLCOTT CITY PEDIATRIC ASSOCIATES

Reviewed by _____ ECPA

PATIENT INFORMATION

FIRST NAME		LAST NAME		M.I.
DATE OF BIRTH	PATIENT RESIDES WITH ☐ BOTH PARENTS ☐ MOM ☐ DAD ☐ LEGAL GUARDIANS ☐ STEP PARENT (name):			SEX ☐ F / ☐ M
ADDRESS		APT	CITY	ZIP
PATIENT'S CELL (if over age of 17) _____ - _____ - _____		RACE	ETHNICITY	
PREFERRED LANGUAGE :		☐ ASIAN ☐ AFRICAN AMERICAN OR BLACK ☐ HAWAIIAN OR PAC.ISLANDER ☐ CAUCASIAN OR WHITE ☐ NATIVE AMERICAN OR ALASKAN ☐ DECLINED TO ANSWER	☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN ☐ DECLINED TO ANSWER	

1. PARENT / GUARDIAN INFORMATION *(if Legal Guardian, please provide us with paperwork)*

FIRST NAME	LAST NAME		DATE OF BIRTH
ADDRESS (IF DIFFERENT FROM PATIENT'S)		APT	CITY ZIP
EMAIL (it will be your Patient Portal ID)	HOME PHONE: _____ - _____ - _____ CELL PHONE : _____ - _____ - _____ WORK PHONE: _____ - _____ - _____		RELATIONSHIP TO PATIENT :
SOCIAL SECURITY NUMBER	EMPLOYER	OCCUPATION	

2. PARENT / GUARDIAN INFORMATION *(if Legal Guardian, please provide us with paperwork)*

FIRST NAME	LAST NAME		DATE OF BIRTH
ADDRESS (IF DIFFERENT FROM PATIENT'S)		APT	CITY ZIP
EMAIL (it will be your Patient Portal ID)	HOME PHONE: _____ - _____ - _____ CELL PHONE : _____ - _____ - _____ WORK PHONE: _____ - _____ - _____		RELATIONSHIP TO PATIENT :
SOCIAL SECURITY NUMBER	EMPLOYER	OCCUPATION	

PREFERRED CONTACT REGARDING APPOINTMENT REMINDERS (CHECK ONE)

☐ TEXT TO CELL	☐ CALL HOME NUMBER	☐ EMAIL	☐ NO CONTACT
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INSURANCE INFORMATION *(Medical Assistance MUST be Secondary if you carry Commercial Insurance)*

FINANCIALLY RESPONSIBLE PERSON (CHECK ONE)

☐

PATIENT

☐

MOTHER

☐

FATHER

☐

OTHER

POLICY HOLDER'S NAME:

DOB

SEX:

☐

M

/

☐

F

POLICY HOLDER'S ADDRESS *(IF DIFFERENT FROM PATIENT'S)*

INSURANCE NAME:

ID :

GROUP:

EFFECTIVE DATE:

S.S.N. :

EMPLOYER:

POLICY HOLDER'S PHONE

SECONDARY INSURANCE

FINANCIALLY RESPONSIBLE PERSON (CIRCLE ONE)

☐

PATIENT

☐

MOTHER

☐

FATHER

☐

OTHER

POLICY HOLDER'S NAME:

DOB

SEX:

☐

M

/

☐

F

POLICY HOLDER'S ADDRESS *(IF DIFFERENT FROM PATIENT'S)*

INSURANCE NAME:

ID :

GROUP:

EFFECTIVE DATE

S.S.N. :

EMPLOYER:

POLICY HOLDER'S PHONE

AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ellicott City Pediatric Associates (ECPA) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ECPA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree to pay any collections and/or legal fees necessary for collection, if such situation was to arise.

Signature of Subscriber or Beneficiary_____
Date**SIBLINGS**

NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE#
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Ellicott City Pediatric Associates, P.A.

FINANCIAL & OFFICE POLICY

Thank you for choosing Ellicott City Pediatric Associates, P.A. as your pediatric provider. It is our hope that our patients understand that our credit, collections and office policies are a necessary part of assuring the financial resources required to maintain vital health care service for our patients. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have questions, please ask a member of our staff.

Standards of Care

- ◆ We follow the American Academy of Pediatrics (AAP) and Maryland Healthy Children guidelines for immunizations, growth & development, risk assessments and screenings. We expect you to comply with these guidelines as well as any health-related guidelines from your insurance company.

Appointments:

- ◆ We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate no less than 24 hours cancellation notice. Please remember that all of our appointments are scheduled appointments and if notice is not received, a **\$50.00** no-show and late cancellation fee may apply. If there are 3 no shows within a one- year period you may be asked to transfer care to another practice.
- ◆ If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may not be possible and it may be necessary to reschedule your appointment.

Initial:

Permission for Medical Care:

- ◆ All children under the age of 18 must be accompanied by an adult. Any adult who is not the patient's legal guardian must have written permission to authorize medical treatment for the child.
- ◆ Patients who are age 18 or older will be given the option to sign a release allowing our office to discuss their care (including diagnoses and lab work) with their parents or guardians. By law, we are not permitted to disclose medical information pertaining to any patient aged 18 or above to their parents unless the patient has given us written permission to do so.
- ◆ Parents of adolescents should be aware that Maryland State law permits adolescents to obtain certain confidential services without notifying the parents.
- ◆ For access to our Patient Portal, a home email address must be provided while you are in the office. Access to the Patient Portal is discontinued if you transfer to another provider.

Initial:

Referrals:

- ◆ Advance notice is needed for all non-emergent referrals, typically 3-5 business days.
- ◆ Retroactive referrals cannot be written.
- ◆ Generally, we will not agree to a referral for a problem we have not been consulted about first.
- ◆ It is your responsibility to know if a selected specialist or lab participates with your insurance.

Initial:

Forms:

- ◆ We require 3-5 business days to complete your forms. Please plan accordingly.
- ◆ The child must have an up-to-date (within the past 12 months) physical exam on file with our office.
- ◆ A \$10.00 form completion fee is due at time of drop off. A \$20 rush form fee is available if you need the form within 24 hours or on the same business day.

Initial:

Insurance Plans:

- ◆ It is your responsibility to keep us updated with your correct insurance information. At each visit you will be asked to present your insurance card to ensure that our office has the most up-to-date card on file.
- ◆ If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- ◆ As we are your primary care provider (PCP), make sure our physician or practice name appears on your most up to date card. If your insurance has not been informed that we are your child's PCP and we cannot confirm that we are, you must pay for the visit or reschedule.

- ◆ It is your responsibility to understand your benefit plan.
- ◆ Not all plans cover well child visits, vision and hearing exams/screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- ◆ If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

Initial:

Financial Responsibility:

- ◆ We do not get involved with domestic disputes and custody issues. Our policy is to obtain the co-payment at the time of service from the parent/guardian bringing the child to the appointment. Any balance left from the insurance company will be billed to the guarantor on the account. If bills are ignored, we will hold the accompanying parent responsible for full payment. It will then be that parent's responsibility to seek repayment from the other party.
- ◆ According to your insurance plan you are responsible for any and all co-pays, deductibles and co-insurances.
- ◆ Co-pays are due at the time of service or a \$5 billing fee will be added. We encourage you to register for us to keep a credit card on file to avoid the billing fee.
- ◆ Patient balances are billed monthly; we ask that you pay your balance upon receipt of the statement.
- ◆ If your insurance has not paid a claim within 60 days, the outstanding balance will be sent to you for payment and you can then seek reimbursement from your insurance.
- ◆ If previous arrangements have not been made with our billing office, any account balances 60 days past due will have a \$15.00 late fee applied to the account. Balances reaching 90 days overdue will have a block placed on the account in which no well-child visits can be scheduled until payment is received. Balances reaching 120 days past due will be forwarded to a collection agency and you will be responsible for paying all collection fees. If your account is sent to a collection agency you will be asked to transfer your care to another practice.
- ◆ A sick patient present in our office will not be denied care due to financial difficulties.
- ◆ A \$25.00 fee will be charged for any checks returned by the bank. Repeatedly presenting checks that are returned will result in your account being placed on a "cash only" restriction.
- ◆ For your convenience the following forms of payment are accepted: Cash, Personal Check, Visa, Master Card and Discover. Online payments can be made through our Patient Portal and a credit card may be kept on file.
- ◆ Ellicott City Pediatric Associates, P.A. reserves the right to change fees without notice.
- ◆ Any families asked to transfer care for non-compliance of our policies will not be accepted back into our practice.

Initial:

I have read and understand this office and financial policy and agree to comply with and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Names – please list all children that are patients of Ellicott City Pediatric Associates:

	DOB		DOB
	DOB		DOB
	DOB		DOB
	DOB		DOB

Responsible Party's Name (Print):

Relationship:

Responsible Party's Signature:

Date:

Patient Communication & Medical Treatment Authorization Consent Form

Patient Full Name (PLEASE PRINT) _____

Date of Birth _____

- A. MEDICAL TREATMENT AND CONSENT - This is used when minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent" gives authority to a designated adult to arrange for medical care for a minor. Medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

For the above named patient and for this section "A", you authorize the following people to accompany your minor child to obtain medical care from Ellicott City Pediatric Associates PA. (Please list first and last name)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

- B. PATIENT COMMUNICATION - It is the office policy of Ellicott City Pediatric Associates, P.A., not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For the above named patient and for this section "B", you authorize Ellicott City Pediatric Associates PA to release medical information to the following people. This can include family members, friends, caretakers, etc. (Please list first and last name).

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

By signing below, this grant of temporary authority shall begin on the date signed and shall remain in effect until terminated by the undersigned or until there is a change in the legal status of the patient.

Parent or Guardian Signature _____

Date: _____

Print Name _____

Contact Phone# _____

FOR OFFICE USE:

Changes to above authorize by patient over phone: _____

Date _____

Staff Initials _____

WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____ **DOB:** _____

I hereby acknowledge receipt of:

1. Notice of Ellicott City Pediatric Associates Privacy Practices
2. Ellicott City Pediatric Associates Financial & Office Policy

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Self

Signature: _____

Date: _____

PATIENT NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY

Has your child ever had any of the following:

Serious Injuries or accidents?	☐ Yes	☐ No
Surgeries?	☐ Yes	☐ No
Hospitalizations?	☐ Yes	☐ No
Chickenpox?	☐ Yes	☐ No
Frequent ear or sinus infections?	☐ Yes	☐ No
Pharyngitis/tonsillitis?	☐ Yes	☐ No
Other infectious illnesses?	☐ Yes	☐ No
Allergic rhinitis or other allergy?	☐ Yes	☐ No
Asthma, bronchitis, bronchiolitis, pneumonia, or croup?	☐ Yes	☐ No
Heart problems or heart murmur?	☐ Yes	☐ No
Abdominal pain or GERD?	☐ Yes	☐ No
Constipation requiring doctor's visits?	☐ Yes	☐ No
Bladder or kidney infection, or other urologic problem?	☐ Yes	☐ No
Bed-wetting (after 5 years of age)	☐ Yes	☐ No
Eye conditions or corrective lenses?	☐ Yes	☐ No
Problems w/ ears or hearing?	☐ Yes	☐ No
Chronic or recurrent skin problems (acne, eczema, etc.)?	☐ Yes	☐ No
Anemia or bleeding problems?	☐ Yes	☐ No
Blood transfusions?	☐ Yes	☐ No
Frequent headaches?	☐ Yes	☐ No
Seizures, developmental delays, ADD/ADHD, or other neurologic disorder?	☐ Yes	☐ No
Mental health concerns?	☐ Yes	☐ No
Orthopedic problems?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Thyroid or other endocrine problems?	☐ Yes	☐ No
If female, have menstrual periods started?	☐ Yes	☐ No
If female, any problems w/ periods?	☐ Yes	☐ No
Use of alcohol or drugs?	☐ Yes	☐ No
Emotional problems?	☐ Yes	☐ No
Other significant problems?	☐ Yes	☐ No

DOB: _____

[illegible]

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO ECPA

****Send this to your previous physician and obtain your records BEFORE your visit to us.****

RECORDS TO BE RELEASED FROM: (your previous physician)

Provider: _____

Address: _____

phone# _____

fax # _____

I hereby request and authorize you to furnish records for the purpose of _____

or at my request.

Release : (*Please select only 1*)

☐

All Records (fees might apply, please check with provider)

☐

Immunization Records

☐

Abbreviated Records (Immunization, Growth Chart, Last Physical, recent Lab, Xray)

☐

Release Records from _____ to _____

RECORDS TO BE SENT TO :

Ellicott City Pediatric Associates

9011 Chevrolet Drive, Suite 1-6

Ellicott City, MD 21042

Phone: 410-465-7550 fax 410-465-6359

PATIENT INFORMATION :

1. Patient name: _____ DOB: _____

2. Patient name: _____ DOB: _____

Address _____

The authorization is **effective for one year** from the date on which it was signed. I further understand that I may revoke this authorization (in writing) at any time, except to the extent that action has been taken in reliance on it. I understand that the medical records to be release may contain medical information pertaining to psychiatric, drug and/or alcohol, HIV/AIDS diagnosis and treatment. I further understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws and may be subject to re-disclosure.

Signature of Patient or Legal Guardian

Date