

Unity Pediatrics New Patient Registration Form

Patient information:

CHILD NAME #1 _____ DOB _____ SEX _____

CHILD NAME #2 _____ DOB _____ SEX _____

CHILD NAME #3 _____ DOB _____ SEX _____

Home Address: _____

City: _____ State: _____ Zip: _____

How did you hear about the practice? _____

Please **circle** appropriate answers below:

Ethnicity:	Hispanic or Latino	Non-Hispanic or Latino	Decline to specify		
Race:	Black/African American	White/Caucasian	Asian		
	Native American	Pacific Islander	Decline to specify		
Language:	English	Spanish	French	Chinese	Korean
	Hindi	Portuguese	Vietnamese	Other	_____

Insurance information:

Primary Insurance:

Insurance Company: _____

Member ID #: _____ Group ID #: _____

Policy Holder: _____ Policy Holder's DOB: _____

Relationship to Child: _____

Secondary Insurance (if applicable):

Insurance Company: _____

Member ID #: _____ Group ID #: _____

Policy Holder: _____ Policy Holder's DOB: _____

Relationship to Child: _____

Parent/Guardian #1:

Name: _____ DOB: _____

Home Address: _____ Home phone #: _____

Mobile phone #: _____ Work phone#: _____

Email Address: _____

Employer: _____ Occupation: _____

Preferred Contact (choose one): Call mobile Call home phone Text Email

Parent/Guardian #2:

Name: _____ DOB: _____

Home Address: _____ Home phone #: _____

Mobile phone #: _____ Work phone#: _____

Email Address: _____

Employer: _____ Occupation: _____

Preferred Contact (choose one): Call mobile Call home phone Text Email

Emergency Contact (other than parent or guardian):

Name: _____ Relationship: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

Address: _____

Acknowledgement and Signature:

I confirm that the information on this form is current and accurate. I understand that I am financially responsible for all charges whether paid by the insurance company or not. I also acknowledge that I have reviewed the Notice of Privacy Practices prior to any service provided by Unity Pediatrics, LLC. The effective date of this notice is November 15, 2022 and may be updated periodically. By signing this written acknowledgement, I give Unity Pediatrics LLC consent to use and disclose the patient’s medical information. A copy of the notice may be given upon request.

Signature of parent, guardian, or patient 18 years or older

Date

Medical History

Patient Name (Last, First): _____ DOB: _____ Date: _____

Birth History:

Name of hospital: _____ Vaginal or C/Section: _____ Birth Weight: _____

Weeks gestation: _____ Adopted (Y/N): _____ Problems during pregnancy, labor, or delivery(Y/N): _____

If yes, please explain: _____

Immunizations: What age was the last time your child received vaccines? _____

Medications (Prescription, OTC, or Vitamins):

1. _____ 3. _____

2. _____ 4. _____

Medication and Food Allergies (list reactions): _____

Medical Conditions (Include history of bone fractures):

1. _____

2. _____

3. _____

Specialists (Name and phone number): _____

Hospitalizations (Where child stayed overnight except at birth.):

Date	Location	Reason
1. _____	_____	_____

2. _____

Surgeries (include dental procedures under general anesthesia):

Date	Location	Reason
1. _____	_____	_____

2. _____

Family History

Date: _____

Has anyone in the family ever been diagnosed with any of these conditions? Please use these initials to specify the relationship to the child(ren). **(M)** mother, **(F)** father, **(S)** sibling, **(MGM/F)** maternal grandmother/father, **(PGM/F)** Paternal grandmother/father, **(MA)** maternal aunt, **(PA)** paternal aunt, **(MU)** maternal uncle, **(PU)** paternal uncle, and **(C)** first cousin.

ADD/ADHD	High blood pressure
Allergies(food-specify) Allergies (seasonal)	High Cholesterol High Triglycerides
Asperger's	Inflammatory Bowel Disease
Asthma	Irritable Bowel Syndrome
Autism	Kidney Disease/Cysts
Birth Defects	Lazy eye
Blood Disorders	Liver Disease
Cancer (what type?) 1. 2. 3. 4.	Mental Illness: 1. Anxiety 2. Bipolar disorder 3. Depression 4. OCD
Celiac Disease	Migraines
Congenital Heart Disease	Obesity
Diabetes	Seizures
Drug Abuse (include Alcoholism)	Sickle Cell Disease Sickle Cell Trait
Eczema	Stroke
GERD	Thyroid Disease
Hearing Problems	Vision Problems

Other: _____

Social History

Who lives at home with the child(ren)? _____

Does child(ren) live in a house, apartment, or shelter? If there are two separate households, please list both. 1. _____ 2. _____

Please circle your choices.

Are parents: Single Married Separated Divorced
 Smokers at home? Yes / No Smoke/CO detectors working? Yes /No Guns in the home? Yes/ No
 Do you have pets? Yes / No
 If yes, what kind? _____

CONSENT TO TREAT

I, (Parent, Legal guardian, or Patient 18 years and older): _____
hereby give consent to Unity Pediatrics, LLC to provide medical treatment by any licensed physician and clinical staff of Unity Pediatrics, LLC to the patient(s) listed below. Such consent may include, but is not limited to, immunizations, administration of medications, nebulizer treatments, lab tests, injections, or procedures that may be deemed necessary or advisable. It is understood that this authorization is given in advance of any specific diagnosis or treatment required. This authorization shall remain effective unless revoked in writing by the undersigned.

Patient #1 _____ DOB _____

Patient #2 _____ DOB _____

Patient #3 _____ DOB _____

Signature: _____ Date: _____

PERMISSION TO TREAT MINOR(S) WITHOUT PARENT OR GUARDIAN PRESENT

I authorize, if I am not present, that the people listed below are 18 years or older and may accompany my child(ren) to Unity Pediatrics, LLC. They can authorize any immunizations, administration of medications, medical treatments, lab tests, injections, or performing procedures that may be deemed necessary or advisable for my child(ren), on my behalf, via written or verbal consent. I understand that they will receive relevant protected health information and that I remain personally and financially responsible for all medical services and treatment delivered to my child(ren) pursuant to this authorization. Also, whether I am present or not for the visit, the co-payment, deductible, or co-insurance is due on the date of service. This person must provide a photo ID at the time of the visit.

Person #1: _____ Relationship to the child: _____

Phone#: _____

Person #2: _____ Relationship to the child: _____

Phone#: _____

Signature: _____ Date: _____

This authorization will remain in effect for **1 YEAR** from the date of signature.

Office Policy

Vaccine Policy:

Vaccine records are a requirement for all new patients. We only accept families who vaccinate their children. Unity Pediatrics, LLC passionately believes in the effectiveness of vaccines to prevent serious illnesses and save lives. We require all patients to undergo vaccination in accordance with AAP guidelines. We do **not** follow any alternative vaccination schedules, because there is no verification of the safety and efficacy of these schedules. We do not split or delay vaccines. We cannot accept the risk that unimmunized or under-immunized children pose to other children and their families in our practice and in our communities. If you sign up as a patient and change your mind regarding this vaccine policy, you will have thirty days, from making that decision, to find another physician who shares your values.

Initial _____

Behavioral Etiquette:

At Unity Pediatrics, LLC we pride ourselves on a cordial and respectful environment for all present in our facility. However, we do not tolerate inappropriate behavior that does not fit that philosophy. We do not condone any rude, disruptive, or threatening behavior, whether in person, written, verbal, or via electronic communication. These behaviors include but are not limited to use of profanity, harassment, threats, physical assault, intimidation, or compromise of staff, patients, and/or physicians' personal space. This will result in immediate dismissal.

Initial _____

Appointments:

Office hours are 9:00am to 5:00pm Monday to Thursday and 9:00am to 4:00pm on Fridays. Visits are by appointment only. We do NOT have walk-in hours. At times, there may be variations in the schedule, especially with inclement weather. You will receive notification of that change. We ask parents/guardians to give us at least **24-hour notice** of any cancellations. Missed appointments will incur a \$50 fee. This includes telehealth visits and appointments rescheduled the same day. This includes telemedicine visits. Please note there are times when telemedicine visits are via phone call (i.e., audio only). The charges will undergo billing as per insurance guidelines. There may be an additional fee for appointments that occur after hours, weekends, or on federal holidays.

Initial _____

Late Appointments:

If you are running late, please call the office. There is a possibility if you are more than 15 minutes past your well check appointment, you will have to reschedule. If the patient is sick or has a telemedicine visit, we will try to accommodate. Patients who arrive on time will have priority. Continuous late arrivals may result in being discharged from the practice.

Initial _____

Telemedicine Appointments:

The laws that protect privacy and the confidentiality of medical information also apply to telehealth services. Any information obtained in the use of telemedicine services is only for the purpose of continuity of care. The doctors at Unity Pediatrics, LLC will not take video, audio, or photo recordings of your child(ren) during telemedicine services without your consent. I also understand that I may not record any portion of the video visit, take photographs or screenshots without the consent of the telemedicine physician. Telemedicine appointments may require a copayment as per your insurance company.

Initial _____

Guidelines for telemedicine visit:

Place the patient in a well-lit room with as little distractions as possible. Obtain the child's temperature and weight. Have a flashlight handy, if needed. Make sure to have a strong Wi-Fi connection. Update pharmacy information. Telemedicine visits **will not take place when** the parent/caretaker is driving.

Initial _____

Referrals:

If your insurance plan requires a referral for your child to see a specialist, obtain labs, or receive a radiologic study, you must allow three business days for us to complete the proper form(s) prior to obtaining the services. You may have to reschedule your child's appointment if we do not receive adequate notification. In general, we will not be able to issue a referral without an evaluation from the physician.

Initial _____

Phone Calls:

Phone calls, during business hours, which require an extensive discussion about your child's medical care, may be subjected to a charge, per insurance guidelines. Physicians are available on call after business hours. Those calls are **only** for urgent matters. Please call the office for further information. For any life-threatening emergencies, please call 911 immediately. If there is an accidental poisoning or ingestion, please call Poison Control first 1-800-222-1222.

Initial _____

Prescriptions:

Prescription refill requests will occur during normal business hours. We require regular medication follow ups of chronic conditions such as Asthma and ADHD every 3 months. Please allow up to three business days for completion of requests.

Initial _____

School Forms:

The completion of forms will only occur if the child has had a well child check **within 1 year of form request**. The child's name and date of birth must be on the top of each page. Parent/Legal Guardians must fill out their designated sections and provide the entire form for review. We will not begin to fill out the form unless all sections, required by the Parent/Legal Guardian, are complete. **If you present a physical form at the time of the well child appointment, there will be no fee.** Payment is due at the time of form drop off. If we receive forms at any other time, there will be a charge. We cannot send these fees for payment to your insurance company. We do not send bills for forms.

FEES:

School forms: \$15 (5-7 business days). Rush fee: \$25(within three business days). Family: \$40 (flat rate) up to three forms; four or more \$10 each additional form

Medication forms: \$10 each; \$20 (2-3 forms); 4 or more: \$ 30 flat rate **FMLA form:** \$30. Rush fee \$40.

Extensive/Detailed letters: \$10 fee.

You may provide the school's fax number to send completed forms to the school.

Initial _____

General Photography Release:

I hereby authorize Unity Pediatrics, LLC to publish photographs taken of me and/or my child(ren) on practice events, for use in the Unity Pediatrics, LLC's website, Facebook, prints, online and video-based marketing materials, as well as other Company publications. I hereby release and hold harmless Unity Pediatrics, LLC from any reasonable expectation of privacy of confidentiality associated with the images specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever. I hereby release Unity Pediatrics LLC, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials from liability for any claims by me or any third party in connection with my participation.

Initial _____

Separated or Divorced Parents:

Physicians and office staff will not be involved in domestic issues or disagreements over the phone or in the office. Please make decisions about appointments and vaccinations before coming to the appointment. Only in situations where there is a confirmed and documented court order will one of the parents not have access to the minor child’s electronic chart. If there is no court order on file, with our office, either parent or legal guardian can sign a medical authorization form. This will allow any named individuals to bring your child to our practice, be present during the visit, and consent to any treatment during that visit.

We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. It is both parents’ responsibility to communicate with each other about the patients’ care, office visit dates, and any other pertinent information relevant to the patient. It is not the responsibility of the physician to communicate visit information to each custodial parent separately. Our doctors will not call the non-attending parent following visits. Additionally, we will not call the other parent for consent regarding appointments scheduled and restrict either parent’s involvement in the patient’s care unless authorized by law. We will not tolerate appointment scheduling or canceling patterns of behavior between parents.

Furthermore, payments including copays, deductibles, coinsurance, or any additional fees charged by your insurance, are due at the time of service regardless of which parent is responsible for medical expenses. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent. Any disputes about payment that end up in the collections process will require payment at the time of service or the patient cannot have an appointment. If we feel that any of the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice.

Initial _____

Medical records:

Complete the medical authorization form to request transfer of medical records. There is no fee for transfer of records to another physician or health care facility. Fee for personal use is \$0.25 cents per page for the first twenty pages and \$0.50 cents per for pages 21 and over. There will be an additional charge for postage and handling. **Please note:** We will only provide records of your child’s visits to Unity Pediatrics, LLC **only**. For records from outside providers or facilities, you should obtain it from them directly.

Initial _____

Termination of Practice-Patient Relationship: Family dismissal:

Enforcement of this policy will happen if there is a violation of the behavioral policy, unpaid balances despite payment plan in place, refusing to pay fees owed to practice, three or more missed appointments per family, and vaccine refusal. There may be other reasons the practice, in its sole discretion, deems termination of practice-patient relationship must occur.

Initial _____

FINANCIAL POLICY

We are committed to providing you with the best medical care available. The following financial policy is to avoid any misunderstanding and provide you with an outline of our expectations.

Please note that Unity Pediatrics, LLC is under contract with your insurance company to collect your co-pay or deductible at the time of service. The party that brings the child to the office will be financially responsible for the co-payment. Those families that have divorced, separated, or custodial parenting arrangements, Unity Pediatrics, LLC will not become involved in any financial disputes about the responsibility of payment for a child's medical expenses. Parents are responsible for communicating with each other about the treatment and payment issues. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial, or other arrangement places that obligation on your former spouse or the child's other parent. We can provide you receipts for paid medical bills, upon your request. Please note that if a child is not with a parent/legal guardian, the accompanying adult will have to make any applicable payment. A summary or information regarding each visit will be available on the patient portal which may be used for parent communication.

Insurance, Billing, & Patient Responsibility

As a courtesy to our patients, Unity Pediatrics, LLC will bill your insurance company. Please remember that your insurance is a **contract between you and the insurance company, not the physician**. You are financially responsible for all charges not covered by the insurance company. You must report ALL insurance coverage correctly. Failure to do this is insurance fraud. This will also result in full patient responsibility for your bill. If the claim is reprocessed due to invalid insurance information, there will be a \$25.00 refiling fee.

Balances after primary or secondary insurance processed the claim is your responsibility. Please refer to your EOB for expected patient's responsibility. Payment is due after the receipt of the statement. If you do not understand your specific plan coverage, call your insurance company. We encourage you to get clarification at least two weeks prior to your appointment. It is your responsibility to know if your insurance covers well-checks, vaccines, annual vision screens, hearing screens, labs, or other procedures. The cost may be towards the deductible.

The focus of well child visits is preventive care and monitoring of developmental milestones. At times, **you may have additional questions or concerns that may arise** that fall beyond the scope of these visits. For your convenience, if time allows, we will try our best to address these concerns at the time of the visit. However, your insurance company may recognize these services as outside the level of a well visit. This **may incur an additional charge (co-pay) from your insurance company**.

This policy does not apply to patients with Medicaid and Medicaid HMO insurance.

Credit Card Authorization

We will request to have a credit card on file. Your signature below will authorize Unity Pediatrics, LLC to charge the credit card for all balances which your health insurance plan deems as "patient responsibility" i.e., co-pays, deductibles, non-covered service, etc. Your copay or deductible will be due at the time of service. You understand that once the health insurance has processed your child's claims, you will receive an Explanation of Benefits (EOB). The EOB will show any balances due. This is the responsibility of the parent/guarantor. A secure site will hold your credit card information for future payment of services. You will receive a copy of the receipt. We only accept credit/debit cards for office visits.

Self-pay

If you do not have insurance, we do not accept your insurance, or we cannot validate your insurance coverage, you will be responsible for full payment of charges. We do not send bills if it is self-paid. If you provide proof of participating insurance, you will receive a refund of the amount collected. If insured by a non-participating insurance carrier, we will expect payment from you at the time of service. It is **your responsibility** to submit any claims to your insurance company for direct reimbursement. All statement payment is due upon receipt. If charges remain unpaid after 30 days, we will send a second statement requesting immediate payment. If the statement remains unpaid after 60 days, you will receive another notification and the bill will accrue late fee charges. You will receive a letter

informing you that our relationship is subject to cancellation after 30 days of urgent or emergent care. We reserve the right to place your account with our collection agency after all internal efforts have not resulted in payment.

PAYMENT PLANS:

We understand extraordinary circumstances can prevent timely payment of your balance in full. We will collaborate with you to arrange a payment plan if necessary. We must have a signed payment plan and you must pay regularly to keep your account from further action. We can keep your credit card on file securely for monthly automatic payments. If your account becomes 90 days or more past due, without correspondence or payment from you, your account will automatically go to an outside collection agency. We reserve the right to place your account with our collection agency after all internal efforts to obtain payment have been utilized. You will be responsible for the fee charged by the agency for the costs of collection in addition to the original amount due. Unpaid balances sent to the collection company may result in family dismissal from the practice.

NO SHOW/CANCELLATION OF APPOINTMENTS:

If it is necessary to cancel your appointment, we require that you give notice **at least 24 hours** prior to the appointment. Failure to do so will result in a \$50.00 fee. This includes appointments rescheduled the same day. Payment of this fee must be prior to scheduling the next appointment. As a courtesy, we call or text for reminders; however, you are still responsible for the cancellation even if you did not receive a call and/or text. We reserve the right to discharge you from our practice for missing three appointments.

PAYMENT RESPONSIBILITY:

At the time of service, the accompanying adult who signs a minor child into our practice accepts final responsibility for payment. We will send statements to the guarantor listed on your registration sheet.

By signing below, the responsible party acknowledges, reads, and understands the financial policy of Unity Pediatrics, LLC and is bound by the terms and conditions set forth therein. The terms of this financial policy may undergo revisions, by the practice, at any time without notification to the guarantor. Failing to sign this agreement may result in the patient's release from the practice.

Signature of parent, responsible party, or patient >18yrs

Date

Patient Name

DOB

Patient Name

DOB

Patient Name

DOB