PATIENT INFORMATION (please print)

Last Name: _____ First Name: _____ Middle: _____

Sex: ____M ____F Date of Birth: _____ Social Security #_____

Home Address: _____

_____

Home#_____ Cell#_____ Work#_____

Pharmacy preferred: _____ Street: _____

Preferred Primary Care Physician: _____

If New Patient, How did you hear about us? _____

PARENT(S)/GUARDIAN(S) INFORMATION

Mother's Name: _____ Biological: _____Y _____N

Address (If different from patients):_____

_____

Home#_____ Cell#_____ Work#_____

E-mail:_____

Father's Name: _____ Biological: _____Y _____N

Address (If different from patients):_____

_____

Home#_____ Cell#_____ Work#_____

E-mail:_____

Emergency Contact: _____ Relationship to patient: _____

Home#_____ Cell#_____ Work#_____

INSURANCE INFORMATION - POLICY HOLDER

Name of Insurance: _____ ID#_____

Policy Holder Last Name: _____ First Name: _____

Sex: ____M ____F Date of Birth: _____ Social Security #_____

Address: _____

_____

Home#_____ Cell#_____ Work#_____

Employer: _____

Party responsible for non-covered balance? Same as above Y / N Other: _____

Authorization to Release Individual Health Information

Privacy Notice

The Health Insurance Portability & Accountability Act (HIPPA) is a federal law designated to protect the privacy of your health information. We understand that information about you and your health is personal and Neighborhood Pediatrics is committed to protecting the privacy of that information. Because of this commitment we must obtain your special authorization before we may use or disclose your protected health information for the research purposes described below. This form provides that authorization and helps up make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

Consent for Disclosure of Health Information for Treatment, Payment and Healthcare Operations

I consent to Neighborhood Pediatrics PC using and disclosing protected health information about my/my child and/or his/hers/my family to carry out treatment, payment or healthcare operation. Examples of such instances include, but not restricted to;

1. Your medical insurance carrier
2. Local or state Medicaid office
3. Physicians to whom your child is referred
4. School Health Officials

I understand and have read the above Notice of Privacy Practices, which provided a description of how my health information may be used or disclosed. I understand that I have a right to review the notice prior to consent.

I understand that I have the right to revoke this consent by notifying Neighborhood Pediatrics PCs in writing except to the extent that Neighborhood Pediatrics has taken action in reliance on my consent. I understand that my revocation will take effect within 30 days after Neighborhood Pediatrics receives it.

Patient Name: _____ DOB: _____

Signature of Parent/Guardian/Patient_____

Printed Name: _____ Date: _____

The following people have permission to seek medical care and or information on my/my child's behalf:

Name	Relationship
_____	_____
_____	_____

FINANCIAL POLICY

Thank you for choosing Neighborhood Pediatrics as you healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our office is available to discuss our fees and billing policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, and MasterCard. As a courtesy to you, it is the policy of Neighborhood Pediatrics to bill your insurance carrier, *although you are ultimately responsible for the entire bill.* As the responsible party, please understand;

(PLEASE INITIAL THE FOLLOWING)

____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

____2. Fess for service, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

____3. *All charges are your responsibility whether your insurance company pays or does not pay.* IF your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Neighborhood Pediatrics, you recognize an obligation to promptly remit payment to Neighborhood Pediatrics.

____4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Neighborhood Pediatrics, I will be responsible for all costs of collecting monies owed and collection agency fees.

____5. The above does not apply for those patients that are considered Worker's Compensation. However, be advised that as compensation patient you may be held responsible for charges in the event that your claims is controverted.

At Neighborhood Pediatrics, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing, if you have any questions please call (978) 342-4437.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____ DOB_____

Signature of Patient or Responsible Party: _____

Date: _____

ASSIGNMENT OF BENEFITS

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare, Medicaid, Medicare Supplement or other insurance benefits to Neighborhood Pediatrics for treatments, medication(s) and medical equipment furnished to my child by Neighborhood Pediatrics and their medical providers.
2. Direct billing to Medicare, Medicaid or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns, as needed for the limited purposes of processing payments, treatment for Neighborhood Pediatrics operations.
4. Neighborhood Pediatrics and/or any of their affiliates to obtain medical or other information necessary in order to process my claims(s), including determining eligibility and seeking reimbursement for medical treatments, medical supplies and/or medication(s).
5. I agree to pay all mounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments, and deductibles.
6. Neighborhood Pediatrics and/or any of their affiliates to contact me by telephone or mail regarding my/my child's medical treatments.

Patient Name: _____ DOB:_____

Signature of Parent, Guardian and/or Patient: _____

Date: _____

Self-Pay Patient Policy

Thank you for coming to Neighborhood Pediatrics. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have a question or problem with our fees or payment process, please don't hesitate to talk to any of our front desk staff.

(PLEASE INITIAL THE FOLLOWING)

___ 1. Fees for services are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

___ 2. Services paid in full at the time of service will receive a courtesy discount.

___ 3. I understand and agree that if I fail to may any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Neighborhood Pediatrics, I will be responsible for all costs of collecting monies owed and collection agency fees.

At Neighborhood Pediatrics, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing, if you have any questions please call (978) 342-4437.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____
DOB_____

Signature of Patient or Responsible Party: _____

Printed Name:_____

Date: _____

Medical History Form

This questionnaire is designed for your doctor to have information about you and your family that will help provide your child with the best medical care. Please complete the form before your child's first appointment. If a question does not apply to you, leave it blank.

Today's Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____

Mother's name _____ ❑ lives with child

Father's name _____ ❑ lives with child

Name of Guardian' (if other than parents) _____ ❑ lives with child

Parents:

❑ Married ❑ Separated ❑ Mother Remarried

❑ Single ❑ Divorced ❑ Father Remarried

If parents are not together, how often does your child see the parent not living at home? _____

My child is: ❑ Biological ❑Adopted ❑Step ❑Foster ❑Other

If adopted, how old was he/she when adopted? _____

Does the child know he/she is adopted? _____

How did you hear about Neighborhood Pediatrics?

❑ Friend ❑ Another doctor ❑ Hospital ❑Internet ❑Saw building ❑ Other

Please list any other children you have that are not living with you, and where they reside: _____

_____

Past Medical History

Has your child had any of the following medical problems? **If yes, please use the space below to describe problems in detail.**

YES	NO		YES	NO	
❑	❑	ADD or ADHD	❑	❑	Fibromyalgia
❑	❑	Allergies	❑	❑	GERD/Reflux
❑	❑	Anemia	❑	❑	Heart Problems
❑	❑	Anxiety Disorder	❑	❑	High Cholesterol
❑	❑	Arthritis	❑	❑	Hospital Admission (other than birth)
❑	❑	Asthma	❑	❑	Hypertension
❑	❑	Bedwetting	❑	❑	Hyperthyroidism
❑	❑	Bladder or Kidney Problems	❑	❑	Hypothyroidism
❑	❑	Blood Diseases	❑	❑	Kidney Disease
❑	❑	Bronchiolitis/RSV	❑	❑	Kidney Stones
❑	❑	Cancer	❑	❑	Liver Disease
❑	❑	Chicken Pox	❑	❑	Muscle, Joint or Bone Problems
❑	❑	Congenital Anomalies	❑	❑	Seizures/Epilepsy
❑	❑	Constipation	❑	❑	Serious Illness or Injuries
❑	❑	Croup/Recurrent Bronchitis	❑	❑	Skin Problems
❑	❑	Depression	❑	❑	Stroke
❑	❑	Developmental or Behavioral Disorders	❑	❑	Thyroid Problems
❑	❑	Diabetes	❑	❑	Tuberculosis
❑	❑	Ear or Hearing Problems	❑	❑	Vision or Eye Problems
❑	❑	Eczema, Hives or other skin conditions	❑	❑	Other: _____

Family Medical History

Do any biological relatives have any of the following medical problems? **If yes, please use the space below each item to describe the specific problem and relation to the child. <u>Please specify who in the family has the problem.</u>**

	YES	**Family Relation (PLEASE SPECIFY WHO)**											
		Immediate Family				Mother's Side				Father's Side			
		Mom	Dad	Brother	Sister	GF	GM	Aunt	Uncle	GF	GM	Aunt	Uncle
ADHD	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Alcohol/Substance Abuse	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Anxiety Disorder	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Bleeding/Clotting Disorders	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Bowel or Stomach Issues	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Developmental Disorders	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes Childhood Onset/Adult Onset	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Endocrine Problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Epilepsy/Seizures	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Headaches/Migraines	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart Attack (MI)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart Problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Hepatitis C, HIV	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Immune Problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Liver Problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
MRSA infections	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Sickle Cell Disease or trait	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Sleep Apnea	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Suicide	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Prenatal History

Mother's prenatal medical history.

YES	NO		YES	NO	
❑	❑	Abnormal AFP	❑	❑	HIV
❑	❑	Abnormal Ultrasound	❑	❑	Infections
❑	❑	Bleeding	❑	❑	Multiple Gestations
❑	❑	Gestational Diabetes	❑	❑	Pregnancy Medications: _____
❑	❑	Group B Strep			_____
❑	❑	Hepatitis	❑	❑	Other: _____
❑	❑	Herpes			

Birth History

Child's birth weight: _____

Mother's age at birth: _____

Has your child had any of the following medical problems? **If yes, please use the space below to describe problems in detail.**

YES	NO		YES	NO	
❑	❑	Prematurity? If yes, weeks: _____	❑	❑	Oxygen Needed
❑	❑	Maternal Infections	❑	❑	Intubation
❑	❑	C-Section	❑	❑	Jaundice
❑	❑	Vacuum	❑	❑	Other: _____
❑	❑	Breathing Problems			
❑	❑	NICU Admit			
❑	❑	Fetal Distress			
❑	❑	Infection			