PREMIER PEDIATRICS
PATIENT REGISTRATION

CHILD 1 Last Name_____ First Name_____

BIRTH DATE: ____/____/____ **Sex**: ◯M ◯F **Primary Language**: _____

Ethnicity: ◯Hispanic ◯Not Hispanic ◯Unknown **Gender:**_____

Race: ◯ Asian ◯Black ◯White ◯Native American ◯Hawaiian

CHILD 2 Last Name_____ First Name_____

BIRTH DATE: ____/____/____ **Sex**: ◯M ◯F **Primary Language**: _____

Ethnicity: ◯Hispanic ◯Not Hispanic ◯Unknown **Gender:**_____

Race: ◯ Asian ◯Black ◯White ◯Native American ◯Hawaiian

CHILD 3 Last Name_____ First Name_____

BIRTH DATE: ____/____/____ **Sex**: ◯M ◯F **Primary Language**: _____

Ethnicity: ◯Hispanic ◯Not Hispanic ◯Unknown **Gender:**_____

Race: ◯ Asian ◯Black ◯White ◯Native American ◯Hawaiian

CHILD 4 Last Name_____ First Name_____

BIRTH DATE: ____/____/____ **Sex**: ◯M ◯F **Primary Language**: _____

Ethnicity: ◯Hispanic ◯Not Hispanic ◯Unknown **Gender:**_____

Race: ◯ Asian ◯Black ◯White ◯Native American ◯Hawaiian

CHILD 5 Last Name_____ First Name_____

BIRTH DATE: ____/____/____ **Sex**: ◯M ◯F **Primary Language**: _____

Ethnicity: ◯Hispanic ◯Not Hispanic ◯Unknown **Gender:**_____

Race: ◯ Asian ◯Black ◯White ◯Native American ◯Hawaiian

Child(ren)'s Primary Address:

_____

(Street or PO Box) (City) (State & Zip)

Who lives at this household? _____

Child(ren)'s Primary Phone: (_____) _____ - _____

PRIMARY CONTACT PERSON/PARENT: (Check One)

◯ Biological Mother ◯ Step-Mother ◯ Adoptive Mother ◯ Foster Mother ◯ Legal Guardian ◯ Other

◯ Biological Father ◯ Step-Father ◯ Adoptive Father ◯ Foster Father

Name:_____ Birth Date: ____/____/____ Home Phone: _____

Address: _____ Cell Phone: _____ Work Phone: _____

City: _____State: _____ Zip:_____ Primary Contact: _____Home _____Cell

Email Address: _____ Do you live with the patient? _____Yes _____ No

Social Security #: _____ Employer: _____

SECONDARY CONTACT PERSON/SECOND PARENT: (Check One)

◯ Biological Mother ◯ Step-Mother ◯ Adoptive Mother ◯ Foster Mother ◯ Legal Guardian ◯ Other

◯ Biological Father ◯ Step-Father ◯ Adoptive Father ◯ Foster Father

Name:_____ Birth Date: ____/____/____ Home Phone: _____

Address: _____ Cell Phone: _____ Work Phone: _____

City: _____State: _____ Zip:_____ Primary Contact: _____Home _____Cell

Email Address: _____ Do you live with the patient? _____Yes _____ No

Social Security #: _____ Employer: _____

Primary Insurance:

Insurance Carrier: _____ Policy #: _____

Insurance Phone #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth ____/____/____ SS# _____-_____-_____

Relationship to patient: _____ Do you live with patient? ◯ Yes ◯ No

Secondary Insurance:

Insurance Carrier: _____ Policy #: _____

Insurance Phone #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth ____/____/____ SS# _____-_____-_____

Relationship to patient: _____ Do you live with patient? ◯ Yes ◯ No

SIGNATURE ON FILE FORM

USE OF PHOTOGRAPH

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

ASSIGNMENT OF BENEFITS/AUTHORIZATION/NOTICE OF COLLECTION ACTION

I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to Premier Pediatrics. I authorize Premier Pediatrics to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, copayments, charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action (e.g. late fees, collection agency, court, or attorney costs). Please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

The undersigned certifies that each has read and understands the above terms and conditions.

Signature: _____ Date: _____

Printed Name: _____

ACKNOWLEDGEMENT OF PREMIER PEDIATRICS' NOTICE OF PRIVACY PRACTICES

Premier Pediatrics is required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 to provide each patient and his/her legal representative with a copy of our Notice of Privacy Practices. We are also required to obtain a signed acknowledgement of receipt from each patient and his/her legal representative. We appreciate your cooperation in signing below to fulfill this requirement.

I, _____, acknowledge receipt of Premier Pediatrics' Notice of Privacy Practices on
(PRINT YOUR NAME)

behalf of _____.
(PRINT THE PATIENT'S NAME)

Signature: _____Date: _____

PREMIER PEDIATRICS PAYMENT POLICY

Financial Topic	Initials
Insurance. We participate with many insurance plans including Managed Medicaid plans. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you *are* insured by a plan with which we participate, but do not have an up-to-date insurance card, payment in full is required at each visit until we can verify your coverage. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage provisions.	
Proof of insurance. All patients must complete our patient information form before seeing the doctor. We will need a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.	
Co-payments. All co-payments shall be paid at the time of service. This arrangement is part of your/our contract with your insurance company. It is our policy to collect a co-payment at every visit. It is impossible for us to know which insurance companies do not require copayments; often we must wait up to three months for the insurers' explanations of benefits' statement to find this out. If we should find out about a waived copayment when we receive the statement, we will adjust your previously paid co-payment as a credit balance or a refund, if requested by you in writing.	
Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any balance is your responsibility. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.	
Return Check Fee. A $30.00 fee will be assessed to your account for any returned checks.	
Non-covered services. Please be aware that based on your specific insurance coverage some services you receive may not be covered. Our office follows nationally accepted standards for coding and submitting claims to insurance companies. Occasionally there are discrepancies in coverage and claims payments which may result in an unpaid portion of a claim. This denied portion becomes your payment responsibility.	
Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may need to refer your account to a collection agency, and your children may be discharged from our practice. Should this occur, you will be notified by regular and or certified mail that you will have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you for ongoing and emergency care.	
Missed appointments. We reserve the right to charge for missed appointments and for canceled appointments if the cancellation is not made at least two hours before the appointment. These charges will be your responsibility and will be billed directly to you. Multiple no-show appointments will result in being discharged from the practice. Please help us to serve you better by keeping your scheduled appointment or by cancelling prior to the day of the scheduled visit.	
Acute/sick concerns at well visits. Occasionally, during a well child visit, there might be other concerns voiced by the parent/guardian regarding a potential medical illness or condition. Likewise, the physician may, during the encounter by history or by physical examination, find an abnormality that requires further investigation. This may include (but is not limited to) ear infection, poor weight gain, rash, developmental delay, behavior/learning problems, or other illness or concern. These issues may, and usually do, require additional time to fully evaluate and discuss. Occasionally a prescription may need to be written, a medical workup may need to be initiated, or a referral may be made to a specialist. These issues or concerns would normally require you to make an additional office visit to address; however, in the interest of expediting treatment, our practice will attempt to offer comprehensive medical services at the time of the well visit. Physicians are required to code all diagnoses observed or discussed at every visit, including the well visit. Your insurance company will process the sick/acute visit according to your benefits. Some insurance companies may apply these charges to a deductible, coinsurance, or copayment. Charges that are not fully covered by your insurance company will be your responsibility and will be billed directly to you. Please contact our billing department if you have any questions regarding your statement or account.	
Screening tests and other services. There are certain screening tests and additional services that are recommended by the American Academy of Pediatrics during a well visit. These include (but are not limited to) nutrition counseling, developmental screening, alcohol/drug use screening for adolescents, depression screening, dyslipidemia screening, lead screening/testing, tuberculosis screening/testing, hemoglobin testing, hearing testing, and vision testing. Your insurance company will process these additional screenings/tests according to your benefit plan. Some insurance companies may apply these charges to a deductible, coinsurance, or copayment. Charges that are not fully covered by your insurance company will be your responsibility and will be billed directly to you.	

Signature of Parent/Guardian_____ Date_____

Premier Pediatrics, LLC Medical Record Transfer Form

I, _____, hereby authorize

Name and Address of Previous Practice

_____

_____

_____

To release my child(ren)'s medical records to:

☐ **Premier Pediatrics, LLC**
2600 Glasgow Avenue, Suite 213
Newark, DE 19702
Phone: 302-836-4440
Fax: 302-836-4466

Child's Name (please print)	Date of Birth

_____ _____
Signature of Parent/Guardian Date

_____
Parent/Guardian Name (please print)

NEWBORN INSURANCE REMINDER

Please contact your insurance and/or employer directly to enroll your newborn **immediately**. If you are enrolled in a state program, please contact your case worker **immediately** to start the enrollment process.

If you miss the deadline to enroll your newborn, it may be extremely difficult, if not impossible, to enroll your baby under your plan until your insurance plan's next annual enrollment period. Therefore, at the time of your baby's one-month visit you MUST have proof that you have obtained the baby's coverage. THIS ID card MUST be presented at your baby's one-month physical.

If you do not have this ID card, you may be asked to reschedule or remit payment at the time of service. Having this ID card as proof of coverage is the best way for you to ensure your insurance will pay for your baby's checkup and vital immunizations.

This policy is to protect you from the financial hardship associated with the costly vaccines given at the one-month checkup.

We at Premier Pediatrics are committed to keeping your baby health and do regret any inconvenience.

Child's Name _____ _____
Last Name, First Name, MI Date of Birth

Parent/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

We understand that information about your child's health is very personal and therefore, we will strive to protect your privacy as required by law. We will only use and disclose your child's personal health information ("PHI"), as allowed by applicable law. This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of our patients' PHI and to provide you with notice of our legal duties and privacy practices with respect to your child's PHI. We are required to abide by the terms of this Notice of Privacy Practices so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice of Privacy Practices effective for all PHI maintained by us. You may receive a copy of any revised notice by mailing a request to Premier Pediatrics, 2600 Glasgow Avenue Suite 213, Newark, DE 19702.

USES AND DISCLOSURES OF YOUR PHI: The following categories detail the various ways in which we may use or disclose your child's PHI.

Your Authorization. In specific situations, Premier Pediatrics will not use or disclose your child's PHI without you signing an authorization form. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke this authorization in writing, except to the extent we have already acted upon it.
Except as outlined below, we will not use or disclose your child's PHI for any other purpose unless you have signed a form authorizing the use or disclosure.
Uses and Disclosures for Treatment. We will use and disclose your child's PHI as necessary for treatment which may include institutions and individuals outside of Premier Pediatrics that are or will be providing treatment to your child.
Uses and Disclosures for Health Care Operations. We will use and disclose your child's PHI as necessary, and as permitted by law, for health care operations.
Uses and Disclosures for Payment. We will make uses and disclosures of your child's PHI as necessary for payment purposes, subject to your right to **Request Restrictions on Disclosures to your Health Plan**.
Persons Involved In Your Child's Care. Unless you object, we may, in our professional judgment, disclose to a member of your family or any other person you identify, your child's PHI, to facilitate that person's caring for your child.
Appointments and Services. We may use your child's PHI regarding appointments or to follow up on your child's visit.
Business Associates. Certain aspects of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, consulting and legal services. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment/billing activities and health care operations. In such cases, we require these business associates and any of their subcontractors, to appropriately safeguard the privacy of your information.
Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your child's PHI without your consent or authorization. Subject to conditions specified by law:

- For any purpose required by law;
- For public health activities, such as required reporting of disease;
- To certain governmental agencies if we suspect child abuse or neglect;
- To entities regulated by the Food and Drug Administration, if necessary, to report adverse events, product defects, or to participate in product recalls;
- To a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- In emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- By a court or administrative order, subpoena or discovery request; usually you will have notice of such release;

RIGHTS THAT YOU HAVE

Access to Your PHI. Generally, you have the right to access, inspect, and/or receive paper and/or electronic copies of the PHI that we maintain about your child. Requests for access must be made in writing and be signed by you or your representative. We will charge you for a copy of your child's medical records in accordance with a schedule of fees established by applicable state law. You may obtain an access request form from our office.

Amendments to Your PHI. You have the right to request the PHI that we maintain about your child be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. Please note that even if we accept your request, we may not delete any information already documented in your medical record. You may obtain an amendment request form from our office.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your child's PHI except for disclosures made for purposes of treatment, payment, and health care operations or for certain other limited exceptions. Requests must be made in writing and signed by you or your representative.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on certain uses and disclosures of your child's PHI for treatment, payment, or health care operations. A restriction request form can be obtained from our office. We are not required to agree to your restriction request, unless otherwise described in this notice, but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event we have terminated an agreed upon restriction, we will notify you of such termination.

Restrictions on Disclosures to Health Plans. You have the right to request a restriction on certain disclosures of your PHI to your health plan. We are only required to honor such requests for restriction when you or someone on your behalf, other than your health plan, pay for the health care item(s) or service(s) in full. Such requests must be made in writing and should identify the services that the restriction will apply to. You may obtain a restriction request form from our office.

Confidential Communications. You have the right to request communications regarding your child's PHI from us by alternative means and we will accommodate reasonable requests by you in writing.

Breach Notification. We are required to notify you in writing of any breach of your child's unsecured PHI as soon as possible, but in any event, no later than 60 days after we discover the breach.

Paper Copy of Notice. As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means. Our Notice may also be obtained on our website at www.premier4kids.com.

Complaints. If you believe your privacy rights have been violated, you may file a complaint in writing with our office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. All complaints must be made in writing and will not affect the quality of care you receive from us.

For further information. If you have questions or need further assistance regarding this Notice of Privacy Practices, you may contact us in writing at: Premier Pediatrics attention: Privacy Officer, 2600 Glasgow Avenue Suite 213, Newark, DE 19702, by telephone at (302) 836-4440, or by e-mail at premier4kids@gmail.com.

Effective Date. This Notice of Privacy Practices is effective October 1, 2013.