Today's Date:_____

PATIENT REGISTRATION

IT IS IMPORTANT TO COMPLETE ENTIRE FORM FOR CLAIMS TO BE SUBMITTED PROPERLY

Patient Name_____ Nick Name: _____ Birth date: _____

Address:_____ City _____ State _____ Zip_____

Home Phone: (____)_____ Primary Email address for appointment reminders:_____

GENDER: □ Male □Female **RACE:** □ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian/Other Pacific Islander □White □Refuse to Report □ Other

ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Refuse to Report

PREFERRED LANGUAGE: □ English □ Japanese □ Other (please specify):

PARENT/LEGAL GUARDIAN #1 – GUARANTOR

(Individual responsible for bills and payment)

Last Name:_____ **First Name:**_____ **Middle Initial**: _____

Relationship to child (check all that apply): □ Mother □ Father □Legal Guardian □ Stepmother □Stepfather □ Other (please specify): _____

Address (if different than above)_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Social Security Number:_____ Date of Birth: _____

Employer:_____

PARENT/LEGAL GUARDIAN #2

Last Name:_____ **First Name:**_____ **Middle Initial**: _____

Relationship to child (check all that apply): □ Mother □ Father □Legal Guardian □ Stepmother □Stepfather □ Other (please specify): _____

Address (if different than above)_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Social Security Number:_____ Date of Birth: _____

Employer:_____

EMERGENCY CONTACT

Last Name:_____ **First Name:**_____

Relationship (Please specify): _____Home Phone: (____)_____ Cell Phone: (____)_____

May we release Protected Health Information to this individual? □ Yes □ No

May we leave a message at your home:

With other residents? [] Yes [] No On your answering machine/voice mail? []Yes [] No

INSURANCE INFORMATION

I have insurance: □ Yes □ No (self pay)

Primary Insurance: _____

Subscriber: _____

Relation: _____

Date of Birth: _____

Social Security #: _____

Secondary Insurance: _____

Subscriber: _____

Relation: _____

Date of Birth: _____

Social Security #: _____

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at River's Edge Pediatrics, Inc. which outlines by privacy rights and how my Protected Health Information (PHI) may be used and disclosed.

Initials: _____

Photograph for Patient Identification

Patient pictures taken in the office will not be shared outside our practice. Pictures are used for identification purposes only.

Initials: _____

Missed Appointments

Any missed appointments not canceled 24 hours prior will be charged a $25 fee. Special circumstances may apply at the discretion of the staff.

Initials: _____

Financial Policy

All practices are monitored closely to ensure we comply with State and Federal laws. As healthcare providers, we are trained to provide appropriate services for our patients. The managed care companies and government now outline which services we may provide, what we must document in your medical record, and what we must charge for specific services. Please be aware office visit charges are based on numerous items, such as: the number of problems/diseases, examination, acuity of your illness/disease, etc. Fees vary with the nature of your visit; and are based on services required by the doctor and staff to meet your health care needs.

We are mandated to collect your co-pay at the time of the visit. We accept cash, personal check, Visa/Mastercard and Discover. An administrative fee of $10 will be applied to your account for any co-payment not received by the end of business day on the day services were rendered. There will be a $25 fee for all returned checks.

All balances billed to you are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject or our collection process. All balances greater than 60 days could incur additional collection cost. We are happy to work with you to establish a mutually acceptable payment plan if you have difficulty with your account.

Insurance

Many people have insurance policies that aid in the cost of their child's medical care. Your insurance is a contract between you, your employer and the insurance company. Please remember that our relationship is with YOU! It is **your responsibility** to bring your insurance card to every visit. All charges are itemized for the convenience of your insurance company. We will be happy to bill them for your office visits and procedures. If your insurance plan is not one with which we participate, we request payment-in-full at the time-of-service. We will provide a copy of your encounter form so you can submit it to your insurance company and possibly get reimbursement from them.

It is your responsibility to be aware of your insurance company's pre-certification requirements for outpatient procedures. Lab procedures performed in our office (rapid strep, urine cultures, etc.) may be required to be sent to an outside lab for further testing. Please be aware you may receive a separate bill from that facility. Our practice sends all of our labs to Nationwide Children's Hospital. If you prefer us to send your lab to a difference facility that must be communicated to the physician at each visit.

By signing below, I am acknowledging that I have read and understand the above Financial Policy and Insurance statements.

Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date Signed

Patient History

Please circle where appropriate and clarify as needed

Patient Name: _____ Date of Birth: _____

Pregnancy and Birth History

Mother's age at pregnancy _____ Any illness during pregnancy? **Y N** _____

Any medications during pregnancy? (Exclude vitamins & iron) _____

Smoking/Alcohol/Street drugs during pregnancy**? Y N** _____

Was your baby **early/late/on time**? Weeks of gestation? _____ Birth Weight? _____

Was the delivery **vaginal/ C-section/ spontaneous/ induced** Apgar Score _____

Any complications of delivery or problems with infant at time of delivery or shortly thereafter? **Y N**

Child's Past Medical History

Medications allergies _____ Environmental Allergies _____

Medications taken on a regular basis _____

Immunizations up to date? **Y N** Do you have a record? **Y N**

ER visits or Hospitalizations? **Y N** When/Where/Why? _____

_____

Developmental/Behavioral/Emotional/School Issues? _____

_____

_____

Past history of any of the following: (Please circle)

Anemia **Bleeding Tendency** **Chicken Pox** **Eczema** **Hepatitis**
Measles **Mumps** **Problems w/ Hearing / Vision**
Reactive Airway Disease (RAD) or Asthma
Recurrent Ear Infections / Throat Infections
Rheumatic Fever
Rubella (German or 3-day measles)
Scarlet Fever **Seizures** **Tuberculosis** **Whooping Cough**
Other _____

Family History (Please circle condition and list all blood relatives of your child who have had the following problems)

AIDS / Immune Deficiency / Anemia / Blood Disorder _____ Epilepsy / Seizures _____
Asthma / Cystic Fibrosis / Tuberculosis _____ Migraine _____ Diabetes _____
Hearth Disease / High Blood Pressure / High Cholesterol _____ Cancer (type) _____
Birth Defects / Sudden Infant Death / Mental Retardation _____
Alcohol / Drug Problem _____ Early Deafness /Arthritis /Muscular Dystrophy _____

Siblings: Name(s) and Date(s) of Birth _____

Signature of the person filling out this form _____ **Date:** _____

River's Edge Pediatrics, Inc. Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.

I. **This is formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice.** It is important that all patients and staff understand the importance of maintaining the privacy of patient information.

II. This practice, which uses electronic medical records (EMR), has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. We cannot release information to others without your written consent, including conversations, appointment reminder calls, test results and other information that may be of a confidential nature. Patient information about health care information is identified as **"PHI" or protected health information**.

This change in policy requires that you, the parent/legal guardian, identify and clarify at the time of registration or re-registration with this practice to whom we can talk to, how we can leave information on your child's behalf, and the process for ongoing continuity of your child's medical care. **You can change this information at any time with written notification**. Changes are not retroactive, but are effective the date received.

Others involved in your child's healthcare: You must identify any person we may discuss your child's PHI. If you are unable to agree or object to such a disclosure, we may use our professional judgment to disclose the necessary information for your child's best interest. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your child's care of your child's location, general condition or death. Finally, we may use or disclose your child's PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your child's health care.

III. **Uses and Disclosures**

Your child's PHI is an intricate part of your child's medical care, and can be used or disclosed without your consent for treatment, payment, and health care operations (TPO):

- For your child's treatment in this practice and other locations under the physician's immediate care. This may include any referral for services such as diagnostic testing or treatment related to your child's condition or medical care needs. This may also include conversations with other physicians.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state law regulations.

Also for:

- Appointment reminders and health related benefit services only with your consent as identified on the registration form.
- Disclosure to your family and friends concerning any related health care information on the registration form which can be modified at any time orally, followed by written consent.

Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that, in the judgment of the physician or medical entity, required immediate and full information for care on your behalf.

Certain disclosures can be made **without your authorization:**

- Disclosure required by the government or law enforcement agencies.
- Information used for public health purposes (reporting to the Center for Disease Control (CDC))
- We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- Disclosure of PHI to a person subject to the jurisdiction of the Food and Drug Administration if that person has responsibility to report adverse events, product defects or problems, or biologic product deviations; to track products; to enable product recalls, repairs, or replacements; or, to conduct post marketing surveillance.
- Disclosure of PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- Disclosure of PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to the victims of crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of River's Edge Pediatrics, Inc., and (6) medical emergency (not on River's Edge Pediatrics, Inc. premises) and it is likely that a crime has occurred.
- Disclosure of PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- Information related to certain research procedures. The majority of this is void of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Consistent with applicable federal and state laws, we may disclose your child's PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purposes of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to foreign military if you are a member of the foreign military services. We may also disclose your child's PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- Worker's compensation review.
- We may use or disclose your child's PHI if they are an inmate of a correctional facility and your physician created or received your child's PHI in the course of providing care to him/her.
- Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

IV. Your rights with respect to your child's PHI

- The right to request limits on the uses and disclosures at registration or any time during your child's care.
- The right to have River's Edge Pediatrics, Inc. use only confidential means of communicating with you about your child's medical information. This means you may have information delivered to you at a certain time or place (charges may apply), or in a manner that keeps your information confidential.
- The right to see and obtain copies of this information; there may be copy and postage fees.
- The right to obtain a listing of whom we have made the disclosures to regarding your child's PHI.

The right to correct and update your child's file through and amendment/correction process. River's Edge Pediatrics, Inc. may refuse to amend information that is accurate, that was created by someone else, or is not to be disclosed to you.

- The right to receive a paper copy of this notice.

V. River's Edge Pediatrics, Inc. is required by law to keep medical information about your child private and to provide you a copy of this notice. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Privacy Statement will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Statement. An updated Privacy Statement will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your child's PHI is being used, from this date forward, you may contact our privacy officer at the address listed below for a possible resolution. You may also contact the Office of Civil Rights or the Ohio Medicare carrier, GBA Palmetto, if you are not satisfied with our response. River's Edge Pediatrics, Inc. will not retaliate against you for making the complaint.

- Contact the Privacy Officer and complete a complaint form for review and discussion:
  River's Edge Pediatrics, Inc.
  Attn: Privacy Officer
  4335 W. Dublin-Granville Road
  Dublin, Ohio 43017
  (614) 899-7772
- If you are not satisfied with this response, you may report the practice to:
  Office of Civil Rights
  Regional Manager
  Department of Health and Human Services
  233 N. Michigan Avenue, Suite 240
  Chicago, Illinois 60601
  (312) 886-1807

  Or the local Medicare Part B Intermediary
  GBA Palmetto
  Part B Operations – HIPAA Compliance Concern
  PO BOX 182957
  Columbus, Ohio 43218

This privacy plan is a working draft, which became effective December 1, 2002. It was revised on August 11, 2008.

I have been provided an opportunity to receive a copy of this Practice Privacy Statement for River's Edge Pediatrics, Inc.

Patient or Parent/Legal Guardian signature on receipt of Privacy Notice **Date**

Patient or Parent/Legal Guardian unable to sign due to: _____ **Date** _____

Patient or Parent/Legal Guardian refused to sign – witness: _____ **Date** _____

River's Edge Pediatrics, Inc.
General Office Information

Updated 3/2017

Website: www.repkids.net

Like Us on Facebook!

Phone Schedule

Our phones are answered from 9:00am-4:45pm except for our lunch period of 12:00noon – 1:00pm. During this time you may reach a physician for an emergency, by calling our office number, and listening to the options on the recording.

Phone Options

If you need to speak with the billing department, request a prescription refill, or request an insurance referral, please call the office and listen to the recorded message and the possible options before making your selection.

Nurse Triage

All of our clinical personnel have extensive training in answering questions regarding the care of pediatric patients. They can also provide to the physician any information you have to share, any requests for medication refills and clarification of any other situation. All messages left on the nurse line are answered on the same day that they are received.

Receptionists

The receptionist can schedule, reschedule and cancel appointments. They cannot provide medical advice or answer medical questions. If you feel you have an urgent matter, the receptionist will have you speak with a nurse or physician immediately.

Walk-in Hours

No appointment necessary. Acute sick visits only. These hours are available M – F 8a.m. to 9 a.m. at the Dublin office and M,T,W,F 8a.m. to 9a.m. at the Westerville office.

Saturday Office Hours (Excluding summer months – Memorial day through to Labor day)

Saturday mornings our DUBLIN office is open from 7:30 a.m. to 9:30 a.m. for urgent sick visits only. We do not schedule these appointments ahead of time. You need call the office at 7:30 a.m. on Saturday to schedule an appointment. A clinical staff member is also here at that time to answer your medical questions and help you determine if an appointment is necessary.

Shot Only Appointments

Patients receiving allergy injections or the Gardasil vaccine are required to remain at the office for 20 minutes after the injection is given and must be evaluated by a clinical staff member before leaving the office.