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 <u>at each visit</u>.

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.
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.