

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: _____ **Secondary Insurance:** _____

Subscriber: _____ Subscriber: _____

Relation: _____ Relation: _____

Date of Birth: _____ Date of Birth: _____

Social Security #: _____ 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. I know that I can review this HIPAA notice on River’s Edge Pediatrics, Inc. website at any time.

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 in advance of your scheduled appointment 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. 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 understand that finances can be a sensitive issue, but we encourage you to reach out to our billing department if you are having any difficulties paying your bill. We are happy to work with you to establish a mutually acceptable payment plan.

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 an itemized statement 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. If your child has a laboratory test performed that we need to send to Nationwide Children's Hospital please be aware you will be billed and receive a separate bill from Nationwide Children's for the lab processing.

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 _____

Heart 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 5/2018

Website: www.repkids.net

Like Us on Facebook!

Phone Schedule

Our phones are answered from 8:30am-4:45pm except for our lunch period of 12:00noon – 1:00pm. If you need to speak with the billing department, request a prescription refill, or request an insurance referral, please listen to the recorded message and follow the prompts.

Walk-in Hours

No appointment necessary! Acute sick visits only. These hours are available:

Dublin office - M – F 8a.m. to 9a.m.

Westerville office - M,T,W,F 8a.m. to 9a.m.

After Hour Phone Calls

We are here for you! If your child has an urgent medical problem after hours, follow the prompts and leave a message for the doctor on call.

Insurance

Please be sure you bring your current insurance card with you to each visit. It is important that you understand what your insurance may and may not cover. We encourage you to review your plan's benefits and coverage.

Missed Appointments

Patient will be charged a fee if an appointment is missed. We consider an appointment missed if you do not cancel at least 24 hours in advance of your scheduled appointment time.

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. Any medical advice given is reviewed by the physician. 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.

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.