Welcome to Caring Pediatric Associates

We strive to make each of your child's visits a pleasant experience.
Please fill out this form completely, print clear

TODAY'S DATE_____

PATIENT'S NAME: _____**GENDER** _____ **D.O.B.** _____

PATIENT LIVES WITH: PARENTS_____ **MOTHER** _____ **FATHER**_____ **GRANDPARENTS**_____ **GUARDIAN/RELATIONSHIP**_____

MOTHER'S NAME_____ **D.O.B**. _____ **S.S. #** _____

MOTHER'S Cell# _____**Email:** _____

MOTHER'S ADDRESS: _____

FATHER'S NAME_____ **D.O.B.** _____ **S.S. #** _____

FATHER'S Cell# _____**Email:** _____

FATHER'S Address: _____

MOTHER'S AGE _____ **FATHER'S AGE**_____ **SIBLINGS AGES**_____

MARTIAL STATUS: MARRIED_____ **SINGLE** _____ **JOINED CUSTODY**_____ **SEPARATED**_____

INSURANCE INFORMATION

Primary Insurance Name: _____

Policy Holder: _____**D.O.B**. _____ **S.S. #**_____

Insurance ID# _____ **Group #**_____**Copay: $** _____

Secondary Insurance Name: _____

Policy Holder: _____**D.O.B.** _____**S.S. #** _____

Insurance ID# _____ **Group #**_____**Copay: $** _____

Financial Arrangements

Your Insurance Company requires that all copays be paid during service. All Unpaid co-pays will be assessed a $10 handling fee. All forms carry a $5.00 fee for one form, $2 for each additional form, ready in 3-5 business days, and same-day forms $10 Fee. Pre-op Medical Clearance forms a $15 fee. Referrals for any specialist called on the same day of service $25 fee. No Shows Fee $50.00. Personal Medical Record Release 0.75 per page.

Authorization and Release

I authorize the doctor to release any information, including the diagnosis and records of any treatment or examination provided to my child to my insurance company and/ or other healthcare providers.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the service bill. I agree to be responsible for the payment of all services rendered on my behalf or my dependents

X_____ _____

Signature of Patient or Parent, if minor, **Date**

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

- **Co-payment**: By law, we must collect a designated co-pay at the time of service. If we have to bill you for a co-pay, a **$10.00 charge fee** will be applied, in addition to your co-pay.
- **No Shows**: There is a **$50.00 Fee** for appointments that are not canceled within 24 hours
- **Non-Co-pay Plans**: If your plan does not require a co-pay and we participate, we will accept your designated fee. You are responsible for any deductible and co-insurance balance that your plan indicates in its explanation of medical benefits.
- **Referrals:** If your plan requires a referral to see a specialist, it is your responsibility to call our office and obtain a referral within 48 hours. Notice, prior to your appointment, and have it with you at the time of your visit. If you do not obtain a referral, it will be your responsibility if you receive a statement from your specialist. If a referral is needed and you forgot to obtain one, a **$25.00 fee** will be charged to process a Same Day referral on the same day of your appointment.
- **Payments**: We accept cash, checks, and credit cards with a $1.00 fee to process your payment. There will be **a $25.00 fee** for any returned checks.
- **Pre-op Forms**: $15.00
- **Letters**: $25.00
- **Disability Forms**: $35.00
- **Detailed Forms**: $10.00
- **Forms**: All Physical forms take 3-5 business days to complete with a **$5.00 fee** per form, and same-day forms have a **$10.00 fee** per form.
- **Personal Medical Records Release**: Submit the request with your child/children's name, D.O.B, sign, and date. A **0.75 fee** per page and a postage fee if mailed. 7-10 business days to process the request.
- **Any Changes**: It is the Policyholder’s responsibility to notify the office of any changes to insurance information, home address, telephone numbers, etc.
- Prices may change year to year.

Print the name of the parent or guardian responsible

X _____ Date: _____

Signature of parent or guardian

HIPAA Privacy Notice

Caring Pediatrics Associates has always recognized the importance of privacy; this new federal law formalizes a practice that has been followed routinely.

Background: In 1996, Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated as HIPAA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.

- By Law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This also allows for a prescription to be called into your pharmacy and for the scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment-related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.
- However, ***Caring Pediatric Associates*** has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marking a product for you. • Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical records, and you may amend the record if you believe it to be incomplete or inaccurate.
- You have the right to review when and to whom your information was released. • You may suggest additional restrictions about certain uses and disclosures if you wish. • Portions of the notice may be modified, as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
- The law requires that you acknowledge receipt of this notice: this has been included on the signature release on your acceptance policies form.

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Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccines and the vaccine schedule are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating.

We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, ***should you have doubts, please discuss these with us in advance of your visit.*** In some cases, we may alter the schedule to accommodate parental concerns or reservations.

Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated. Infants will receive all age-appropriate recommended vaccines by three months of age, with additional recommended vaccines as well as booster doses by two years of age. Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. *Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.* **PLEASE KEEP THIS PAGE**

Patient Responsibilities

- You, your family, and visitors are responsible for following the rules involving patient care and conduct.

- You are responsible for providing a complete and accurate medical history. This history should include all prescribed and over-the-counter medications, including herbal supplements that you are taking.

- You are responsible for informing us about all treatments and interventions both past and present, including hospitalizations, medicines, medical directives, past illnesses and any therapies.

- You are responsible for following the suggestions and advice prescribed in a course of treatment by your health care providers. This includes instructions from any medical professional who is carrying out the physician's order or advice.

- You accept responsibility for whatever may happen if you refuse treatment or do not follow the physician's instructions. If your refusal of treatment prevents us from providing care, according to ethical and professional standards, we may need to end our relationship with you after giving you reasonable notice.

- You are responsible for being considerate of the rights of other patients and Caring Pediatrics Associates personnel and property.

- You are responsible for providing information and asking questions about your concerns or difficulties involving your health care or health care providers. **Caring Pediatrics Associates** realizes that there may be times when a patient, parent, or legal guardian has questions about decisions and actions related to their care. The way to deal with these concerns is to talk directly with the physician.

- You are responsible for making it known whether you clearly understand your plan of care and the things you are asked to do.

- You are responsible for making appointments and arriving on time. You must call us in advance when you cannot keep a scheduled appointment.

- You are responsible for providing us with correct information about your sources of payment and your ability to pay your bill.

- You are responsible for notifying the doctor or nurse when your child is in pain, not feeling well, to work with them to develop a management program. If you have a concern, please talk to the caregiver or person in charge first. If you are unable to resolve your concern, you can contact the office manager or the Pediatrician at (516) 796-4433

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NO SHOW NO CALL POLICY

Thank you for trusting your medical care to Caring Pediatric Associates.

When you schedule an appointment with Caring Peds, we set aside enough time to provide you with the best quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours before your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. ***Please see our Appointment No-Show Policy below.***

★ Effective January 1, 2024, any established patient who ***No-Show/No-Call*** an appointment (*office visit, physical exam, med-check, and monthly visit)* and has yet to contact our office with ***at least 24-hour notice*** will be charged a ***$50.00 fee***.

★ Any established patient who ***No-Show / No-Call*** a Second Time and has not contacted our office with at least 24-hour notice will be charged a ***$60.00 fee***.

★ If a third ***No-Show*** with no 24-hour notice should occur, the patient will not be rescheduled.

★ Any New Patient who ***Does Not Show*** for their initial visit will not be rescheduled.

★ If you schedule an appointment on the ***Same Day*** and ***Do Not Show***, you will be charged ***a $25 fee.***

★ The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

★ As a courtesy reminder, texts are automatically sent out 2 days before your appointment and 1 day prior. Please update your cell phone numbers below.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the no-show fee one time only! You may contact Caring Peds 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

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