Riverside Pediatrics LLC

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Patient Information: ***Please use full names***

Today's Date:_____ New patient(s): Yes_____ No_____

Child's Last Name:_____ First Name:_____ DOB:_____ Sex: F / M

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Child's Last Name:_____ First Name:_____ DOB:_____ Sex: F / M

Child's Last Name:_____ First Name:_____ DOB:_____ Sex: F / M

Child's Last Name:_____ First Name:_____ DOB:_____ Sex: F / M

Primary Parent/Guardian Contact:

Last name:_____First name:_____ DOB:_____

Address:_____City/State:_____Zip:_____

Mobile phone:_____ Home:_____Work:_____

Email:_____
(Used for office communication and portal access.)

Secondary Parent/Guardian Contact:

Last name:_____First name:_____ DOB:_____

Address:_____

Mobile phone:_____ Home:_____Work:_____

Email:_____
(Used for office communication and portal access.)

Newborns:
Name of Obstetricianist:_____Delivered at:_____

Demographics: (optional)

Language spoken:
- ❑English
- ❑Spanish
- ❑Other:_____

Race:
- ❑African American/Black
- ❑Asian
- ❑Caucasian/white
- ❑American Indian or Alaska Native
- ❑Native Hawaiian or Other Pacific Islander

Ethnicity:
- ❑Hispanic/Latino
- ❑Non-hispanic/latino

Riverside Pediatrics, LLC

Riverside, CT New Canaan, CT

Official Financial Policies

Payment Agreement

*All patients are required to bring a valid insurance card and credit card to each visit.
Credit cards will be used for any copay/deductible or other medical expenses not covered by insurance that are not paid while in the office *

IF YOU HAVE A MANAGED CARE PLAN IN WHICH WE DO PARTICIPATE:

1. You are responsible for providing us with CURRENT and ACCURATE insurance information at each visit. Notify us IMMEDIATELY of any insurance changes. We will bill your insurance company directly for our services. Your child's name should appear on your insurance card and if a doctor's name is required on the card as your Primary Care Physician, it must be a name of a Riverside Pediatrics, LLC doctor, otherwise full payments may be due at the time of each visit.
2. Copays must be paid at the time of service. If you cannot pay while in the office, payment must be paid by the end of the business day. Failure to do so will result in an additional charge of $25.00.
3. You may be responsible for fees if routine services provided are not covered by your insurance plan, or if your insurance company denies payment for covered services. You are also responsible for fees incurred if we do not have your current insurance information AT THE TIME OF SERVICE.
4. <u>There is an additional fee billed to insurance for After Hours Care. This includes weekends, holidays and services provided outside our normal office hours. By receiving services during after hours, you are accepting responsibility for any balance remaining, not covered by your insurance. This may be in the form of a copay, deductible or coinsurance.</u>

IF YOU HAVE A PRIVATE INSURANCE IN WHICH WE DO NOT PARTICIPATE

1. Professional services rendered are charged to the patient, not your insurance company. Payment is expected as services are rendered. We accept cash, checks, Mastercard, Visa, and American Express. Your insurance company should reimburse you for your payments.
2. You will receive a superbill for each visit. We will submit your initial claim to your insurance plan on your behalf, as a courtesy, and reimbursement will be paid to you directly. If you wish to file a charge with your company yourself, you must obtain a claim form from your carrier. Complete your portion of the form (Part 1 of Part A), attach a copy of the superbill and submit it to your insurance company according to their directions. The doctor's signature, which appears on the superbill, verifies the services rendered. Whether we file a claim initially for you, or you file directly, your balance on account with us will remain a patient responsibility and will be collected as such.
3. You will receive a monthly statement if you have a balance due. Payment for services is the patient's responsibility even if the insurance company wrongfully denies the claim. Our office will not collect your insurance payment or negotiate a settlement on a disputed claim. If your claim is denied, you should communicate directly with your insurance company.

IF YOU DO NOT HAVE INSURANCE COVERAGE (SELF-PAY)

1. If you do not have medical coverage, payment in full is due at the time of service. We accept cash, checks, Discover, Master Card, Visa, and American Express for your convenience.

COLLECTION/OVERDUE PAYMENT POLICIES

1. <u>We require an active credit card be left on file for all families at Riverside Pediatrics. The credit card you provide will be charged when a balance is due on account.</u>
2. If we must refer your account to a collection agency or law firm to collect an unpaid balance, you will be required to pay the cost of collection as well as the unpaid balance.
3. There is a $50 fee in addition to any bank changes associated with checks not honored by our bank.
4. We cannot schedule any non-urgent child care appointments if there is an outstanding patient balance for more than 30 days. Also, completed forms will not be released for patients with an outstanding account balance over 30 days.
5. Patient balance more than 60 days overdue will be subject to a cost of collection of 18% of the principal balance.
6. Patient failure to pay balances for more than 60 days is the reason for termination of the physician-patient relationship at Riverside Pediatrics.

CANCELATION/MISSED APPOINTMENT POLICY

Well visits not canceled 24 hours prior to the scheduled appointment will be subject to a **$100.00** charge. Sick visits not canceled at least 2 hours prior to the scheduled appointment will be subject to a **$100.00** charge.

We value our patients and their families' time. Please come on time to your appointment so that we are not delayed in seeing other patients. If you are more than **15 minutes** late arriving, patients may not be able to be seen by the physician and therefore, will be subject to the missed visit fee and require rescheduling.

SCHOOL HEALTH FORM ADMIN FEE - $25 per form | MEDICAL RECORDS RELEASE - $0.65 per page

Parent/Guardian Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient (if 18 or older)/Parent or Guardian Name: _____

Patient or Parent/Guardian Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below.

Reason:

_____

_____

_____

Signature: _____

Print Name: _____

Title: _____

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Riverside, CT New Canaan, CT

Preferred Laboratory Authorization

In regard to sending lab specimens, by default, our office sends all specimens to Greenwich Hospital Lab, an affiliate of Yale New Haven Health. Specimens are defined as venous blood samples, streptococcal throat cultures, skin cultures, urine cultures and COVID PCR tests. Should your insurance plan have a preferred lab facility, we can send to alternative locations, but it must be indicated on this form. Please list below all patients in the family, associated dates of birth and preferred lab facility for specimen processing. **This is the patient 's responsibility to determine which lab is suitable.** Our office does not have financial responsibility for specimens sent to the incorrect laboratory, if a preferred laboratory was not indicated so by the patient.

Patient Name(s) and DOB(s)

Patient 1:_____ DOB:_____

Patient 2:_____ DOB:_____

Patient 3:_____ DOB:_____

Patient 4:_____ DOB:_____

Patient 5:_____ DOB:_____

Patient 6:_____ DOB:_____

Preferred Laboratory Facility (circle one):

- ☐ No preference
- ☐ Greenwich Hospital
- ☐ Quest Diagnostics
- ☐ LabCorp
- ☐ Stamford Hospital
- ☐ Other:_____

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<u>Required</u> Credit Card Authorization Form

Please provide the following information to be kept on file. Refer to the Payment Agreement form.

Family Last Name:

_____

First Name Child/Children:

_____

Circle one: Visa Mastercard Amex Discover

Credit card #:

_____

Expiration: _____ CVV: _____

Please print the name as it appears on the credit card:

_____

MISSED VISITS
Well visits not canceled 24 hours prior to the scheduled appointment will be subject to a **$100.00** charge. Sick visits not canceled at least 2 hours prior to the scheduled appointment will be subject to a **$100.00** charge.

By signing, you acknowledge this card will be charged for copays, deductibles and applicable office fees, as stated in the Payment Agreement:

_____ _____
Signature Date

Insurance Information

Check here if you do not have medical insurance _____

Name of primary insurance company:
Insurance company address/PO Box:
Responsible party name:
Responsible party's date of birth:
Member ID number:
Group number:
Signature of responsible party:

Name of secondary insurance company:
Insurance company address/PO Box:
Responsible party name:
Responsible party's date of birth:
Member ID number:
Group number:
Signature of responsible party:

You are responsible for providing us with ACTIVE and ACCURATE insurance information at each visit. Notify us IMMEDIATELY of any insurance changes. We will bill your insurance company directly for our services. Your child's name should appear on your insurance card.

There are many types of insurance plans out there. You are responsible to check with your insurance company if Riverside Pediatrics, LLC is a participating provider in your network.

Some plans may require you to elect a PCP. If your plan does, please contact your member services and update your PCP on file to Riverside Pediatrics, LLC.

The above criteria should be checked BEFORE rendering services, otherwise full payment may be due at the time of each visit.

Initial _____

Riverside Pediatrics, LLC
Riverside, CT New Canaan, CT

I, _____, legal guardian of _____, give the following adults permission to discuss and make decisions regarding the necessary and/or routine treatment of me or my child, including but not limited to examinations, injections, immunizations, and/or diagnostic procedures including x-rays or laboratory analysis.

I understand that myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except immunization) of my teen (16 years of age or older) without requiring the presence of an adult. However, if my teen needs immunizations, and comes in alone, a parent/guardian must be available by phone for verbal consent.

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

I understand that any person bringing the patient for treatment not listed above must have a letter of consent or treatment may be refused or delayed. I understand that, in an emergency, efforts will be made to contact me prior to rendering of medical treatment, but medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minors is canceled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Riverside Pediatrics, LLC of any changes as to the health status of my children or the above information.

Who may we contact in case of an emergency?

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Completed by (print name): _____

Signature:_____

Date:_____

Well Visit Schedule

- recommended visit schedule
- Flu vaccine only given during flu season (Oct-Feb)
- All Meningococcal vaccines should be completed before college

Age:	Vaccine/Test Done at Well Visit:
2 weeks of age	Weight Check
1 month of age	Weight Check
7 weeks of age	Pentacel #1 Prevnar #1 Rotateq #1
3 months of age	Hep B #1 (if not given in hospital) Hep B # 2 (if given in hospital)
4 months of age	Pentacel #2 Prevnar #2
5 months of age	Rotateq #2
6 months of age	Pentacel #3 Prevnar #3 Flu #1* Vision Screening
7 months of age	Hep B#2 (if not given in hospital) Hep B # 3 (if given in hospital) Rotateq #3 Flu #2*
9 months of age	Hep B #3 (if not given in hospital)
12 months of age	Hep A #1 MMR #1 Test: Hgb/lead/ppd
15 months	Prevnar #4 Varicella #1
18 months	Pentacel #4 Hep A #2 Vision Screening
24 months	Test: Hgb/Lead
2.5 years	Growth and developmental check
3 years of age	Vision Screening
4 years of age (must be at least 4 years of age for this visit)	Kinrix (Dtap#5/Polio#5) Test: Hgb
5 years of age	MMRV (MMR#2/Varivax#2) Test: PPD
10 years of age	Cholesterol Screening
11 years of age	Start HPV- 3 dose series Menactra TDAP Test: PPD
16-18 years of age	TDAP booster Menactra booster Start Trumenba 3 dose series (meningococcal B)* Test: PPD