WESTERVILLE PEDIATRIC SPECIALISTS, INC. /SUNBURY MILLS PEDIATRICS

Parent/Guardian Name: _____M.I._____ Relationship:_____

Mailing Address: _____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ _____Work Phone:_____

Email Address: _____ Employer: _____

Parent/Guardian Name: _____M.I._____ Relationship:_____

MailingAddress:_____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ _____ Work Phone:_____

Email Address: _____ Employer: _____

PHARMACY Name, Address & Phone Number: _____

I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: Yes No

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CHILDREN: **Please circle:**

Name: _____ M/F_____Date of Birth: _____

Name: _____ M/F _____ Date of Birth:_____

Name: _____ M/F ___ _Date of Birth: _____

Name: _____ M/F _____Date of Birth:_____

Name: _____ M/F _____Date of Birth:_____

Name: _____ M/F_____Date of Birth: _____

In order to assist us in meeting Meaningful Use Measures with the U.S. Government, please answer the following questions below regarding your children:

Race: (Please circle one) American Indian or Alaskian Asian Black or African American Native Hawaiian or Other Refuse to Report/Unreportable White

Ethnicity: (Please circle one) Hispanic or Latino NonHispanic or Latino Refuse to Report

Primary Language: (Please circle one) English Hearing Impaired Other _____

INSURANCE INFORMATION (Please present insurance card upon check-in)

1) Name of Insurance Company:_____

Name of person who carries the insurance: :_____ SSN#:_____

Relationship to Patient: _____

2) Name of Insurance Company:_____

Name of person who carries the insurance: :_____ SSN#:_____

Relationship to Patient: _____

Assignment and Release

Payment and/or copayment is required at the time the service is rendered. I hereby authorize my insurance benefits be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature:_____**Printed Name:**_____**Date:**_____

Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082

Sunbury Mills Pediatrics
700 W Cherry St.. Suite B
Sunbury OH 43074

Child's Name _____

Date of Birth _____

Drug Allergies _____

Current Medications	**Dosage**	**Times/Day**

Social History (circle all that apply)
Child lives with: Both parents Mom Dad Step Mom Step Dad Adoptive Parents
Foster Family Maternal Grandparents Paternal Grandparents Guardian
Other (specify) _____

Birth History
Term or Preterm (<37 weeks):
Type of Delivery (vaginal or c-section):
Complications at delivery or shortly after birth:

Hospitalizations if your child has been in the hospital overnight – state the year- illness/operation

Year	**Illness/Operation**

Past Medical History
Has your child ever had the following (circle yes or no, leave blank if uncertain).

ADD/ADHD	Y	N	Intestinal Disease	Y	N
AIDS or HIV	Y	N	Jaundice	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Asthma	Y	N	Learning Disability	Y	N
Allergies	Y	N	Liver Disease	Y	N
Apnea	Y	N	Mental Retardation	Y	N
Arthritis	Y	N	Mental Illness	Y	N
Bladder infections	Y	N	Menstrual Abnormalities	Y	N
Bleeding Tendency	Y	N	Pneumonia	Y	N
Bone or Joint Disease	Y	N	Rheumatic Fever	Y	N
Bronchitis	Y	N	Seizure Disorder	Y	N
Bronchiolitis	Y	N	Sleep Disturbance	Y	N
Cancer	Y	N	STD	Y	N
Cerebral Palsy	Y	N	Thyroid Disease	Y	N
Chicken Pox	Y	N	Transfusions	Y	N
Constipation	Y	N	Tuberculosis	Y	N
Developmental delay	Y	N	Ulcer	Y	N
Diabetes	Y	N	Whooping Cough	Y	N
Gastroespheal Reflux	Y	N			
Genetic Disease	Y	N			
Heart Murmur	Y	N			
Headaches	Y	N			
Hypertension	Y	N			

Comments (please give details of your child's medical condition such as onset of illness, treatment and outcomes)
_____
_____
_____

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PRIVACY CONSENT

Consent for care: I, with my signature, authorize Westerville Pediatric Specialists, Inc. and Sunbury Mills Pediatrics, and any employee working under the direction of the physicians, to provide medical care for this patient for which I am the legal guardian. This medical care may include services and supplies related to this person's health and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice's privacy notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts deemed to be my responsibility by the payment sources, as required by the contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent related to the Privacy Statement: I have had a chance to review the Practice Privacy Statement as part of this registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse services to me if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Parent/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

Copy of Practice Privacy statement signed or initiated with parent/guardian on:_____

Effective, April, 2003

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740/965-6369
FAX: 740/965-6371

PRIVACY STATEMENT

Effective April 1, 2003
Revised 4/2009, Revised 6/2015

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

- This is a formal notification, as defined by CMS (Centers for Medicare and Medicaid Services) and Federal and State laws concerning the privacy policy of this practice and reporting requirement regarding identity theft and fraud. It is important that all patients and staff members understand the importance of guarding patient information.

- Medical records and personal health information, by law, must be maintained in the strictest of confidence. We cannot release such information to others without your written consent, including conversations, reminder calls, test results and any other information that may be of confidential nature. Patient information about health care is identified as "PHI" or protected health information.

- This policy requires that you, the parent or legal guardian, identify who we may talk to, how we can leave information on your child(s)behalf, and the process of ongoing continuity of medical care at the time of registration with this practice.

- Your protected health information (PHI) can be used or disclosed with your written consent as follows:
  - For treatment in this practice and other locations under the physician's immediate care. This may include any referral for services such as labs, x-rays or other diagnostic testing or treatment related to your 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 procedure 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 laws and regulations.
  - Appointment reminders and health related benefit services <u>only</u> with your consent identified on the registration form.
  - Disclosure, concerning any related health care information, with family and friends indicated on the registration form. This list may be modified at any time orally, followed by written consent.
  - **Consent is not required for emergency care and treatment.** An emergency is considered a medical condition that, in the judgment of the physician or medical entity, requires immediate and full information for care.
- Certain disclosures can be made without your consent. They are as follows:
  - Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds and any suspected victims of abuse or neglect.

- Information used for public health purposes, medical examiners or related to a person's death, or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program
- Information related to organ donation
- Information related to certain research procedures. The majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to avoid harm if there is a threat to the patient's or other's safety.
- Specific governmental functions.
- Workers compensation review.

❖ Your rights with respect to your protected health information
- The right to request limits on the uses and disclosure at registration or any time during your care
- The right to choose how we send this information to you, including an alternate address
- The right to see and obtain copies of this information, but you may expect copy and postage fees
- The right to obtain a listing of those to whom we have made disclosures to regarding your PHI
- The right to correct and update your file through an amendment process, if appropriate

❖ Westerville Pediatric Specialists, Inc. reserves the right to modify or change this Privacy Statement and process at any time. Revisions to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

❖ If you have a concern or complaint about how your protected health information is being used, you should first contact our office to see if we can resolve your concerns. You may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.
- Contact the office manager, Teri Campbell, and complete a complaint form for review and discussion.
- 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 Ave, 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, OH 43218

_____

Parent/Legal Guardian Signature Date

This confirms receipt of Privacy Notice & copy given to Parent/Legal Guardian

----------**OFFICE USE ONLY**----------

Refused to sign – witness_____

Scanned to EMR _____

Date Patient(s) name(s)

Westerville Pediatric Specialists, Inc., and Sunbury Mills Pediatrics Financial Policy

Thank you for choosing us as your child's healthcare provider. It is our goal to provide quality care to our patients and their families. Your understanding of our office policies is important to our professional relationship.

Child/Children's Name_____ **Date of Birth**_____

Required at Check-In

- Provide current personal information at each visit
- Provide a current insurance card at each visit
- Payment of your co-pay, co-insurance, or any deductible
- Payment of any outstanding balance
- Payment of today's visit if you do not have insurance

Insurance Plans

Your insurance plan is a contract between you, your employer, and the insurance company; we are not a party to that contract. Please understand that we will bill for all services rendered according to approved CPT Coding Guidelines. This may result in a co-pay/co-insurance/or deductible amount that becomes your responsibility, even for a preventive visit. We will be happy to file your claim(s) with the primary insurance company; all charges are your responsibility from the date that services are rendered. **For us to file a claim, you must present a current copy of your insurance card at each visit and let us know of any changes in your personal information.**

Miscellaneous Charges

- **Returned Check Charge** – Non-Sufficient Funds (NSF) checks are subject to a $40 fee (in addition to fees from your bank).
- **Medical Records/Shot Record Charge** – There is a $35 fee per patient if you would like a copy of your medical records/shot records sent to a non-physician entity, yourself, or another physician. However, if a collaborating physician or specialist requests portions of your chart to assist in your child's care, there is no charge.
- **Correspondence/Forms Charge** - There is a $15 fee per patient per correspondence/form i.e., letters, Life Insurance applications, F.M.L.A. and Social Security Disability applications, etc.
- **Collection Fee** - If your account balance becomes 90 days past due, you will be given a 30-day notice. At the end of the 30 days, all portions due (not including insurance pending) will be sent to an outside collection agency. Please note that an additional 30% collection fee will be applied to your balance at this point, and we will be unable to see your children. You agree, for us to provide services for you and your account and/or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- **Non-Payment of Co-pay Fee** - Nonpayment of your co-pay by the end of the business day on the date of service will result in an additional $25 charge.
- **Missed Appointment/Late Cancel/Reschedule Fee** – A $40 fee will be billed when there is a failure to provide a 24-hour cancellation notice of well child appointment and recheck appointment or a failure to provide a 2-hour cancellation notice for a same day scheduled appointment per child. This charge is not covered by insurance and you will be responsible for payment. Our office provides reminder calls for appointments scheduled in advance; this is a courtesy only and has no effect on the financial obligation for missed appointments.
- **Missed Appointment Fee that requires Interpreting Services** - If an interpreter is scheduled and you miss your appointment or fail to cancel 24 hours before the appointment time, your missed appointment fee is subject to the Interpreting Company's fee we incur.
- **Telehealth/Medicine Convenience Fee**-$60

_____

Printed Name Signature Date

5/2021

Westerville Pediatric Specialists, Inc. and Sunbury Mills Pediatrics
Missed Appointments Policy

Here at Westerville Pediatric Specialists, Inc., it is our goal to provide quality care to our patients and families. It is important to recognize the length of the appointment time slot varies to allow the physician or nurse practitioner enough time to spend with your child.

Please call our office 2 hours prior to cancel a sick appointment. Call at least 24 hours prior to your child's well check-up or recheck appointment. We ask this of you so that another patient who needs an appointment can use a cancelled appointment time slot.

We have implemented the following **non-cancelled** Missed Appointments Policy therefore, your account will be subject to the following:

- $40 charge for each non-cancelled missed appointment per child
- No longer be able to schedule early morning, evening, or Saturday appointments for well child or rechecks (only sick will be scheduled)

Please be advised that excessive, **non-cancelled** missed appointments will result in review of your account and in possible dismissal from our office.

We appreciate your understanding and will be happy to answer questions that arise. Thank you.

Print name Signature Date

3/18 This policy is subject to change without notice at the discretion of management.

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AUTHORIZATION TO SEEK MEDICAL CARE

Patient(s) name(s): _____

_____

_____

The following individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care for illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

1) _____
Relationship

2) _____
Relationship

3) _____
Relationship

4) _____
Relationship

Please note: We understand that grandparents, baby sitters, or otherwise might render care for your children. However, if the visit with Westerville Pediatric Specialists, Inc. is for a well child routine visit, it is the policy of Westerville Pediatric Specialists, Inc. not to perform such services unless a parent, or legal guardian is present. **Additionally, immunizations must be authorized by the parent or legal guardian by federal law.**

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____
Printed Name Signature Date

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____

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Authorization for Step-parent To Seek Medical Care

Patient(s) name(s): _____

_____

_____

The following **step-parent(s)** named below is authorized to schedule appointments and seek care for well child routine visits including immunizations, illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

_____

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____

Printed Name Signature Date

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____

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Authorization for Co-Custodial Parent To Seek Medical Care

Patient(s) name(s): _____

_____

_____

The following **co-custodial parent(s)** named below is authorized to schedule appointments and seek care for well child routine visits including immunizations, illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

_____

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____

Printed Name Signature Date

Notary: _____ **Witness:** _____

County: _____ **State:** _____ **Expires:** _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name, Address & Fax number of previous doctor: _____

_____

The undersigned understands and acknowledges that:

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and discloses (releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving of this authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by Federal privacy law.

_____Date:_____

Signature of parent or legal guardian

Child's name: _____Date of birth: _____

Child's name: _____Date of birth: _____

Child's name: _____Date of birth: _____

Child's name: _____Date of birth: _____

CIRCLE THE LOCATION THAT RECORDS SHOULD BE MAILED TO:

Westerville Pediatric Specialists, Inc .
575 Westar Crossing, Suite 101
Westerville OH 43082
614/508-2223

or

Sunbury Mills Pediatrics
700 West Cherry Street, Suite B
Sunbury OH 43074
740/965-6369

IMMUNIZATION RECORD *ONLY* MAY BE FAXED TO:

Westerville
614/508-2233

Sunbury
740/965-6371

Description of information to be released/disclosed (circle all that apply):

□ All medical records □ Immunization record

□ Other: _____

Purpose or need for release (circle applicable purpose):

□ Continuation of medical care □ Payment of insurance claim □ Legal

□ Personal □ Other: _____

This authorization is in effect for six (6) months from date of signature, or until: ____/____/____

Printed Name: _____

A copy of this authorization will be made available upon request to the individual granting the authorization.