Haymarket Pediatrics

Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: ____/____/____ *Sex*: _____

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: ____/____/____ *Sex*: _____

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: ____/____/____ *Sex*: _____

Child 4: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: ____/____/____ *Sex*: _____

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Primary Phone: (_____) _____ - _____

Who lives at this household? _____

(Please note, this information is being requested to improve intake of your child's Social History.)

Contact 1: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

How would you ideally prefer to be contacted regarding (circle one):

Appointment Reminders: Cell Phone (text) / Primary Phone (call) / Home Email

Recall Notices: Cell Phone (text) / Primary Phone (call) / Home Email

General Practice Notices: Cell Phone (text) / Primary Phone (call) / Home Email

Patient Portal Notifications: Cell Phone (text) / Primary Phone (call) / Home Email

Contact 2: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Cell Phone: (____) _____ - _____ *Work Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

If this contact will need to be notified in addition to Contact 1 for Appointment Reminders, Recall Notices, General Practice Notices and Patient Portal Notifications list their preferences here:

_____

_____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

Insurance:

***Primary Policy**: Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy *Holder's Sex:* Male / Female

Insurance Company: _____

ID/Policy # _____ *Group #* _____

Insurance Company Address: _____

Phone: _____ *Effective Date:* _____

If parents are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ *Phone*: (___) _____ - _____

2: _____ Relationship _____ *Phone*: (___) _____ - _____

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information, for this or any claim to my insurance carrier.

Parent/Guardian Signature _____ Date: _____

Haymarket Pediatrics
Office/ Financial Policy

Welcome to Haymarket Pediatrics, PLC. We are pleased you have entrusted us with your child's medical care. We are committed to providing you with the highest quality of care and service. We ask that you carefully read and sign the following policy.

Appointments

1) We value the time we have set aside to see and treat your child. If you know that you will not arrive at your scheduled appointment time, please call ahead to let us know. You may be asked to reschedule if you arrive more than 15 minutes late for a well child appointment. Please provide at least 24 hours notice if you must cancel a well child visit. There will be a $25.00 charge if you fail to keep a scheduled appointment and do not notify us in advance.

Insurance

1) As a courtesy to you, we will file your health benefits claims with your Primary Insurance Company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof.
2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for the charges.
3) It is your responsibility to understand your benefits and coverage. Not all plans cover annual well child physicals, sport physicals, hearing or vision screenings. If these are not covered, you will be responsible for payment.
4) If your insurance company has not been informed that we are your primary care physician, you may be financially responsible for the current visit.

Referrals

1) It is your responsibility to know if a written referral or authorization is required to see specialists.
2) Advance notice is needed for all non-emergent referrals, typically 3-5 business days.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all copayment, deductibles and coinsurances. All copayments are to be paid at the time service is rendered.
2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance carrier for reimbursement.
3) Should a monthly payment plan ever become necessary, arrangements can be made with our business office. Failure to pay for services or adhere to an arranged payment plan will result in collection action.

I have read and understand Haymarket Pediatrics office /financial policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patients Name(s)_____

_____

_____

Responsible Party's name_____

Relationship_____

Responsible Party's Signature_____Date_____

Haymarket Pediatrics PLC

HIPAA

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

As the parent, patient or legal guardian, I hereby give consent for Haymarket Pediatrics PLC to use and disclose protected health information about me or my child/children to carry out treatment, payment, and healthcare operations. I have the right to review the Notice of Privacy Practices and I have been given the opportunity to review that document prior to signing this consent. I am also aware that I have the right to request a written copy of the office's Notice of Privacy Practices and that Haymarket Pediatrics PLC reserves the right to revise its Notice of Privacy Practices at any time. There is no expiration date for this consent.

Name of Child/Children:

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

Parent, Patient or Legal Guardian:

Print Name: _____

Relationship: _____

Signature: _____ **Date:** _____

PATIENT INFORMATION

NAME_____ DOB_____

Father's Name_____

Mother's Name_____

Chronic Health Issues	Allergies

Birth History [ ] Full Term [ ] Premature_____wks

Hospital_____
Birth Weight_____Length_____Head_____
Complications: During Pregancy_____
During Delivery_____

Feeding: [ ] Breast [ ] Bottle (Formula Type_____)

Family History

	Age	Allergies	Heart Disease	Cancer	Diabetes	Seizures	Thyroid
Mother							
Father							
Sibling							
Sibling							
Sibling							
Sibling							