PATIENT REGISTRATION FORM

MARYLAND PEDIATRIC CARE LLC
19525 Doctors Drive, Germantown, MD 20874

Phone: 301-424-2400
Fax: 301-517-6762

Patient's Name: ______________________________DOB: _______________ Sex: __________ Ethnicity: _____________ Race: __________

Address (Street/City/State/Zip): ____

Primary Phone: ________________________ Secondary Phone: _______________________ Email Address: ____________________________

Emergency contact name: _______________________ Relationship to patient: _____________ Emergency contact Phone: ________________

Known Allergies to Medication/s: ____

Name of Mother/Legal Guardian: ___________________________ DOB: ________________ Address:_________________________________

Home Phone: ___________________________ Cell Phone: _______________________ Email Address:________________________________

Work Phone: ____________________________ Occupation: ____________________ Employer: _____________________________________

Name of Father/Legal Guardian: ____________________________ DOB: _____________ Address:____________________________________

Home Phone: ___________________________ Cell Phone: _______________________ Email Address:________________________________

Work Phone: ____________________________ Occupation: ____________________ Employer: _____________________________________

Brothers and Sisters: (Include all siblings in our practice)	**Date of Birth**	**Sex**	**Known Allergies to Medication**
1. ____	_____________	__________	_____________________________________
2. ____	_____________	__________	_____________________________________
3. ____	_____________	__________	_____________________________________
4. ____	_____________	__________	_____________________________________

If there is any legal custody agreement for any child mentioned on this registration form: Yes ____ No ____

If Yes to above question, please provide a copy during your initial registration

Medical Insurance Policy /Holder Information: (*Please provide insurance card/s for official record)*

Primary Insurance Name: ____________________________ Policy #: ____________________________ Group #: ________________________

Policy Holder Name & SSN#: ________________________________ Subscriber's ID: ____________________ Employer: ___________________

Secondary Insurance Name: ____________________________ Policy #: ____________________________ Group #: ______________________

Policy Holder Name & SSN#: ________________________________ Subscriber's ID: ____________________ Employer: ___________________

Preferred Pharmacy (Name, Address, Phone): ____

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I acknowledge all the information provided on this form is correct and I hereby authorize the release of any medical Information necessary to provide medical care and process any claims with any insurance company. A copy of this authorization and assignment may be used in place of the original. I understand that I am financially responsible for charges not covered by my health insurance plan.

Name: ____ Signature: ____

Date: ____

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AUTHORIZATIONS/CONSENT TO TREAT

TREATMENT AUTHORIZATION: Authorization is hereby granted for my child/children to have examinations, immunizations, or routine screening procedures as recommended by the providers at Maryland Pediatric Care LLC. The authorization shall be continuous unless revoked by your office, the parents or guardian. I also authorize Maryland Pediatric Care LLC to initiate any medical treatment required in emergency situations.

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of medical/surgical benefits to Maryland Pediatric Care LLC for services rendered by them in person or under their supervision I further Authorize Maryland Pediatric Care LLC to release my medical or incidental information that may be necessary for processing of medical claims or applications for financial benefits. A photocopy of this assignment shall be valid as the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

ELECTRONIC COMMUNICATIONS AUTHORIZATION: I acknowledge that by providing my contact information, phone numbers and email address, I hereby authorize my healthcare provider (Maryland Pediatric Care LLC) to utilize automated messaging system and outreach mechanisms to use my personal information, the name of my health care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of any appointments, required examinations, balance dues, lab results, or any other healthcare related function. I hereby also authorize Maryland Pediatric Care LLC to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided.

PAYMENT POLICY: I understand and agree that, (regardless of my insurance status): I am ultimately and financially responsible for the balance of my child's/children's account for all professional services rendered including services not covered by my insurance company.

I have read all the above information and certify that the information provided by me to Maryland Pediatric Care LLC is true and current to the best of my knowledge. I will notify this office of any changes in child's/children's health status or the above information.

Signature of Parent/Guardian: ____

Name of Parent/Guardian: ____ Date: ___________________________

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NOTICE OF PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plane for future care or treatment. This Information, often referred to as your health or medical record, serves as a basis for planning your care or treatment, a mean of communication among the many professionals who contribute to your care, a legal document describing the care you received, a means by which you or a third-party payer can verify that services billed were actually provided. Understanding what is in your record and how your health information is used helps you to ensure accuracy, and better understand who, what, when, where and why others may access your health information makes more Informed decisions when authorizing discloser to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of Maryland Pediatric Care LLC, the information belongs to you. You have the right to request ·a restriction on certain uses and disclosures of your information. This includes the right to obtain a copy of your health record for a fee. You also have the right to be scheduled by an appointment. You may obtain an accounting of disclosures of your health information, request communications, of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health Information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health Information by alternative means or at alternative locations. We reserve the right to change our practice and make new provisions effective for all protected health information we maintain. Should our information practice change, we will mail a revised notice to the address you have supplied us.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the office at (301) 424-2400. If you believe your privacy rights have been violated, you can file a complaint with our· practice, contact the office at the above number. All complaints must be in writing. You will not be penalized for filing a complaint.

DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:

We will use your health information for treatment and for payment. We will also use it as needed for business associates such as other physicians, labs, and billing companies. To protect your health information, however, we require the business associate/s to appropriately safeguard your Information. Health professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will also provide your health Information as required by federal, state, or local laws. Any authorization you provide to us regarding the use and disclosure of health-information may be revoked at any time in writing. Please note, we are required to retain records of your care.

A more detailed version of the Notice of Privacy Practice is available for inspection in the office.

______________________________ ______________

Patient's (Parent/Guardian) Signature **Date**

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STATEMENT OF OFFICE POLICIES

The following polices have been adopted to provide better pediatric care to our patients. It is important to follow these policies to ensure smooth service and a respectful, nurturing office environment that meets your needs.

1. A valid insurance card must be presented at the time of service. Otherwise, your office visit has to be paid for as fee-for-service at the time of your visit.
2. Co-payments must be paid at the time of sign-in.
3. Our office will submit claims to all of the insurance plans that we participate with. Any resubmissions of insurance claims can be arranged if needed. Any insurance disputes must be settled within 120 days. Any unpaid balance has to be paid within 30 days of receipt of statement from our office.
4. If the patient's insurance company deems an office visit, vaccine, or any other service as a non-covered service and denies payment, then the patient's financially responsible person will be responsible for the full cost of the services rendered. Subsequent filing for reimbursement or balance owed will become the responsibility of the financially responsible person, once the denial occurs.
5. Any outstanding balance will be turned over to the collection agency and an additional 30% will be added to the unpaid balance.
6. Minimum 72 hour notice must be provided to the office to obtain referrals.
7. School forms require a minimum of 48-72 hours to be completed and ready for pick-up. Forms can be mailed only if a self-addressed and stamped envelope is provided. We will not fax any school/daycare forms.
8. Faxing of documents to and from the office is not encouraged, except to/from health care providers & insurances.
9. A written request is necessary to transfer medical records to another office and can be done within two weeks from the time of request.
10. There is a fee for copying medical records. Please check with us for more information about the fee.
11. A fee will be charged for no-show appointments. Appointments must be cancelled at least 48 hours in advance to avoid the no-show fee. Please check with us for more information about the fee.
12. There is a $45.00 charge for all returned checks, in addition to the check amount Checks will NOT be accepted from those whose check was previously returned unpaid from the bank.

I acknowledge that I have read and understand the Statement of Office Policies.

______________________________ ______________________
Signature of parent/legal guardian Date

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Printed name of parent/legal guardian