PATIENT REGISTRATION: 12 YEARS OLD AND UP

Partners in Pediatrics & FAMILY HEALTH

"no such thing as a dumb question"

303 Memorial Blvd. W. ▪ Hagerstown, MD 21740
Phone 301-791-7060 ▪ Fax 301-791-8990

READ: Please fill out all information requested below honestly. Do not leave out any part. Any dishonesty jeopardizes your health, your child's health, and the doctor - patient relationship. It is the patient's responsibility to update any changes in disclosed information. Any failure to disclose requested information in a timely manner OR dishonesty or deceitfully by any patient/responsible party will result in discharge from the practice.

Today's Date: _____

Patient Name: _____ **DOB:** _____

Sex: __ **Female** __ **Male** ***SSN:** _____

***Home Address:** _____

***Mailing Address:** _____

***P O Box:** _____ ***Cell Phone#:** _____ **Other Phone #:** _____

***Email Address:** _____

Ethnicity: ___ **Hispanic/Latino** ___ **Not Hispanic/Latino** ___ **Decline to specify**

Race: ___ **American Indian** ___ **Asian** ___ **Black/African American** ___

Pacific Islander ___ **White** ___ **Decline to specify.**

How did you hear about us? _____

_____

RESPONSIBLE PARTY

Primary Responsible Party's Name: _____ **Relationship:** _____

***Cell Phone#:** _____ **Other Phone #:** _____

Email: _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Cell Phone #: _____ **Other Phone #:** _____

Patient's Name: _____ **DOB:** _____

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COARDINATION OF CARE

Preferred Pharmacy Name: _____Location: _____

Dentists Office: _____ Date of Last Visit: _____

Known Allergies: _____

Daily Medication and Dosage: _____

_____

PRIMARY INSURANCE

Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable):_____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider's Phone Number: _____

SECONDARY INSURANCE

Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable):_____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider's Phone Number: _____

TERTIARY INSURANCE

Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable):_____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider's Phone Number: _____

Patient's Name: _____ **DOB:** _____

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AUTHORIZED RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Partners In Pediatrics and Family Health to release my medical information to the following people listed below.

Without giving consent, no HIPAA protected information can be provided to anyone, regardless of their relationship to the patient. You are giving consent to the following members of your care team (e.g., Doctor, therapist):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Cell Phone #: _____ Cell Phone #: _____

Other Phone #: _____ Other Phone #: _____

OFFICE POLICIES

PLEASE INITIAL BELOW:

- Photo ID and valid insurance cards must be presented at each visit. _____
- It is the patient's responsibility to know the terms of their insurance. _____
- Appointment cancellations required 24 hours notice, otherwise a $25 missed-appointment fee will be administered. This includes cancellations on day of appointment. _____
- All account balances, co-pays, coinsurance and deductibles must be paid/cleared before the patient is checked-in for the day's appointment. _____
- Our time is extremely valuable to other patients. We observe a 3-strike policy. Persistent cancellations or No-Shows of appointments is a waste of our time and the time of other patients who need appointments. The persistent appointment canceller/" No-Shows patient" Will be placed on the discharge list and subsequently discharged from the practice. _____
- Being more than 10 minutes late may require the appointment to be rescheduled. _____
- Medical records request, school forms, immunization records, FMLA, Worker's comp paperwork and any other paperwork requests require 5-6 business day for such requested document to be prepared and ready to be picked. _____
- Some records and paperwork, including medical records and letters from our provider, require a preparation fee. See our service fees list. _____
- All patients are required to behave in a professional, respectful and responsible manner. Parents/Guardians must control their children/wards. Our office is a professional environment, no cursing, foul language (the "F", "N", "B" etc. words) or adult temper tantrums are allowed. _____

Patient's Name: _____ **DOB:** _____

PATIENT REGISTRATION: 12 YEARS OLD AND UP

OFFICE POLICIES (Contd.)

PLEASE INITIAL BELOW:

- Partners In Pediatrics an Family Health operates a drugs free, non smoking/vaping campus. Please do not bring any drugs, cigarettes/e-cigarettes/vape pens/cigars, or other nicotine/marijuana delivery systems onto our property. _____
- Be responsible, throw your trash, including used face masks candy/food wrappers, used diapers, and such, into the trash bins. Do not leave any mess in the restrooms, examination rooms, waiting rooms, carport or parking lot, of our property. Use the trash bins. Respect our property. _____
- The property of Partners In Pediatrics and Family health is not a playground. Stay out and keep your children/wards out of the decorative stones/pebbles' beds around our property. Your insurance does not pay for the upkeep of the property. _____
- Failure to comply with any of our office's policies may result in the patient being discharged from our Practice. _____

NOTICE OF PRIVACY PRACTICE

A paper/electronic copy of the notice of privacy practice has been offered to me.

I accept_____ or decline _____ my paper copy. I have been notified that a master copy is always available in the office for my review at any time. (Also available in Spanish).

Patient's Name (Print):_____ Date: _____

Patient or Guardian's signature (for Minors): _____ Date: _____

ASSIGNMENT OF BENEFITS/PERMISSION TO TREATMENT

I certify that this registration information is true and accurate. I certify that this medical information is, to the best of my knowledge, accurate. I authorize partners In Pediatrics and Family Health to treat my child/ward, listed above as the patient.

I authorize Partners In Pediatrics and Family Health to bill my medical insurance for services rendered on my behalf.
I authorize payment of health insurance benefits directly to DEJ Med Practice, LLC dba Partners In Pediatrics and Family Health under the terms of my Insurance.

I understand failure to provide valid insurance information at anytime will result in full financial responsibility on my part. I understand that I am responsible for all co-pays, deductibles and coinsurance amounts as per my contract with my insurance company.

Guardian's Name (Print): _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____

Patient's Name: _____ DOB: _____

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SOCIAL HISTORY

Home Life: 12 - 18

Lives with both biological parents? _____ Split custody between parents? _____

Sole custody of one parent? _____. Sole custody of a guardian? _____

Foster guardian(s)? _____. Adoptive guardian(s)? _____

Number of Siblings: _____

Do you smoke? Yes: _____ How much: _____ No: _____

Do you drink alcohol daily? Daily: _____ Occasionally: _____ No: _____

Do you use recreational drugs? Yes: _____ No: _____

Have you ever been sexually abused? Yes: _____ No: _____

Have you ever been physically abused? Yes: _____ No: _____

Do you drink water daily? Yes: _____ How much: _____ No: _____

Do you exercise? Daily: ____ Frequently: ____ Rarely: ____ Never: ____

Do you have a healthy support system at home? Yes: _____ No: _____

Do you regularly attend social events with family and friends? Yes: _____ No: _____

PATIENT MEDICAL HISTORY

Check any and all that you have had or currently have:

ADD ____	ADHD ____	Allergies ___	Anemia ____
Autism ____	Constipation ____	Asthma ____	Cataracts ___
Diabetes ___	Depression____	Frequent Sore throat__	
Diarrhea ____	Reflux ___	Eczema ___	Hearing Loss ___
Heart Disease ____	Pneumonia ____	Rash ____	Seizures ____
Cancer ___	Urinary problems___	Ear Infections ___	Chicken Pox ____

Other medical history to report _____

List any hospital stay and/or surgeries _____

List all current medication _____

Patient's Name: _____ DOB: _____

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FAMILY HISTORY

Please check any that apply to blood relatives of the patient and list the relationship to the patient.

(Mother, father, maternal grandmother/grandfather, paternal grandmother/grand father, paternal aunt, paternal uncle)

DISEASE	RELATIONSHIP TO PATIENT	DISEASE	RELATIONSHIP TO PATIENT
HIV/AIDS		Alcoholism	
Allergies		Anemia	
Arthritis		Asthma	
Genetic Disorders		Depression	
Mental Illness		Cancer	
Diabetes		Drug Abuse	
GI Disease		Hearing Loss	
Heart Disease		High Blood Pressure	
High Cholesterol		Kidney Disease	
Liver Disease		Migraines	
Seizures		SIDS	
Stroke		Thyroid Disease	
Tuberculosis		Multiple Sclerosis	
Obesity		Sleep Disorder	
Epilepsy		COPD	
Alzheimer's Disease		Physical Abuse	
Sexual Abuse			

Other family history to report _____

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Authorization for Release of Patient Identifiable Health Information

Date of Request: _____

I, _____hereby authorize Partners in Pediatrics and Family Health

_____ To release to _____To obtain from

Name of Physician, Hospital, Insurance Company, Self, Etc. _____

_____

Address, P.O.BOX, City, State, Zip Code

The following information will be released from the Medical Records of:

_____ _____ _____

Patient Name D.O.B Social Security number

Specific Information to be disclosed: _____ Entire Medical Record ____ Immunization Record

____ Other (please specify) _____

This Health Information is need for:

__ Personal Use __ Continuing Medical Care __ School
__ Leaving the Practice __ Legal Reasons
__ Social Security Disability __ Other __ Military

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immuno-deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of specific information.
- I also understand that the person giving authorization by written and dated notice to the Medical Record Department may revoke this authorization.
- I understand that this revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it,
- I understand I may be charged for copies of my healthcare information.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
- I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this to ensure healthcare treatment.

Patient's Signature: _____ **Date:** _____

Parent/Guardian's Signature (for Minors) _____ **Date:** _____

There is a $30 charge for a copy of each complete medical record for those transferring from this office.

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General Consent/Authorization Form

***Year: _____**

Please answer **all Questions **honestly**; your answers will be kept confidential. If you are dishonest in your answers, you will be discharged as a patient from our practice.*

***Today's Date: _____ *Patients Name: _____ *Date of Birth: _____**
***Current Cell Phone#: _____ * Other Phone#: _____ *Email Address: _____**

Please read carefully:

- All charges (co-pay, deductibles, self-pay, etc) are **due at the time professional services are rendered**.
- For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Partners In Pediatrics and Family Health, hereafter known as PIPFH.
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- For minors: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by PIPFH.
- I hereby authorize PIPFH to furnish information to any insurance company or authorized agency.
- specified regarding information concerning my medical care.

Consent for Treatment: I authorize providers at PIPFH to perform examinations, procedures, laboratory tests and to administer such medication as; in his/her opinion is necessary for my care.
Patient / Guardian's signature (for minors): *_____ * Date: _____

Consent for Medication History: I consent to the use of my medication history from any participating medical information exchanges.

Ancillary Services: I understand that PIPFH and other independent lab may be performing laboratory studies as ordered by my physician and collected at PIPFH. These studies will be billed to me by PIPFH lab. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of Information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to the person you designate. Please complete the section below.

Consent to Release of immunization records to other Organizations/Schools: *Yes ( ) No ( ).
*Organizations/School Name (s): _____

Receipt of Notice of Privacy Policy: I have received/reviewed ( ) or declined ( ) a copy of the Notice of Privacy Policy titled: "Your information. Your rights. Your responsibilities".

I authorize PIPFH to release any information required in the course of my examination or treatment to the following designated persons:

*Name: _____
*Relationship: _____
*Current Phone #: _____

*Name: _____
*Relationship: _____
*Current Phone#: _____

*Patient Signature: _____ Date: _____
*Guardian's Signature (**for minors**): _____ Date: _____

This document is **valid for only one year** from the date of signature.