CARING HANDS PEDIATRICS

Patient's Name_____ **Male / Female**

Date of Birth / / Race_____ **Language**_____ **Hispanic origin ☐ Yes ☐ No**

Address: _____ **City**_____

State/Zip Code: _____ **Home Phone** _____

Father/Guardian Name _____**DOB** _____ **Birth father ☐ Yes ☐ No**

Father cell phone _____ **Preferred method of contact (circle only one)**

Fathers email address_____ **Home Cell Email**

Mother/Guardian Name _____ **DOB** _____ **Birth mother ☐ Yes ☐ No**

Mother cell phone _____ **Preferred method of contact (circle only one)**

Mothers email address_____ **Home Cell Email**

FINANCIALLY RESPONSIBLE PARTY

(If different from above)

Responsible Party's Name _____

Responsible Party's Address _____

PLEASE PRESENT INSURANCE CARD(S) FOR SCANNING AND COMPLETE ALL REQUESTED INFORMATION BELOW

Insurance Company #1 _____**Social Security Number** _____

Primary Card Holder Name _____**Date of Birth**_____

Policy# _____**Group #** _____**Relationship** _____

Insurance Company #2_____**Social Security Number**_____

Primary Card Holder Name _____**Date of Birth**_____

Policy# _____**Group #** _____**Relationship** _____

Please share with us how you were referred to our office _____

AUTHORIZATION FOR CARE

We believe that it is best for you child to be with a parent or legal guardian at every office visit. However, we realize that this is not always possible. We would like to know who has your permission to present your child for medical care.

First and last name _____**Relationship to patient** _____

First and last name _____**Relationship to patient** _____

PARENT/GUARDIAN SIGNATURE_____ **DATE / /**

CARING HANDS PEDIATRICS

www.caringhandspediatrics.com

Authorization for Care and Release of Protected Health Information

We believe it is best for your child to be with a parent or legal guardian at every visit. However, we realize that this is not always possible. If you would like to give permission to another individual to bring your child for care or treatment, please complete the information below. Please be aware that this individual will also have access to your child's personal health information during the visit**.**

If you would like any information excluded, it must be documented below.

PATIENT INFORMATION

Last: _____ First: _____Middle:_____

Address: _____

Date of Birth: _____/_____/_____ Phone ( ) _____

I _____ parent of _____ give permission for the individual(s)
(Parent's name) (Child's name)
named below to bring my child in for care and treatment by ***Caring Hands Pediatrics and/or Staff***. I am aware that protected health information, including but not limited to, insurance, address, phone number, test results and healthcare information may be discussed at this time.

Name of Person: _____

Relationship to Patient: _____

Phone: ( ) _____

Please exclude the following information:

_____

_____

Name of Person: _____

Relationship to Patient: _____

Phone: ( ) _____

Please exclude the following information:

_____

_____

I understand that:

- **I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization.**
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be contingent upon my signing this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE UNLESS OTHERWISE EXCLUDED.**
- The information Authorized for release also may include protected health information related to mental health.
- The information/record is protected by the HIPAA Privacy Rule.
- **This Authorization will expire at the end of the calendar year of my signature below unless an earlier termination date is specified.** _____

Signature of Parent _____ Date_____

Relationship to Patient _____

You have the right to receive a copy of signed authorizations upon request.

CARING HANDS PEDIATRICS
Acknowledgement of Receipt of Notice of Privacy Practices

Caring Hands Pediatrics has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgment.
We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised note by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer

Mail: Caring Hands Pediatrics
Attention Privacy Officer
105 Braunlich Drive Suite 102
Pittsburgh, Pennsylvania 15237

Telephone: (412) 369-7720
Fax: (412) 369-7751

Acknowledgement of Receipt

I acknowledge that I have received the "Notice of Privacy Practices" for Caring Hands Pediatrics.

_____
Name of Patient

_____ _____
Signature of patient (or personal representative) Date

Personal Representative Name: _____

Relationship/Authority: _____

.....

Good Faith Effort to Obtain Acknowledgement of Receipt

I provided the above named patient/personal representative with the" Notice of Privacy Practices".

Describe how the notice was provided:

( ) Offered copy and individual refused to accept delivery
( ) Offered copy and individual accepted delivery

Describe efforts to obtain signature on acknowledgement of notice form:
( ) Patient/personal representative was asked to sign and refused.

_____ _____
Signature of Staff Member Date

CARING HANDS PEDIATRICS

www.caringhandspediatrics.com

Medical Information Disclosure

Caring Hands Pediatrics would like to ensure your child's health information is disclosed correctly. ***If you have restrictions regarding voice mail messages, texts or emails please provide the information below.*** If you choose no restrictions, that entitles our staff, physicians, and or representatives to leave information regarding your child's medical and financial information via email, text or phone.

Child(ren) Name(s): _____ _____

_____ _____

_____ _____ _____

I, _____, the undersigned, hereby authorize Caring Hands Pediatrics P.C., its representatives, physicians and staff, to share any and all medical and financial information based on my option below (Please choose only one):

***** Both biological parents will automatically have authorization unless court documents are presented specifically stating one is not authorized by the courts.***

□ **NO RESTRICTIONS:** Okay to leave messages on designated phone numbers and/or text or email.

□ **RESTRICTED:** Person to person with Parent/Guardian Only

□ **RESTRICTED**: See note below:

_____

_____

_____

Parent Name: _____ Date:_____

Signature: _____

PREFERRED CONTACT METHOD

Please complete the information below to help update our records.

Patient Name: _____

Our default method of contact to notify you of your appointment reminders, recalls, general notices, medical issues and portal notifications is **EMAIL**. Please list the appropriate person to receive these notifications.

**** Please note if you are 18 years of age and older please document yourself as the contact person with your information.**

Contact Person: _____

Relationship to Patient: _____

Email address: _____

** **If you <u>DO NOT</u> want to receive an email notification, you may choose an alternate method. Please update your preferred method of contact.**

Contact person: _____

Relationship to Patient: _____

Phone Number: _____

Method of contact preferred.
Choose only one option.

- ☐ Home phone voice message
- ☐ Cell phone voice message
- ☐ Text message

Our default method of receiving billing statements is mail. You have the option to receive e-Statements by registering at **https://pay.instamed.com/caringhandspediatrics.**

I understand that I am personally responsible for being aware of dates and times of my scheduled appointments. Caring Hands Pediatrics provides reminders to appointments out of courtesy. We request that cancellations are made 24 hrs. in advance. You will receive a charge of $25.00 for any missed appointment.

I hereby consent to the above contact methods from Caring Hands Pediatrics.

Signature of Parent: _____ Date:_____

REQUEST FOR PATIENT PORTAL ACCESS

Please list the names of all of your children.	Child's Date of Birth

*Patient Portal access is for all family members under the age of 18.

Parent's Name: _____

My relationship to the above children:

☐ Parent ☐ Legal Guardian (Must provide a copy of Court Order) ☐ Self – I am 18 or older

By signing below, I acknowledge and agree to the following terms:

- I must have parental rights or legal guardianship rights to access the medical records for the above listed children.
- I have not been denied custody for the above children and there are no court orders or restraining orders in effect limiting my access to the medical records for the above listed children.
- I will keep my Patient Portal log in and password confidential and will not share with anyone.
  (A separate log in will be given for each parent/guardian)
- I will only update the Patient Portal with true and accurate information.
- I understand the portal is not a complete version of my child's medical record.
- I may not use messaging through the Patient Portal for emergency situations. I will call the office directly.
- I will no longer have access to the records for the above listed children once they reach their 18th birthday unless received in writing from patient.
- All patient portal alerts will be sent to the email address I have on file with Caring Hands Pediatrics. It is my responsibility to update my email address within the portal when change occurs.

_____/_____/_____

Signature Relationship to Children Date

Email address for Patient Portal access :_____(required)

For Official Use:

Signature and identity of parent/guardian verified on _____/ Employee Signature: _____

Date

☐ **Driver's License** ☐ **Court Custody Papers Attached**

CARING HANDS PEDIATRICS
LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print clearly. Form must be signed and dated each year.

Patient Name: _____

Date of Birth: _____

Entity Requested to Release Information– I hereby authorize the entity below to disclose or provide protected health information, about me/my child.

Facility/ Individual: _____

Address: _____

Phone: _____ Fax:_____

Authorized Individual to receive PHI information (who will be authorized to receive information):

Facility: CARING HANDS PEDIATRICS
Address: 105 Braunlich Drive Ste 102 , PITTSBURGH, PA 15237
Phone: 412-369-7720 Fax: 412-369-7751

Description of information to be disclosed – I authorize the practice to disclose the following PHI about me/ my child to the entity or person identified above:

☐ Entire patient record; or check only those items of the record to be disclosed:

☐ Office notes
☐ Lab results and X-ray reports
☐ Immunizations only
☐ Entire medical Record for previous 2 years
☐ Record of HIV and communicable disease testing
☐ Record of mental health or substance abuse
☐ Only send the following:_____

Purpose of disclosure (please disclose the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify):_____

- This authorization will expire at the end of the calendar year of your signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____
- You may have the right to terminate this authorization at any time by submitting a written request to our Privacy Officer. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Guardian Signature Date

You have the right to receive a copy of signed authorizations upon request.

CARING HANDS PEDIATRICS

WELL VISIT POLICY

Well visits (also known as preventative exams or physicals) are recommended per the American Academy of Pediatric guidelines based on age ranges. During a routine well visit, a complete physical exam is performed along with additional age appropriate screenings recommended by the AAP guidelines. **The additional screenings may include but aren't limited to surveys or questionnaires, hearing/vision exam, diagnostic lab testing, and/or fluoride varnish.** It is important for you to understand that a well visit is considered preventative care, meaning we are evaluating patients to identify issues early before they become larger problems. In order to provide the best standard of care, we encourage all recommended screenings to be performed. Your insurance requires us to bill these additional screenings separately from the well visit exam. They may or may not be covered services depending on your insurance plan.

Please note well visits **do not include** care of other chronic medical conditions (asthma, ADHD, allergies, mental health issues) or acute illnesses (ear infections, strep throat, viruses, etc.) that occur at the same time as a well visit. If we evaluate or treat a chronic or acute condition during the course of the well visit, we are mandated by your insurance company to document and bill separately for those issues. As such, you may be required to pay a copay, co-insurance or deductible. Please know that this is required by the insurance company and we are forced to comply with their policy, as failure to do so would constitute insurance fraud. Our providers are willing to provide care for chronic and acute conditions during a well visit if time permits out of courtesy. Alternatively, a separate visit can be made to address the chronic or acute illness at a later date, at which a copay, co-insurance or deductible would still apply.

<u>Acknowledgement of Well Visit Billing Procedures:</u>

I acknowledge I have read and understand the above policy. I understand that additional services may be performed and billed for preventative well visits. I understand that acute or chronic illnesses are not part of a preventative exam and will be billed separately if performed to my insurance plan.

Patient Name: _____ DOB: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL POLICY
CARING HANDS PEDIATRICS
Effective 8/1/2015

Due to recent changes to employer-sponsored health coverage as a result of the Affordable Care Act, **Caring Hands Pediatrics** has implemented policies to insure we can continue to provide quality medical care for our families and remain fiscally sound. Most families will have an increase in family contributions in the form of higher co-payments and larger annual deductibles, which in turn created the need to put a new policy in place regarding payments. We value you as a patient of our practice. Please be assured that we make every effort to keep costs low while maintaining a high level of professional care.

PLEASE REVIEW AND INITIAL NEXT TO EACH SECTION BELOW AND RETURN TO OFFICE.

X_____ PAYMENTS:

- All copayments and coinsurance must be paid in full on the day of service.
- The custodial parents of the minor child will be responsible for medical expenses originating from our office.
- **For families with a yearly deductible:**
  - A **deductible** is an amount set by your insurance company, requiring you to pay in full up to this amount before your insurance will begin to pay for charges. A deductible is the patient's financial responsibility.
- The remaining balance must be paid in a maximum of 3 monthly payments.
- All balances will need to be kept current and in good standing before upcoming appointments can be scheduled.
- Payment plans can be approved by the office manager for those with extenuating circumstances.
- All outstanding balances not paid after 3 billing statements will be sent to collections unless other payment arrangements have been made in advance.
- Self- pay patients (patients with no insurance) are responsible for payments in full on the day of service.

**** Caring Hands Pediatrics accepts cash, personal checks (in-state only), VISA, MasterCard, and Discover. There is a service charge for returned checks. If an insufficient funds (NSF) check is received for payment on your child's account, you will be charged a $25.00 NSF fee. In this case, you will be required to pay with cash, money order, cashier's check or credit card. Payments are also accepted online through our patient portal, or by using the following web link: https://pay.instamed.com/caringhandspediatrics.**

Patients with an outstanding balance **90 days or more overdue** must make arrangements for payment prior to scheduling appointments.

X_____ INSURANCE:

- It is your responsibility to provide our office with correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment for the visit if the claim is not submitted to the correct insurance in a timely manner.
- It is your responsibility to ensure that we are listed as your primary care doctor on your insurance card on the day of your visit. If your insurance company is not informed that we are the PCP, you may be financially responsible for the visit.
- We bill all insurance companies. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.
- If a claim is denied by your insurance company for any reason, such as a non-covered service, this amount becomes your financial responsibility. If you have a question regarding a claim that was denied, please contact your insurance company for clarification.
- If you need assistance or have questions, please contact the billing office between 7:30 a.m. and 4:00 p.m., Monday through Friday at 412-346-2406.

X_____ EXTENDED OFFICE HOUR FEE

If your child is scheduled for an evening appointment after 5pm during a weekday or anytime on a Saturday or holiday at either office, your child's claim to the insurance company will include an additional code for extended hours. Some insurances are covering this charge. However, if your insurance applies this charge to your deductible or coinsurance, you are then responsible for covering the fee.

X_____ MANAGED CARE:

If you are enrolled in a managed care insurance plan, (i.e.,HMO), you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if you require a referral or prior authorization for all services. Please call your insurance in advance of all specialty appointments, lab testing and/ or radiology testing to insure service is covered under your plan.

X_____ MISSED OR LATE APPOINTMENTS/ CANCELLATIONS:

- We value the time we have set aside to see and treat your child. We request that cancellations are made 24 hours prior to the appointment. There is a charge of $25.00 for missed appointments. These fees are the patient's responsibility and cannot be billed to the insurance company. Excessive abuse of scheduled appointments may result in discharge from the practice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

X_____ FORMS:

- If your child has a school, camp, or work form to be completed, there is a $5.00 charge per form. An annual physical must be on file for your child and completed in the past year.
- If your child has a drivers' form that needs to be completed, he/she must have a physical no earlier than 6 months prior to their 16th birthday. A $15.00 fee is charged. If your teenager requires a drivers' physical, a $25.00 fee is charged and not billable to your insurance.
- If your child has a sports physical that needs to be completed, all WPIAA physicals must be done after June 1st of the current school year. A $25.00 fee is charged and not billable to your insurance.
- If a form is brought to the appointment on the day of the physical no charge is applied.
- Any balance on patient's account must be paid in full to receive a physical form completion, unless other payment arrangements have been made.

X_____ TRANSFER OF RECORDS:

- If you transfer to another physician, we will provide a copy of your child's record free of charge if mailed directly to the new physician.
- If you request a copy of your child's medical record for your own personal use, a fee is charged, based on the allowable annual rates from the PA Medical Society. Please ask staff for current rates.

**** PLEASE NOTE: Not all services provided by our office are covered by every insurance plan.**

<u>Any service determined to not be covered will be your financial responsibility.</u>

I have read and understand **Caring Hands Pediatrics'** Financial Policy. I agree to assign insurance benefits to **Caring Hands Pediatrics** whenever necessary. I agree to accept the responsibility for any payment that becomes due as outlined above.

Signature of insured or Authorized representative: _____

Print Name:_____ Date: _____

Relationship to Patient: _____

Revised 11/1/15

CARING HANDS PEDIATRICS

Authorization for Payment Card on File

Authorization: Until further written notice, I authorize Caring Hands Pediatrics to keep the requested payment card on file and to charge the patient-responsible balances on my account(s) to the payment card. Once the payment card is swiped, all information is kept encrypted and secure offsite by our merchant processing provider InstaMed.

****Payment card must be given to staff at Caring Hands Pediatrics to swipe into the EMR system to save on file for each child listed below.**

This payment card authorization shall be applied to the following accounts:

Patient Name(s): _____ DOB: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE CHOOSE ONE OPTION BELOW.

INSURANCE SAVINGS CARD (Circle one): H.S.A. H.R.A F.S.A

Last 4 digits of my card: ☐☐☐☐ Expiration Date: _____

Name on card (please print): _____

CREDIT/ BANK CARD (Circle one): Visa MasterCard Discover Bank / Debit

Last 4 digits of my card: ☐☐☐☐ Expiration Date: _____

Name on card (please print): _____

- I understand that per my verbal request I may also use the card on file option to pay for balances due, deductibles, copays, co-insurances, and form fees.
- I understand upon card expiration, it will be my responsibility to provide a new credit card to keep on file if I want to continue with this option. (new form must be completed for new credit card).
- I understand that if I would like to sign up for Auto Pay, I will need to create an account through InstaMed and register for the Auto Pay service on their site.
- I understand that I have the option to request to remove the card on file at any time.
- A receipt will be given for all transactions applied to the credit card on file.

Card Holder's Signature: _____ **Date:** _____

Printed Name: _____ **Employee Initials**: _____

PATIENT FAMILY HISTORY

PATIENT NAME:_____ DOB / /

Please check the box if any family members have had the following conditions. Please indicate which family member including immediate family (mom, dad, sister, brother) + grandparents (please use the key below) and their age when the condition was diagnosed.

KEY for grandparents: MGM = Mom's mom, MGF = Mom's dad, PGM = Dad's mom, PGF = Dad's dad

- ☐ ADHD_____
- ☐ Alcoholism_____
- ☐ Anemia_____
- ☐ Anxiety_____
- ☐ Asthma_____
- ☐ Autism_____
- ☐ Autoimmune Disorder_____
- ☐ Birth Defect/Congenital Anomaly_____
- ☐ Bleeding Disorder_____
- ☐ Blood Disorder_____
- ☐ Cystic Fibrosis_____
- ☐ Depression_____
- ☐ Diabetes_____
- ☐ Eczema_____
- ☐ Genetic Disorder_____
- ☐ Heart Disease_____
- ☐ Heart Attack_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Immune Disorder_____
- ☐ Kidney Disease_____
- ☐ Learning Disability_____
- ☐ Liver Disease_____
- ☐ Migraines_____
- ☐ Psychiatric/Mental Illness_____
- ☐ Scoliosis_____
- ☐ Seizure Disorder_____
- ☐ Sickle Cell_____
- ☐ Stroke_____
- ☐ Substance Abuse_____
- ☐ Thyroid Disorder_____
- ☐ Tobacco Use_____
- ☐ Tuberculosis_____
- ☐ Death before age 56_____
- ☐ Cancer (List Type)_____

_____

_____

- ☐ Other_____

_____