Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

DEMOGRAPHICS – ABOUT THE PATIENT

Legal Name: _____ Date of birth: _____

Gender: (M) or (F)

Language Preference: _____ Race/Ethnicity: _____

Adopted or in Foster Care? (Yes) or (No)

About the Parents/Legal Guardians: - Insurance Policy Subscriber *FIRST PLEASE:*

Guardian 1 / Insurance Subscriber:

Name: _____ Date of Birth: _____

Gender: (M) or (F)

Address: _____

_____

Home Number: _____Cell:_____ Work: _____

Occupation: _____ Employer Name: _____

Email:_____

Guardian 2:

Name: _____ Date of Birth: _____

Gender: (M) or (F)

Address – *If different than Subscriber # 1* _____

_____

Home Number: _____Cell: _____Work: _____

Occupation: _____ Employer Name: _____

Email:_____ Preferred method of communication: _____

The patient lives with: _____

Emergency Contact:

Name: _____ Phone Number: _____

Relationship to the patient: _____

Siblings:

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Please describe any vision or hearing impairment that requires accommodation: _____

_____

How did you hear about Hatboro Pediatrics? _____

Pharmacy Name: _____ Number: _____

Today's Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Patient Portal

Patient (s) Name (s): _____ Would you like to add other children/siblings to a family e-mail account? _____

Hatboro Pediatrics Patient Portal is a secure web-based system that will allow you to receive communication from our office and access portions of your child's medical record. Once you have signed up for the Patient Portal, these services are available online anytime through your computer allowing you to communicate with our office at your convenience.

Please check one of the following boxes:

☐

Yes, I would like to have access to Hatboro Pediatrics patient portal.

My e-mail address is: _____

☐

No, I would not like to have access to Hatboro Pediatrics patient portal

_____ _____
Parent Signature Date

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby consent to and authorize the release of all pertinent medical information to or from **Hatboro Pediatrics, PC** as indicated below. In addition, I consent to and the release of medical information if the record contains any information regarding psychological treatment, alcohol treatment, and/or HIV-related treatment.

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

THE ABOVE NAMED PATIENT IS MY (circle one)

SON DAUGHTER SELF FOSTER CHILD OTHER:_____

RELEASE OF MEDICAL INFORMATION

(circle one) **TO** **FROM**

NAME OF PERSON:_____

ORGANIZATION:_____

STREET ADDRESS:_____

CITY, STATE, ZIP CODE:_____

PHONE NUMBER:_____

REASON FOR RELEASE OF INFORMATION:_____

SIGNED (if not the patient, I also certify that I am parent/legal guardian of the patient):

_____ DATE:_____ PHONE:_____

Hatboro Pediatrics
483 East County Line Rd. Hatboro, PA 19040

Advance Beneficiary Notice (ABN)

Please Note: You will need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the item(s) or service(s) that are listed below. The plan that you have chosen as your health insurer does not necessarily cover all of your child's health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that your child should not receive it, especially if Hatboro Pediatrics recommends that he/she receive this service.

Description of Item (s) or Service (s):

Developmental screenings - M-CHAT: Modified Checklist for Autism in Toddlers is designed to screen for Autism Spectrum Disorders in toddlers. The M-CHAT does not allow a clinician to make a diagnosis of an Autism Spectrum Disorder, but is a very useful clinical tool that has excellent sensitivity and specificity. Positive results suggest a high risk for an Autism Spectrum Disorder, and may necessitate referral.

$5.00

Hearing screenings – Audiometry This is a threshold screening performed on a child that is verbal and requires a response from your child upon hearing a beep at different frequencies and decibels. It is a probe placed in the ear canal and the child is tested at 1000, 2000, 4000 and 500 decibels. In the event of a failed screening, the child may be reevaluated at a later date. In the event of a second failed test, we may recommend the OAE screening and refer to an audiologist for further testing and evaluation.

$15.00

Rapid strep testing - A diagnostic test commonly used to demonstrate whether streptococcus bacteria ("strep") are present in the throat. A throat infection with strep needs to be treated with an antibiotic. The traditional test for a strep throat has been a throat culture; the major drawback is that the results of the throat culture take 2 to 3 days. The rapid strep test is much quicker. It can produce results within minutes. If the test does not show strep a culture will be sent to the laboratory.

$10.00

Ear Wax Removal (a.k.a Cerumen Removal) – Cerumen impaction is a condition in which earwax has become tightly packed in the external ear canal to the point that the canal is blocked.

$41.00

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s).

_____ _____

Responsible party signature Date

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

2016 HIPPA Acknowledgement
Notice of Privacy Practices

Print Name of Patient: _____

Patient's Date of Birth: _____

We at Hatboro Pediatrics, PC are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative: _____

Today's Date: _____

E-mail Address of Patient/Legal Representative: _____

Cell Phone of Patient/Legal Representative: _____

Please let us know which number you would like us to call regarding your medical information. Note that this is the number where we will leave a message if we do not reach you.

Home Phone: _____ Cell Phone: _____ Both: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

ROUTINE – WELL CHECK

Hatboro Pediatrics well-check visits are a time when your child will receive routine, preventative care and possibly receive vaccinations. If you would like the doctor to conduct a sick-visit in association with your child's well check, and the doctor has an available time slot, you will be asked to submit your standard "sick appointment" copay, if that applies to your specific insurance.

I understand that I am responsible for payment should these services not be covered by my insurance plan.

_____ _____
Patient's Name *Patient's Date of Birth*

_____ _____
Guardians signature *Date*

FOR PATIENTS THREE YEARS AND OLDER ONLY

Hearing and Vision Screenings

In accordance with the **American Academy of Pediatrics'** guidelines, the doctors at Hatboro Pediatrics believe developmental, hearing and vision screenings are an important part of your child's well check. In an effort to provide top care, we use state of the art technology and well researched screening tools. Prior to testing the patient, we want you to be aware that these screenings may not be covered services under your specific insurance plan, or they may be applied to your deductible or co-insurance.

Unfortunately, with the multitude of different plans available, we are not able to know if your specific plan will cover the cost of these screenings.

Please feel free to obtain more specific information about the tests that we offer at Hatboro Pediatrics and know that you may opt out of any test recommended but must sign a waiver to that effect.

If you DO NOT want these screening test(s) performed, please indicate, sign and date this form.

_____ Hearing
_____ Vision

Please **DO NOT** *perform the screening test(s) indicated above on my child (ren) at this time. I take full responsibility for any abnormalities that may remain undetected because of my choice to opt out these recommended screenings. I understand that I may elect to have it performed at a later date.*

_____ _____
Guardian's signature *Date*

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Consent by Proxy for Non-Urgent Pediatric Care/Release of Information

Patient Name: _____

Patient Date of Birth: _____

I, _____hereby authorize Hatboro Pediatrics, P.C. to allow the below individual (s), who is 18 years of age or older, to assist in the care and treatment of my child in my absence:

Designated Adult (18 or over) Name: _____
Relationship to Patient: _____

Designated Adult (18 or over) Name: _____
Relationship to Patient: _____

Designated Adult (18 or over) Name: _____
Relationship to Patient: _____

Designated Adult (18 or over) Name: _____
Relationship to Patient: _____

By authorizing the above individual (s), I hereby agree to abide by all the financial responsibility associated with the care and treatment of my child. I will be responsible to pay Hatboro Pediatrics, PC.

I agree to the following Terms and Conditions
-The proxy requestor must be the parent or legal guardian of the pediatric patient.
-The proxy requestor must complete and sign this form.
-Each proxy requestor must submit one form per child.
-Proxy access can be terminated only by written request.

Should another adult be designated in the future, I will submit an updated version of this form.

Signature
Parent/Legal Guardian Name: _____ Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Missed Appointment Policy

We want to thank you for choosing Hatboro Pediatrics. In order to provide your child and our other patients with the best care, we ask that you follow our guidelines regarding cancelled/rescheduled appointments. Please note that we have reserved an appointment time specifically for your child.

Missing an appointment without notifying the office creates a missed opportunity for us to help another patient. We ask that you make every effort to keep your scheduled appointment and to arrive on time, if not early.

We do understand that circumstances arise when you are unable to keep your appointment due to a ***serious emergency***. We ask that you give us 24 hours notice of cancellation/reschedule. This will enable Hatboro Pediatrics to offer your appointment time to another patient. It is our policy to charge for a missed appointment that is not cancelled or rescheduled in a timely manner. Exceptions will be made for ***serious emergencies***.

A charge of $25.00 will be made to patients who do not arrive for their appointment and do not contact our office in advance of their scheduled appointment time. This charge will be billed to the family and must be paid prior to scheduling the next appointment.

Thank you in advance,
Hatboro Pediatrics

I have read and understand this policy: _____

Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Patient/Parent/Guardian Release:

Patient Name: _____

Date of Birth: _____

The above named patient is my (circle one):

SON DAUGHTER SELF FOSTER CHILD OTHER: _____

I certify that the demographic and insurance information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or fees, including collections and legal fees, at the provider's current rate, may be charged on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signed (if not the patient, I certify that I am parent/legal guardian of the patient):_____Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Hatboro Pediatrics, P.C. to my child

Child's name: _____.

I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, lack of eligibility or medical necessity.

I understand that I am responsible for the fees not paid in full, co-payments and policy deductibles and co-insurances except where my liability is limited by contract or by State or Federal Law.

Parent/Guardian PRINTED Name: _____ Parent/Guardian Signature: _____

Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Leaving Phone Messages

If it is acceptable by your, for us to leave messages about your or your child's care at Hatboro Pediatrics, PC., then leave the appropriate phone number (s) below where we should attempt to contact you and leave a message if we are unable to reach you in person. The type of information we may leave may include lab results and study results, etc.

I give permission to Hatboro Pediatrics to leave a message on the answering machine or voicemail at the following phone number (s):

Phone Number	Please circle	
_____	cellular	home
_____	cellular	home
_____	cellular	home

Parent/Guardian PRINTED Name: _____ Parent/Guardian Signature: _____

Date: _____

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Well Check/Preventative Care Visits

Hatboro Pediatrics, PC follows the American Academy of Pediatrics guidelines for frequency of preventative/well check visits and immunizations. Routine, preventative well check-ups and immunizations are recommended for every child. The first two years of life are a crucial time in a baby's growth and development. Our doctors want to keep close tabs on your baby's progress.

By signing below I acknowledge that I will follow the preventative care policy and schedule and attend the following visits in the appropriate times:

One month

Two months

Four months

Six months

Nine months

Twelve months

Fifteen months

Eighteen months

Twenty four months

2 ½ years old and yearly following

_____ _____

Patient Name Birth Date Parent Signature

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Vaccine Policy

We at Hatboro Pediatrics, P.C., strongly believe in the benefits of vaccines. Our practice requires that all new patients *(as of March 1, 2015)* receive the vaccines recommended by the American Academy of Pediatrics by age two.

Please sign and date below acknowledging that your child, by age two, will be up to date on vaccines.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Parent/Guardian Signature Date

Hatboro Pediatrics PC
483 East County Line Rd. Hatboro, PA 19040

Policy for Divorced or Separated Parent

Hatboro Pediatrics, PC providers and staff are dedicated to our patients and providing exceptional care to your child (ren). Our focus is on your child's medical, emotional and physical needs. We are not party to or to be involved in legal issues of any kind involving divorce, separation or custody agreements. Please review, agree and sign the following so that we may provide care to your child (ren.)

The Hatboro Pediatrics, PC doctors, nurses, medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.

Please make decisions in regards to appointments *(sick and well),* vaccinating and or any office procedures **IN ADVANCE** of visiting our office.

Only in situations where there is a confirmed, documented **Court Order**, that has been previously, proactively provided to our office will one of the parent's be denied access to the minor patient's medical records or visits at our practice. Hatboro Pediatrics, PC must have a copy of this court order on file in the minor patient's electronic medical record.

If there is **NOT** a **court order** on file with our office *(again that has previously, proactively been given to Hatboro Pediatrics, PC),* either parent or legal guardian, or previously assigned medical proxy may bring the child to our office, obtain medical record information, be present during the visit and consent to any treatment during the visit.

Hatboro Pediatrics, PC will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain medical record information. *(subject to medical records fee).*

It is both parents' duty and responsibility to communicate with each other about the minor patient's care, appointments and any other important information relevant to the

patient. It is not the responsibility of the Hatboro Pediatrics, PC doctors to communicate visit information to each custodial parent separately. The Hatboro Pediatrics, PC doctors will not call the non-attending parent following visits. Additionally we will not call the other parent for permission regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law or tolerate appointment scheduling/cancelling patterns of behavior between parents.

Payments, including co-pays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service, regardless of which parent is responsible for medical expenses. We are not a party to your divorce agreement. We will collect payment from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

If we feel any of the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice. By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in discharge of the family from Hatboro Pediatrics, PC.

_____
Parent/Legal Guardian Printed Name

_____ _____
Parent/Legal Guardian Signature Date