Hatboro Pediatrics

483 East County Line Rd. Hatboro, PA 19040

DEMOGRAPHICS – ABOUT THE PATIENT

Legal Name:_____ Date of birth:_____

Preferred name:_____

Gender Identity: (M) (F) (Other) Biological Sex: (M) (F) (Other)

Language Preference:_____ Race/Ethnicity:_____

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

About the Parents/Legal Guardians

Parent/Guardian 1 / Insurance Subscriber:

Name: _____ Date of Birth:_____

Gender Identity: (M) (F) (Other) Pronouns used: (He/Him) (She/Her)

Address:_____

_____

Home Number: _____Cell: _____ Work:_____

Occupation: _____ Employer Name:_____

Email:_____

Parent/Guardian 2:

Name:_____ Date of Birth:_____

Gender Identity: (M) (F) (Other) Pronouns used: (He/Him) (She/Her)

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:_____

How did you hear about Hatboro Pediatrics? _____

Pharmacy Name: _____ Pharmacy Number: _____

Today's Date: _____

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Vaccination Policy

Due to the national increase in vaccine-preventable disease, the health care providers of Hatboro Pediatrics, PC, have changed our vaccine policy since March 1, 2015. We strongly disagree with delaying or "splitting up the shots." This goes against medical advice. As health care providers, we will not approve deviations from a vaccine schedule developed and established using years of evidence-based data. If you refuse to vaccinate your child according to our vaccine schedule, we will respectfully ask you to find another health care provider. Hatboro Pediatrics vaccine schedule is as follows:

Age	Vaccine
2 Month	Pediarix (DTaP, IPV,Hep B)
	HIB
	Prevnar
	Rotavirus
4 Month	Pediarix (DTaP, IPV,Hep B)
	HIB
	Prevnar
	Rotavirus
6 Month	Pediarix (DTaP, IPV,Hep B)
	Prevnar
1 Year	MMR
	Varicella
	Hep A
15 Month	DTaP
	HIB
	Prevnar
18 Month	Hep A
4 Year	Proquad (MMR, Varicella)
	Kinrix (DTaP, IPV)
11 Year	TDaP
	Men ACYW
	HPV
16 Year	Men ACYW
	Men B

By signing this document, I acknowledge that I have read this document and will follow as scheduled. Failure to complete this schedule as written will result in dismissal from the practice.

Printed name of Parent/Guardian:_____

Signature of Parent/Guardian:_____ Date:_____

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Missed Appointment Policy

We want to thank you for choosing Hatboro Pediatrics, PC. To provide your child and our other patients with the best care, we ask that you follow our guidelines regarding canceled/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 provide us with 24 hours' notice of cancellation and or rescheduling appointment. This will enable Hatboro Pediatrics, PC to offer your appointment time to another patient.

Our office policy is to discharge patients from the practice that has three or more no call no show visits per family. This means an appointment was scheduled and the patient never showed and did not provide the office with prior notification that the appointment would be missed.

Please note that if you reschedule an appointment at the time of the scheduled appointment that is considered a no-call/no-show appointment for the family. Please note our discharged policy encompasses the entire family being discharged as the result of three or more no call no show appointments.

Thank you in advance,
Hatboro Pediatrics, PC

By signing this form, I am stating that I have read and will follow this policy.

Patient Name:_____

Printed name of Parent/Guardian:_____

Signature of Parent/Guardian:_____ Date:_____

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Assignment of Benefits Form

Authorization and Release

I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including private insurance and any other health plans to Hatboro Pediatrics, PC for services rendered. The assignment will remain in effect until revoked by me in writing when the patient reaches the age of eighteen. I understand that if my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

I also authorize Hatboro Pediatrics, PC to release any and all medical information in the course of my treatment to other medical professionals have a part in my medical treatment.

Print Patient Name:_____ Date of Birth:_____

Parent/Guardian Signature:_____ Date:_____

HIPPA Statement

I understand that, under the Health Insurance Portability and Accountability Act off 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy. I understand that Hatboro Pediatrics has the right to change its Notice of Privacy. I understand that I may request in writing that Hatboro Pediatrics can restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Hatboro Pediatrics is not required to agree to my requested restrictions. I understand that this assignment will remain in effect until revoked by me in writing or when the patient reaches the age of eighteen.

Print Patient Name:_____ Date of Birth:_____

Parent/Guardian Signature:_____ Date:_____

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

Patient Name: _____ 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 of Parent/Legal Guardian Name:_____Date:_____

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Patient Portal & **Leaving Phone Messages**

Patient Name:_____

Any siblings to be added to family 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.

In order to be a patient at Hatboro Pediatrics, PC you must sign up for our patient portal.

My e-mail address is: _____

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:_____ Date:_____

Parent/Guardian Signature:_____

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Parents Become/Currently Divorced or Separated Policy

(all parents must sign this policy even if it does not currently apply)

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. Hatboro Pediatrics, PC will not get involved in legal issues involving divorce, separation, or custody agreements. The Hatboro Pediatrics, PC medical providers and staff will not be put in the middle of domestic issues or disagreements over the phone or in the office of any kind.

Please make decisions regarding appointments *(sick and well),* vaccinating, and 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 parents 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 patient's electronic medical record.

If there is not a court order on file with our 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 a visit, and obtain medical record information. *(subject to medical records fee).*

It is both parents' duty and responsibility to communicate with each other about the patient's care, appointments, and any additional necessary information relevant to the patient. It is not Hatboro Pediatrics' responsibility to communicate visit information to each custodial parent separately. Hatboro Pediatrics, PC medical providers, 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/canceling behavior patterns 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 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 being discharged from Hatboro Pediatrics, PC.

Printed name of Parent/Guardian:_____

Signature of Parent/Guardian:_____ Date:_____