Welcome to

HATBORO PEDIATRICS

HP PC

Thank you for choosing Hatboro Pediatrics, PC as your pediatric medical home. To provide the best possible care, we require some information about your family as well as your consent on a number of important topics. Please review and fill out the forms on the following pages. We look forward to providing your family compassionate care with a smile!

483 East County Line Rd. Hatboro, PA 19040

Tel: 215-441-5670 Fax: 215-441-5661

HatboroPediatrics hatboro_pediatrics

HatboroPediatrics.com

483 East County Line Rd.
Hatboro, PA 19040

How did you hear about Hatboro Pediatrics?

_____

Todays Date: (mm/dd/yyyy) ___/___/_____

Please let us know about our new patient

Legal Name: _____ Date of Birth: ___/___/_____

Chosen Name: _____ Race/Ethnicity: _____

Gender Identity: ❑ M ❑ F ❑ Other_____ Birth Sex: ❑ M ❑ F ❑ Other_____

Pronouns Used: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other_____

Language Preference: _____ Adopted or in Foster Care? ❑ Yes ❑ No

And about their Parents/Legal Guardians

Parent/Guardian 1/Insurance Subscriber:

Name: _____ Date of Birth: ___/___/_____

Biological Parent ❑ Adoptive Parent ❑ Gender Identity: ❑ M ❑ F ❑ Other_____

Pronouns Used: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other_____

Address: _____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____

Email: _____ Lives with Patient: ❑ Yes ❑ No

Occupation: _____ Employer Name: _____

Parent/Guardian 2

Name: _____ Date of Birth: ___/___/_____

Biological Parent ❑ Adoptive Parent ❑ Gender Identity: ❑ M ❑ F ❑ Other_____

Pronouns Used: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other_____

Address (If different than above): _____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____

Email: _____ Lives with Patient: ❑ Yes ❑ No

Occupation: _____ Employer Name: _____

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Emergency Contact

Name: _____

Relationship to Patient: _____ (_____)_____-_____

Does the patient have any siblings?

Legal Name: _____ Chosen Name: _____ Age: _____

Legal Name: _____ Chosen Name: _____ Age: _____

Legal Name: _____ Chosen Name: _____ Age: _____

Legal Name: _____ Chosen Name: _____ Age: _____

Legal Name: _____ Chosen Name: _____ Age: _____

Legal Name: _____ Chosen Name: _____ Age: _____

Pharmacy Information

Pharmacy Name: _____

(_____)_____-_____

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Vaccination Policy

Due to the national increase in 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.

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.

Age	Infections Prevented
Birth	Hepatitis B
2 Months	Rotavirus
	Diptheria, Tetanus, Pertusis, Hepatitis B, Polio
	Haemophilus B
	Streptococcus pneumoniae
4 Months	Rotavirus
	Diptheria, Tetanus, Pertusis, Hepatitis B, Polio
	Haemophilus B
	Streptococcus pneumoniae
6 Months	Diptheria, Tetanus, Pertusis, Hepatitis B, Polio
	Streptococcus pneumoniae
12 Months	Measles, Mumps, Rubella
	Chickenpox
	Hepatitis A
15 Months	Diptheria, Tetanus, Pertusis
	Haemophilus B
	Streptococcus pneumoniae
24 Months	Hepatitis A
4 Years	Measles, Mumps, Rubella, Chickenpox
	Diptheria, Tetanus, Pertusis, Polio
9 Years	Human Papillomavirus
10 Years	Human Papillomavirus
11 Years	Tetanus, Diptheria, Pertusis
	Meningitis ACYW
16 Year	Meningitis ACYW
	Meningitis B*

*This vaccine is a 2 dose series taken 6 months apart

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 hour advance 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 have 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 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 Legal Name: _____

Patient Chosen Name: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: ____/____/_____

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Assignment of Benefits

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 Legal Name: _____ Date of Birth: ____/____/_____

Print Patient Chosen Name: _____

Parent/Guardian Signature: _____ Todays 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 Legal Name: _____ Date of Birth: ____/____/_____

Print Patient Chosen Name: _____

Parent/Guardian Signature: _____ Todays Date: ____/____/_____

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Consent for Non Parent/Guardian to Accompany Patient to Appointment and Access Patient Information

Patient Legal Name: _____ **Date of Birth:** ____/____/_____

Patient Chosen Name: _____

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.

Parent/Guardian Signature: _____ **Todays Date:** ____/____/_____

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Parents Become/Currently Divorced or Separated Policy

(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: ____/____/_____

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Consent to Access External Prescription History

Patient Legal Name: _____ Date of Birth: ____/____/_____

Patient Chosen Name: _____

I understand that prescribing history for multiple other unaffiliated medical providers, insurance companies, and pharmacy benefits managers may be obtained and used by my Hatboro Pediatrics provider and staff for treatment purposes, and it may include prescriptions issued back in time for several years. I am authorizing Hatboro Pediatrics to obtain and use the external prescription history via the Med Hx service for the patient listed above.

Parent/Guardian Signature: _____ Todays Date: ____/____/_____

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Consent for Financial Responsibility

Patient Legal Name: _____ Date of Birth: ____/____/_____

Patient Chosen Name: _____

It has been explained to me and I understand that I will be financially responsible for any patient balance due under the following provisions:

Co-Pay Due/Deductible Not Met/Co-Insurance Due

I understand that I will be financially responsible for all co-pays due for services provided or if my deductible has not yet been met, or if there is a co-insurance due.

Non-Covered Services

I agree to be financially responsible for any professional changes incurred for a non-covered service for which my health plan will not make a payment; this can include hearing and vision.

Enrollment Not in Effect/No Health Insurance

I understand that I will be financially responsible for all professional charges incurred if service was provided when my enrollment in a health plan was not in effect or if I have no health insurance.

Parent/Guardian Signature: _____ Todays Date: ____/____/_____

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Patient Portal & Leaving Phone Messages

Patient Legal Name: _____ Patient Chosen 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.

Email Address: _____

If it is acceptable by you, for us to leave messages about 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):

(_____)_____-_____ ❑ Cell Phone ❑ Home Phone

(_____)_____-_____ ❑ Cell Phone ❑ Home Phone

(_____)_____-_____ ❑ Cell Phone ❑ Home Phone

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: ____/____/_____

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Pediatric Medical History Form 1

Patient Name: _____ Date of Birth: ___/___/_____

Parent/Guardian Signature: _____ Date of Birth: ___/___/_____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Effect

If you are on 3 or more medications – please bring them with you to each appointment

PERSONAL MEDICAL HISTORY: Please indicate whether the patient has had any of the following medical problems.

- ❑ Asthma
- ❑ Anemia
- ❑ Pneumonia
- ❑ Diarrhea
- ❑ Hearing Problems
- ❑ Heart Disease
- ❑ Ear Infections
- ❑ Convulsions/Epilepsy
- ❑ Constipation
- ❑ Rheumatic Fever
- ❑ Vision Problems
- ❑ Hay Fever / Allergic Rhinitis
- ❑ Behavioral Problems

Other:_____

_____

HOSPITALIZATONS: Please list all prior hospitalizations and dates.

Reason	Date

PAST SURGERIES

Reason	Date

Do you see any specialists?
❑ Yes ❑ No

Specialists Name	Date

Pediatric Medical History Form 2

PREGNANCY & BIRTH

Is the patient yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑ Other: _____

Were there any medical problems during pregnancy? ❑ Yes ❑ No

If yes, please explain: _____

Were there are problems during labor and delivery? ❑ Yes ❑ No

If yes, please explain: _____

Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after the patient's birth? ❑ Yes ❑ No

If yes, please explain: _____

Where was the patient born? _____

Method of Delivery: ❑ Vaginal ❑ Caesarean Birth Weight/Length: ____lbs. ____oz. ____inches

Was your child born prematurely? ❑ Yes ❑ No If yes how early: _____

Who lives at home with the patient?

Name	Age	Relationship	Highest Level of Education

FAMILY HISTORY

Please indicate in the space provided who in the patient's family has had the following conditions.
In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.

Relation	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer	Colon Polyps	Depression	Other
Mother		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Father		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Sibling		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Maternal Grandmother		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Maternal Grandfather		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Paternal Grandmother		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Paternal Grandfather		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Other Family Members Information: (please write in)

_____

_____

Office Arrival Process

We strive to provide an easy and fast check-in process.

1. **Our automated system will send you a text and email to pre-register for your appointment 4 days prior to the scheduled appointment.**

Please make sure to complete this as thoroughly and accurately as possible. It allows us to be prepared for your visit and provide the best possible care.

- You will be asked to review your demographics and insurance information.
- **For well checks** - You will be asked developmental and screening questions. You will be asked detailed questions about your child.
- **For all other visits** - You will be asked detailed questions about why you child is coming to the office. Please answer as thoroughly as possible.
- If your child has a chronic condition, we may ask additional screening questions. These include depression, anxiety and ADHD screening questions. These are essential for high quality care.

2. **If you are unable to complete your previsit paper work, a nurse will reach out to you to ask the questions over the phone. They will initially do this by text to find a time to talk.**

3. **When you arrive for your appointment: click on the text or email alert from our automated system informing us you are in the parking lot and ready to come in. If you do not hear from us within 5 minutes, please call the office.**

SICK VISITS

Please wait in your car, we will bring you in as soon as possible. This ensures the health of our other patients and staff.

WELL VISITS

You are welcome to enter the Well Visit side of the office, check in and use the waiting area inside. Please ring the doorbell or call the office for entry.