Siena Pediatrics

Child 1: Last Name:_____ First Name: _____

DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No

Ethnicity:☐ Hispanic ☐ Non-Hispanic ☐ Unknown Race: ☐ Asian ☐ Black ☐ Hawaiian ☐ White

Allergies to Medications:_____ ☐ None

Food/Seasonal Allergies:_____ ☐ None

Child 2: Last Name:_____ First Name: _____

DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No

Ethnicity:☐ Hispanic ☐ Non-Hispanic ☐ Unknown Race: ☐ Asian ☐ Black ☐ Hawaiian ☐ White

Allergies to Medications:_____ ☐ None

Food/Seasonal Allergies:_____ ☐ None

Child 3: Last Name:_____ First Name: _____

DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No

Ethnicity:☐ Hispanic ☐ Non-Hispanic ☐ Unknown Race: ☐ Asian ☐ Black ☐ Hawaiian ☐ White

Allergies to Medications:_____ ☐ None

Food/Seasonal Allergies:_____ ☐ None

Child 4: Last Name:_____ First Name: _____

DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No

Ethnicity:☐ Hispanic ☐ Non-Hispanic ☐ Unknown Race: ☐ Asian ☐ Black ☐ Hawaiian ☐ White

Allergies to Medications:_____ ☐ None

Food/Seasonal Allergies:_____ ☐ None

******PLEASE ASK FRONT DESK FOR ANOTHER SHEET FOR ADDITIONAL CHILDREN******

Mother/Guardian Info: Name: _____

Relation to patient:_____ Lives with patient: ☐ Yes ☐ No

Date of birth: _____Social Security Number: _____

Street or PO Box:_____ Apt/Unit No.:_____

City _____State_____ Zip _____

Cell phone: (____)_____Work phone: (___)_____

Employer:_____Occupation:_____

Father/Guardian Info: Name: _____

Relation to patient:_____ Lives with patient: ☐ Yes ☐ No

Date of birth: _____Social Security Number: _____

Street or PO Box:_____ Apt/Unit No.:_____

City _____State_____ Zip _____

Cell phone: (____)_____Work phone: (___)_____

Employer:_____Occupation:_____

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How would you ideally prefer to be contacted regarding the following (check only one):

Medical Issues: ☐ Home phone ☐ Work Phone ☐ Cell Phone ☐ Home email

Recall Notice: ☐ Home phone ☐ Work Phone ☐ Cell Phone ☐ Home email

Patient Portal Notifications: ☐ Cell phone ☐ Home Email ☐ Work email

May we leave voicemail ☐ with detail ☐ without detail

Insurance:

Primary policy:

Policy holder's name: _____

Street or PO Box: _____ City _____ State _____ Zip _____

Policy holder's date of birth: _____ Insurance company: _____

ID# _____ Group# _____

Secondary policy:

Policy holder's name: _____

Street or PO Box: _____ City _____ State _____ Zip _____

Policy holder's date of birth: _____ Insurance company: _____

ID# _____ Group# _____

Pharmacy:

Name of Pharmacy: _____ Telephone # _____

Address or Cross Streets: _____

Additional Contact Questions:

Who should receive billing statements? _____

(If it should be a person other than the one completing this form, please provide legal documentation supporting this claim)

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ Yes ☐ No

If yes, please provide a copy of any legal paperwork that supports this restriction.

_____ _____ _____

Print Name **Signature** **Date**

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my child's health care, **Wijesinghe Pediatrics PC DBA** originates and maintains paper and/or electronic records describing my child's health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Wijesinghe Pediatrics PC DBA** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to **Wijesinghe Pediatrics PC DBA** to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____ _____
Parent/Guardian Signature **Date**

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Authorization Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person brings your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Siena Pediatrics and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the Siena Pediatrics provider/staff.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) **Date**

FINANCIAL AND COLLECTION POLICY

PLEASE READ THE FOLLOWING CAREFULLY:

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
2. We bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.
3. If you have Managed Care insurance, please make sure you have contacted them and named us as your primary care physicians or you will be responsible for payment of services.
4. Photo ID and Insurance card must be provided for each date of service.
5. Basic paperwork requested will take at least 24 hours, FMLA will take a week, and photo ID must be provided during pick up.
6. All outstanding balance must be paid prior to check-in, unless other arrangement has been made.
7. Our office bills are for doctor services only. Fees for lab work or cultures are billed separately by the appropriate lab.
8. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 60 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collections and court costs.
9. Returned checks will be subject to a $35 fee.
10. **There will be a $35.00 No Show fee for any appointment that is not cancelled or rescheduled within 24 hours of scheduled visit.**
11. If there are 3 No shows on account, you will be discharged from practice, however there will be a 30 days' grace period for sick visits only.
12. If there is any change of insurance, it is the parent's responsibility to notify Siena Pediatrics of the changes.
13. Patient's refund will be release once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any copays, coinsurance, deductibles, or any other charges your insurance carrier may apply towards your responsibility. Time frame is usually 6 to 8 weeks. We do understand that temporary hardships may affect timely payment of your balance.
14. For all newborns, parents are responsible to add child within first 30 days post birth. If child is not added within this time period, all balances due will be parent's/guardian's responsibility.

We encourage you to communicate any problems so that we can assist you in the management of your account. We also offer payment arrangements. You may speak with our billing department for further assistance.

_____ _____

Parent/Guardian Signature **Date**

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NON-CONTRACTED INSURANCES

Listed below are the insurances that our practice is not contracted with. By signing this form, you are acknowledging this list and are aware that if you have any one of these insurances and continue to proceed with care from our facility, you will be responsible for all charges for that date of service.

Thank you

***Coventry Healthcare Partners HMO**

***BCBS/Amerigroup Medicaid**

***SilverSummit Healthplan Medicaid**

***PacifiCare HMO**

***All exchange plans except HPN Nevada Exchange**

***Blue Cross Pathway except for Tier 2 network**

***Cigna Local Plus plans**

***Standard Life**

***United Healthcare Compass Balanced Plan**

***Aetna Value Network**

_____ _____

Parent/Guardian Signature **Date**

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NO SHOW/CANCELLATION POLICY

If you need to cancel/reschedule your child's appointment, we require 24 hours' notice, so we can schedule another patient who is in need of medical care. You are required to email **sienapeds@gmail.com** to cancel your appointment. If appointment isn't cancelled, **you will be assessed a $35 penalty fee**. Repeated no shows may result in discharge from Siena Pediatrics.

By signing below, you acknowledge and understand our no show/ cancellation policy. If you have any questions and/or concerns, please contact our office.

We thank you for your understanding regarding this matter and appreciate your cooperation.

_____ _____

Parent/Guardian Signature **Date**