WESTSIDE PEDIATRICS

Information Sheet (**please complete all sections**) Today's Date ___/___/___

PATIENT'S NAME _____ **DOB** ___/___/___ **GENDER** _____
ADDRESS _____ **APT**_____**CITY**_____**STATE**_____**ZIP**_____
HOME PHONE (____) _____ **PLACE of BIRTH** _____
SIBLINGS & AGES _____ _____ _____ _____

PARENT INFORMATION

Parent Name: _____ DOB: _____ Email: _____
Address (if different from child) _____ City: _____ State: ____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____

Parent Name: _____ DOB: _____ Email: _____
Address (if different from child) _____ City: _____ State: ____
Home Phone: _____ Work Phone: _____ Cell Phone:_____
Employer: _____

Emergency Contact (***other than parent***): Name: _____
Relationship: _____ Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Policy Holder: _____ D.O.B: ___/___/___ Relationship: _____
Social Security Number: _____ Insurance Co. Name: _____
Insurance Co. Address: _____ Phone Number: _____
Policy Number: _____ Group Number: _____
Co-pay Amount $_____ Policy Effective Date___/___/___

We do not bill secondary insurance companies or insurance companies that we do not participate with.
Note: The health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan.

RESPONSIBLE PARTY/BILLING INFORMATION

Responsible Party Name _____ Relationship to Patient _____
Address_____ City _____ State_____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____

PHARMACY INFORMATION

Name: _____ Address: _____
Phone Number: _____ Fax Number: _____

Assignments of Benefits
I, the undersigned, request that payment of all insurance benefits payable for medical services provided, be made directly to the physicians of Westside Pediatrics P.C. In addition, I authorize the release of any medical information, as permitted by the law necessary to process a health insurance claim form.
Parent/Guardian
Sign _____ Print Name _____ Date _____

Beneficiary Agreement
I do hereby acknowledge that I was informed that in the event that my health care insurance plan denies payment for services received at Westside Pediatric P.C. I agree to be personally responsible for the payment of these services. It is therefore my responsibility to contact my insurance carrier to confirm the coverage provisions.
Parent/Guardian
Sign _____ Print Name _____ Date _____

Please be advised that there is a **24 hour cancellation policy**. I understand that failure to adhere to this policy may result in a $75 missed appointment fee for well visits and $50 for all others. **Initial** _____

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ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 **(HIPAA**)

PATIENT NAME: _____ **PATIENT DOB:** _____

I hereby acknowledge that I was provided a copy of Westside Pediatrics' Notice of Privacy Practices have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

COMMUNICATION AUTHORIZATION REQUEST AND PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner regarding my child/children (*please check all that apply)*

❑ **Home Telephone**: _____

- ❑ OK to leave a message with call back number
- ❑ DO NOT leave a message

❑ **Work Telephone**: _____

- ❑ OK to leave a message with call back number
- ❑ DO NOT leave a message

❑ **Written Communications**

- ❑ OK to mail to my home
- ❑ OK to fax to (home only) _____
- ❑ OK to email to this address _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosure.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient's Representative (if applicable) Relationship to Patient

- **FOR OFFICE USE ONLY** ----------

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

WESTSIDE PEDIATRICS

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Westside Pediatrics P.C. accepts cash, personal check (in-state only), American Express, VISA and MasterCard. There is a service charge for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE

We currently participate with Aetna, Cigna, Oxford (**Freedom Plan only**) and United Healthcare. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We do not bill secondary insurance companies or insurance companies we do not participate with and/or not except assignment from.

Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact the Billing Office between 9:00 a.m. and 3:00 p.m., Monday through Friday at 212-874-4500.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE

If you are enrolled in a managed care insurance plan (e.g.: an HMO), you must receive a referral from our office *before seeing a specialist*. **NO** retroactive referrals will be given.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late canceled appointments: $75 missed appointment fee for well visits and $50 for all others. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Westside Pediatrics P.C. Financial Policy. I agree to assign insurance benefits to the Westside Pediatrics P.C. practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of Patient or Legal Representative: _____

Print Name: _____ Date: _____

✪ Please remember, it is your responsibility to have an understanding of the benefits your insurance company offers.