



2010 Patient Information

Patient's Full Name: _____ Nickname: _____
DOB: ___/___/___ M / F Primary Guardian: _____
Parent's marital status: married / divorced / separated / widow
Child Primarily lives with: mom / dad / guardian Visitation agreement: _____
Primary Guardians Address: _____
City: _____ State: _____ Zip: _____
Home PH: _____ Work: _____ Cell: _____
Email Address: _____
Billing address if different from above: _____
City: _____ State: _____ Zip: _____
Insurance Name: _____ Policy Holder: _____
Policy Holder's DOB: ___/___/___ Policy ID: _____ Group #: _____

MOTHER'S INFORMATION	FATHER'S INFORMATION
Name: _____	Name: _____
DOB: ___/___/___ SSN: _____	DOB: ___/___/___ SSN: _____
Marital Status: _____	Marital Status: _____
Partner's Name: _____	Partner's Name: _____
Employer: _____	Employer: _____
Work PH: _____	Work PH: _____

EMERGENCY CONTACT INFORMATION (other than parent)

Name: _____ Phone: _____
Relationship to child: _____ Cell: _____
Authorized to seek medical care for patient: NO / YES

Name: _____ Phone: _____
Relationship to child: _____ Cell: _____
Authorized to seek medical care for patient: NO / YES

SIBLING INFORMATION

Name: _____ DOB: ___/___/___
Name: _____ DOB: ___/___/___
Name: _____ DOB: ___/___/___
Name: _____ DOB: ___/___/___

Have there been any changes in the child's home or family life in the past year: NO / YES
Is your child enrolled in childcare? NO / YES If Yes, provide name of provider: _____



Financial Policy

We are committed to providing you with the best possible care and we are ready to discuss our professional fees with you at any time. Your understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or what your responsibility is.

- FULL PAYMENT IS DUE AT TIME OF SERVICE
- WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD AND DISCOVER
- MINORS WHO ARE SEEN IN OUR OFFICE
An adult must accompany all minors and full payment is due at the time of service. If your child is old enough to come to our office on his/her own they will also be required to pay at the time of service.

REGARDING BILLS
It is the policy of this office not to bill or extend credit. You are required to pay at the time of service. We cannot hold checks. There are a few exceptions such as emergencies that must be discussed prior to treatment. If you have an emergency or a problem paying please call our billing department and they will be happy to discuss arrangements with you.

REGARDING RETURNED CHECKS
We understand that sometimes people make mistakes. If you have a returned check with us, you have 15 days to make good on that money owed to us. If after 30 days the account has not been cleared, you will be forwarded to a collection agency. There is a \$30 service charge for each check that is returned to us. If you have more than two returned checks with us, your account then becomes a cash only account and checks will no longer be accepted.

REGARDING INSURANCE
If we accept your insurance, YOU are responsible for any deductibles, coinsurance or co pays AT THE TIME OF SERVICE. Insurance policies with required co pays MUST BE PAID at the time of service or we may charge YOU for the full amount of the visit. If you are unable to provide your current insurance card at the time of service, we may require payment in full at the time of service or you may reschedule your appointment. If your insurance carrier changes, IT IS YOUR RESPONSIBILITY to notify us when checking in. If you fail to do so, you may then become responsible for the FULL amount of the visit. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will not become involved in disputes between you and your insurance carrier. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

- The guardian WHO BRING THE CHILD IN is responsible for payment. Divorce settlement / financial responsibility for child issues are to be worked out between the parents.
- I understand and agree that regardless of my insurance status, I am responsible for the full balance on my account for any and all professional services rendered not covered by my insurance. I have read all the information on this sheet and understand it to the best of my knowledge. I will notify Oceanside Pediatrics of any and all future changes.
- Starting January 1, 2007 all patients that do not show up for their scheduled appointment without a 24 hour notice will be charged a \$25 NO SHOW FEE. If you call prior to the appointment but less than 24 hours before the scheduled appointment, it will be up to Oceanside Pediatrics if you will be required to pay the \$25 NO SHOW FEE.
- Our office requires appointments. It is our policy not to accept walk-in or add-on patients to our daily schedule. If Oceanside Pediatrics agrees to allow your child to be seen as an add-on or walk-in patient then I agree to pay the \$25 WALK IN FEE.

Signature of patient or parent or legal guardian

____/____/____
Date

Name of patient or parent or legal guardian

Relationship to patient



Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by OCEANSIDE PEDIATRICS, for the purpose of diagnosing or providing treatment to me or my minor child, obtaining payment for my healthcare bills or to conduct health care operations of OCEANSIDE PEDIATRICS.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. OCEANSIDE PEDIATRICS is not required to agree to the restrictions that I may request. However, OCEANSIDE PEDIATRICS agrees to a restriction that I request, the restriction binding on OCEANSIDE PEDIATRICS, DR. BARBARA O'REILLY, DR. ELENA MODEL, DR. ANN VONTHRON, AND SHANNON FRAZIER MILLER ARNP, I have the right to revoke this consent in writing at any time except to the extent that DR. BARBARA O'REILLY, DR. ELENA MODEL, DR. ANN VONTHRON, AND SHANNON FRAZIER MILLER, ARNP or OCEANSIDE PEDIATRICS have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my provider, another health care provider or hospital (including all departments as such), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review OCEANSIDE PEDIATRICS NOTICE OF PRIVACY PRACTICES prior to signing this document. The OCEANSIDE PEDIATRICS NOTICE OF PRIVACY PRACTICES will be provided to me upon request. It is also posted in the waiting room and exam rooms for my information. The NOTICE OF PRIVACY PRACTICES describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of OCEANSIDE PEDIATRICS. The NOTICE OF PRIVACY PRACTICES also describes my rights and OCEANSIDE PEDIATRICS duties with respect to my protected health information. OCEANSIDE PEDIATRICS reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised NOTICE OF PRIVACY PRACTICES by calling the office and requesting a revised copy.

Signature of patient or parent or legal guardian

____/____/____
Date

Name of patient or parent or legal guardian

Relation to patient



Signature on File

- _____ I authorize use of this form on all my insurance submissions
- _____ I authorize release of information to all my Insurance Companies
- _____ I understand that I am responsible for my child's bill
- _____ I authorize my provider to act as my agent in helping me obtain payment from my Insurance Company.
- _____ I authorize payment direct to my provider
- _____ I permit a copy of this authorization to be used in place of the original

Parents Name: _____ Child's Name: _____

Parents Signature: _____ Date: ____/____/____