ACADEMY PARK PEDIATRICS REGISTRATION FORM Please complete entire form

Date:_____ (Expires every 12 months or if changes occur)
Patient's Name:_____SS#_____Male/Female DOB_____
Patient's Name:_____SS#_____Male/Female DOB_____
Patient's Name:_____SS#_____Male/Female DOB_____
(Please list all children in household)

Mother's Information: Name_____SS#_____
Address:_____/_____/___/_____Date of Birth_____
Street,Apartment,Unit # City State Zip
Home Phone_____Cell Phone_____Work Phone_____
Mother's Employer_____Position_____
Marital Status_____Email address_____
Father's Information: Name_____SS#_____
Address:_____/_____/___/_____Date of Birth_____
Street,Apartment,Unit # City State Zip
Home Phone_____Cell Phone_____Work Phone_____
Father's Employer_____Position_____
Marital Status_____Email address_____
Step Parent (s) (If applicable)_____
Separate form required for adult other than Mother/Father to accompany child to appointments-ask receptionist please

Financially Responsible Party:_____SS#_____
Address:_____/_____/___/_____Date of Birth_____
Street,Apartment,Unit # City State Zip
Phone_____Alternate Phone_____Work Phone_____
Relationship to patient_____

Emergency Contact:_____Relationship_____Phone_____

Primary Insurance _____ID#_____
Group#_____Policy Holder:_____
Policyholder relationship to patient:_____Date of Birth_____

Secondary Insurance_____ID#_____
Group#_____Policy Holder:_____
Policy holder relationship to patient:_____Date of Birth_____

VFC vaccine program available for uninsured, pre approved Medicaid, or American Indian/Alaska Native

BILLING POLICY

*Copayment/Self Pay due at time of service. Non payment may require postponement of well care appt.
*Balances due may carry a $6/month rebilling charge payable by parent, guardian, responsible party.
*Well Care appts. missed or not cancelled 24 hours in advance may be charged $25 fee per child.
*Patients must be PRE APPROVED for Medicaid or CHP+. If pre approval is not obtained, no past, current or future charges will be billable to Medicaid/CHP+. Medical services will need to be provided elsewhere by an open practice.
I accept responsibility for any unpaid services or services not covered by insurance. Should it become necessary to forward my account for professional collection, in addition to the amount owed, I will also be responsible for reasonable costs of collection, including attorney fees.
SEE HIPAA AND FINANCIAL AGREEMENT for expanded information

SIGNED_____Relationship to patient_____

Signature of patient if over 18 years of age_____

ACADEMY PARK PEDIATRICS
ACKNOWLEDGEMENT OF POLICIES

DATE_____

NAME OF PATIENTS_____

PARENT OR GUARDIAN_____

MISSED APPOINTMENTS-"No Show or late cancellation-less than 24 hour notice"

Appointment times are set aside for you. As a courtesy our staff will call a reminder to you 24-48 hours ahead of previously scheduled well care visits. We will notify you of missed appointments. Multiple missed appointments will result in a charge for the staff and physicians' time. Chronic missed appointments may result in the patients being discharged from our practice.

Initials_____

LATE POLICY

We strive to be as timely as possible with your visit. Please arrive 10-15 minutes prior to your scheduled appointment time to verify and update patient information. If you arrive 15 minutes beyond your appointment time, attempts will be made to reenter you into the schedule. Arriving 30 minutes or more beyond your appointment time will necessitate rescheduling. If your child is seriously injured or ill they will be 'worked in' and will be seen on a first-available basis.

Initials_____

SCHEDULING EXTENDED OR MULTIPLE VISITS

When scheduling an appointment, please notify the receptionist if you feel that your child's issues are complex or if you wish multiple problems to be addressed. We try to schedule adequate time to address issues and concerns.

If multiple children are to be seen, an appointment for each child must be scheduled.

Initials_____

ACADEMY PARK PEDIATRICS, P.C.

PEDIATRIC & ADOLESCENT MEDICINE

7373 WEST JEFFERSON AVENUE · SUITE 102 · LAKEWOOD, COLORADO 80235-2020

PHONE: (303) 988-5252 · FAX: (303) 988-5632 · WEB: www.academyparkpeds.com

4185 EAST WILDCAT RESERVE PARKWAY · SUITE 230 · HIGHLANDS RANCH, COLORADO 80126

PHONE: (303) 996-0730 · FAX: (303) 996-0732 · WEB: www.academyparkpeds.com

NEW PATIENT HISTORY

(Please complete one for each patient)

DATE_____

Patient's full name (last, first, middle) _____

Guarantor Name (last, first, middle) _____

Birth Date_____/_____/_____ 1st visit_____/_____/_____ Race (optional) _____ Gender_____

BIRTH HISTORY

Birth weight_____lbs._____oz. Place of Birth_____ Duration of Pregnancy _____

Delivery: C-Section Vaginal (circle) Obstetrician _____

Complications: (please check each)	Yes	No		Yes	No
Pre-term Labor	___	___	High Blood Pressure	___	___
Pre-eclampsia/eclampsia	___	___	Group B Strep	___	___
Abnormal Prenatal Ultrasound	___	___	Hepatitis B	___	___
HIV infection	___	___			

Newborn Nursery Complications: _____

Other Maternal Complications: _____

Details if answered **"Yes"** to any of the above: _____

MEDICAL HISTORY

Hospitalizations (include diagnosis, place, dates) _____

Surgery:	Yes	No		Yes	No
Myringotomy (ear) tubes	___	___	Tonsillectomy / Adenoidectomy	___	___
Hernia Repair	___	___	Appendectomy	___	___
Sinus Surgery	___	___	Surgical Repair of Fracture	___	___
Other _____					

Please provide details for any above checked **"Yes"** (place, date, complications): _____

_____

ALLERGIES (medications) _____ (other) _____

Significant Accidents or Injuries _____

Significant Medical Problems:	Yes	No		Yes	No
Asthma	___	___	Seasonal Allergies	___	___
Eczema	___	___	Migraine Headache	___	___
ADHD	___	___	Seizure Disorder	___	___
Febrile Seizure	___	___	Heart Condition	___	___

CONTINUED ON BACK OF THIS SHEET

Medical Problems Continued:	Yes	No		Yes	No
Diabetes	___	___	Kidney Reflux	___	___
Gastric Reflux	___	___	Urinary Tract Infection	___	___
Rheumatic Fever	___	___	Crohns or Ulcerative Colitis	___	___
Scoliosis	___	___	Depression	___	___
Irritable Bowel	___	___	Developmental Delay	___	___
Hx of Chicken Pox	___	___	Date_____		

Other Medical Problems: _____

Please provide details for any above problems checked "**Yes**": _____

_____

CURRENT MEDICATIONS: _____

IMMUNIZATIONS: Please attach copy of complete childhood immunization record. If you do not have a copy today it is very important we receive this information as soon as possible.

FAMILY HISTORY

Significant medical problems in the immediate family of the patient (parents, siblings, and grandparents only)

	Yes	No		Yes	No
Asthma	___	___	Coronary Artery Disease	___	___
Seasonal Allergies	___	___	High Cholesterol	___	___
Eczema	___	___	High Blood Pressure	___	___
Kidney Reflux	___	___	Diabetes	___	___
Seizure Disorder	___	___	Migraine Headaches	___	___
ADHD	___	___	Birth Defects	___	___
Gastric Reflux or Ulcers	___	___	Irritable Bowel Disease	___	___
Depression	___	___	Crohns or Ulcerative Colitis	___	___
Growth Disorders	___	___	Psychiatric Disorder	___	___
Thyroid Disorder	___	___			

Other Family History: _____

Please provide details for any above history checked "**Yes**": _____

_____

_____

SOCIAL HISTORY

Marital Status of Parents: Single___ Married___ Divorced___

If your child is less than 5 years are they in daycare? Yes___ No___

If "Yes" how many days per week?_____

Any Pets? Yes___ No___

If "Yes" what kind? _____

Do any Smokers live with this child? Yes___ No___

If you have any specific problems or concerns about you child, please indicate them below: _____

_____

_____

ACADEMY PARK PEDIATRICS HIPAA & FINANCIAL RESPONSIBILITIES

Uses and Disclosures of Protected Health Information:

- ✓ We will use and disclose PHI to provide, coordinate or manage healthcare and any related services. Examples: Information sent to another physician to whom your child has been referred, emergency treatment situations, Public Health authority, Legal investigative units or other legal entities.
- ✓ PHI will be used as needed to obtain payment for services. Includes collection activity.
- ✓ Information required by school, daycare, camp or sports organizations regarding the health status of a child for the child's participation and attendance.
- ✓ Well-child/health maintenance exam reminders may be phoned to the parent/guardian utilizing charting information to evaluate patient well care status.
- ✓ We may disclose PHI in order to support business activities. Examples: Quality assessment, liability insurance, medical review, underwriting, licensing, employee review and billing. Also for insurance audits, legal investigations or inspections.
- ✓ Office representative may leave clinical, appointment information or financial messages on telephone numbers provided on patient registration forms.
- ✓ Signed request required for records by parent/guardian for personal use or to be sent to any outside source. Chart copies and mailing carry a charge per Colorado Department of Health guidelines. Separate signed form requesting records for transfer of care shall be required on office-approved release form.

Parent or Guardian has the right to:

- ✓ Request in writing that certain parts of patient charting information NOT be copied or disclosed to outside sources. Practice is not required to agree to restriction if best interest of patient is not represented by withholding information.
- ✓ Request to review (by appointment only and in presence of clinical office personnel) charting information belonging to their child. Copies of information may be requested in writing and supplied at a charge. Parent/Guardian will be responsible for any charges incurred for appointment made to satisfy this request. Picture I.D.of parent required.
- ✓ Request that any incorrect charting information be amended by medical office staff as agreed upon by the physician/providers. Parent and provider signatures required.
- ✓ Restrict all copying and disclosure of patient charting information. This would mean that no charting duplication could be done for billing, specialists or other providers needs and would require authorizations for all health information completion. Office is not required to comply with this restriction as it may apply to protecting the welfare of a child under legal child protection laws. Written notice signed by both custodial parents required.
- ✓ Parent may pay in full on a date of service & request in writing that insurance not be billed for that Date of Service.

Reporting:

- ✓ Should a parent or guardian of a minor, or a patient who is 18 years or older, feel that our Office has performed any illegal transmission of protected information or other infraction, a report may be made to Academy Park Pediatric office Compliance Officer on a Confidential Incident Report Form.
- ✓ Parent to be notified in writing if Breach of PHI occurs and office shall keep information permanently on a breach log.
- ✓ This office does not market or sell PHI information.

Business Associate Agreements to be obtained, updated and kept on file in Business Office

Parent/Guardian Responsibilities and Financial Agreement:

- ✓ Call minimum 24 hours in advance to cancel well care appointment. $25 charge per child/per appointment payable by parent or guardian may apply. Not billable to insurance.
- ✓ Provide and keep office updated with current insurance and demographic information.
- ✓ Know medical benefits. Insurance policy is a contract between parent/guardian and insurance carrier. Financial responsibility for balances due rests with parent.
- ✓ Call ahead for and obtain referrals as needed.
- ✓ Pay for services not included as benefits by office-contracted insurance carrier.
- ✓ Pay for services in full if insurance is not contracted by office or if self-pay status.
- ✓ Copays are due at time of service. $10 may be charged if copay not paid same business day.
- ✓ Understand that office will only bill codes as documented in patient record. Office will not change or fraudulently falsify diagnosis/procedure codes to secure insurance payment.
- ✓ A diagnosis of illness found on a well visit may generate a copay/deductible by insurance. Exam for sick visit is not considered part of a health maintenance exam.
- ✓ Submit written request for transfer of records upon leaving practice. Records are retained and destroyed following approved clinical and legal guidelines. Charges for copying and mailing apply. Office-approved form required.
- ✓ Aged balance due may carry a $6 per month administrative rebilling charge.
- ✓ Parents: Fees for services provided to a minor child whose parents are divorced are the responsibility of BOTH parents. Copays/Balances are due at check-in and are payable by the presenting adult.
- ✓ Office will keep Health Savings Account or credit card number on file, and with a separate written authorization from card-holder, will charge post-insurance billed balances on the card. Please speak with billing office personnel to arrange for paperwork to authorize automatic payment via card.
- ✓ Office personnel may leave financial, insurance or clinical information on telephone numbers provided by parent/guardian on registration forms.

- ➢ ***Should my account be placed for collection, I will be responsible for reasonable collection costs, court costs and attorney fees.***
- ➢ ***My signature on this document acknowledges that the HIPAA and Financial Notification for Academy Park Pediatrics have been made available to me. I may request a copy. Copies of the notice are available in both reception areas.***

**Signature of parent/guardian*_____

*Date*_____ *Printed Name*_____

*Relationship to Patient*_____

*Patient Name(s)*_____

_____