PEDIATRIC CARE ASSOCIATES CHECK-IN FORM

1. Child's Name Last: ____________ First: ____________ Please call patient:
   Date of Birth: ____________ Patient's sex: __ Male __ Female
2. Child's Name Last: ____________ First: ____________ Please call patient:
   Date of Birth: ____________ Patient's sex: __ Male __ Female
3. Child's Name Last: ____________ First: ____________ Please call patient:
   Date of Birth: ____________ Patient's sex: __ Male __ Female

Primary Home Address: ____________
City, State, Zip: ____________
Home Phone: ____________
Mother's Cell: ____________
Father's Cell: ____________
Secondary Home Address: (if applicable)
Guardian Name: ____________ Relationship: ____________
Street: ____________
City, State, Zip: ____________
Secondary Home Phone: ____________

Mother's Name Last: ____________ First: ____________ DOB: ________
Father's Name Last: ____________ First: ____________ DOB: ________
Other Guardian Last: ____________ First: ____________ DOB: ________ Relationship: ________

INSURANCE INFORMATION

Primary Insurance Company: ____________ Who holds the insurance? Name: ____________
Patient's relationship to insured: ____________ Birthdate: ____________
Address: (if different than above) ____________
Employer: ____________ Phone: ____________

Secondary Insurance Company: ____________ Subscriber Name: ____________
Employer: ____________ Phone: ____________
Patient's relationship to insured: ____________ Subscriber DOB: ____________

ADDITIONAL INFORMATION

Primary Email: ____________
Mother's Work #: ____________ Father's Work #: ____________
Patient Cell: (if over age 15) ____________ Patient Email: ____________

Patient Race: (Required by US government for medical practices using EMR)
__ American Indian or Alaska Native __ Asian __ Native Hawaiian __ African American/Black __ Caucasian/White
__ Hispanic __ Other Race __ Other Pacific Islander __ Choose not to declare
Ethnicity: __ Hispanic __ Non-Hispanic __ Choose not to declare

PHARMACY INFORMATION

Pharmacy of Choice: Name: ____________ City: ____________ Street: ____________

How did you learn about our practice? __ Family/Friend __ Insurance Company __ Hospital Resource
__ Physician __ Internet Source-Which one? ____________ __ Other? ____________

Please read and sign other side →

PEDIATRIC CARE ASSOCIATES, S.C.

INFANTS• CHILDREN• TEENAGERS

Robert A.Boton, M.D. Catherine Fitzpatrick, M.D. Ryan A. McCoy, M.D. Michelle L. Reinstein, M.D. Preeti P.Mirchandani, D.O.
Maria C. Vallort, CPNP-PC Mary Mortlock, PNP, BC,IBCLC

Patient Financial Responsibility Form

Thank you for choosing Pediatric Care Associates, SC ("PCA") as your healthcare provider. We are honored by your choice and are committed to providing you with highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of PCA.
- These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice.
    - Charge for extensive phone consultations and/or after-hours phone call requiring diagnosis, treatment, or prescriptions.
    - Charge for copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize PCA and the physicians, staff and hospitals associated with PCA to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to PCA and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize PCA personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient financial Responsibility Form:

____

Patient(s) Name

____

Signature of Patient or Guardian Date

RECEIPT OF NOTICE PRIVACY PRACTICES FORM

I, __________________, hereby give my consent to Pediatric Care Associates, S.C. to obtain, use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of: __________________________
(Patient's Name)

I hereby give my consent to Pediatric Care Associates, S.C. to obtain any current or previous medical information or records pertaining to the patient(s) stated above from another healthcare facility.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may obtain, use and disclose my confidential information.

I understand that the physician has reserved a right to change his privacy practices that are described in the Notice. I also understand a copy of any revised Notice will be provided to me or made available at my request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed ____________________ Date ____________________

Relationship to patient ____________________

MISSED APPOINTMENT POLICY INFORMED CONSENT

Pediatric Care Associates has a missed appointment fee. Missed appointments constitute any appointment for which a patient does not show up. Pediatric Care Associates will waive the missed appointment fee if the patient cancels their appointment prior to 24 hours before the scheduled appointment time.

Missed appointment place a burden on our pediatric practice by creating wasted physician time, wasted work by the staff in preparing the chart for an office visit, and taking away appointment times that can be used by other patients.

I have read this missed appointment policy and agree to its terms in regards to my children's appointments at Pediatric Care Associates.

Signed ____________________ Date ____________________

Relationship to patient ____________________

FAMILY MEDICAL HISTORY

Patient Last Name: ______________________________

First Name: ______________________________ Birthdate: ______________________

First Name: ______________________________ Birthdate: ______________________

First Name: ______________________________ Birthdate: ______________________

	Check all items that apply	High Cholesterol	High Blood Pressure	Early Heart Disease (under age 55)	Kidney Disease	Mental Retardation	Learning Disability	Autism	Attention Deficit Disorder	Seizure Disorder	Thyroid Disorder	Diabetes Juvenile	Diabetes Adult Onset	Disease Eye Disease	Gastrointestinal	Ulcers	Hepatitis	Hearing Disorder	Depression	Anxiety Disorder	Allergies Drugs	Allergies Environmental	Allergies Foods	Asthma	Skin Disorder	Cancers Adult Onset	Cancers Childhood Onset	Seizure Disorder	Bone or Joint Disease	Other:
Family Member	Name																													
Mother																														
Father																														
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Sib																														
Sib																														
Mat GM																														
Mat GF																														
Pat GM																														
Pat GF																														
Other																														

Please provide details.