New Patient Information Form

Date

PATIENT INFORMATION

Patient's Last Name | ☐ Male ☐ Female | Patient's First Name | Preferred Name | Middle Initial

Date of Birth | SSN# | Primary Language ☐ YES ☐ NO

Email Address | Race/Ethnicity | Is patient of Hispanic Origin?

PARENT 1 INFORMATION

Last Name | First Name | Middle Initial

Address | ☐ This is the primary contact number for this patient. | City & State | Zip Code

Cell Phone | Date of Birth | SSN#

PARENT 2 INFORMATION

Last Name | First Name | Middle Initial

Address *if different than Mom's address. | ☐ This is the primary contact number for this patient. | City & State | Zip Code

Cell Phone | Date of Birth | SSN#

EMERGENCY CONTACT

Please Choose an Emergency Contact: ☐ Mom ☐ Dad ☐ Other

Name | Phone | Relation to Patient

SIBLINGS

Last Name | First Name | ☐ Male ☐ Female

Last Name | First Name | ☐ Male ☐ Female

Last Name | First Name | ☐ Male ☐ Female

Last Name | First Name | ☐ Male ☐ Female

INSURANCE INFORMATION *Please present your insurance card to the front desk staff member.*

Name of Insurance Company | Name of Subscriber | Middle Initial

Group Number | Subscriber Number | Insured Date of Birth *If different than parent.

PREFERRED PHARMACY

Name of Pharmacy | Location/Address | Phone

HOW DID YOU HEAR ABOUT EINSTEIN PEDIATRICS?

Family Medical History

Date

FAMILY INFORMATION

Parent 1 Name *First & Last*

Parent 2 Name *First & Last*

CHILDREN

Last Name	First Name		Last Name	First Name	
		☐ Male ☐ Female			☐ Male ☐ Female
		☐ Male ☐ Female			☐ Male ☐ Female
		☐ Male ☐ Female			☐ Male ☐ Female

FAMILY MEDICAL HISTORY

☐ Family Medical History does not apply. Patient is adopted/fostered child. *If checked, please complete the bottom portion with any concerns.*

Has anyone in your close family (parents, sister, brother, grandparent, aunt, uncle, etc.) experienced the following:

Tuberculosis	☐No	☐Yes	Who _____
Diabetes	☐No	☐Yes	Who _____
Thyroid problems	☐No	☐Yes	Who _____
Asthma	☐No	☐Yes	Who _____
Allergy or sinus problems	☐No	☐Yes	Who _____
Seizures	☐No	☐Yes	Who _____
Mental retardation	☐No	☐Yes	Who _____
Heart attack	☐No	☐Yes	Who _____
High blood pressure	☐No	☐Yes	Who _____
Bronchitis	☐No	☐Yes	Who _____
Alcoholism	☐No	☐Yes	Who _____
Ulcers	☐No	☐Yes	Who _____
Intestinal problems	☐No	☐Yes	Who _____
Kidney problems	☐No	☐Yes	Who _____
Anemia	☐No	☐Yes	Who _____
Cancer or Leukemia	☐No	☐Yes	Who _____
Bleeding problems	☐No	☐Yes	Who _____
Hearing problems	☐No	☐Yes	Who _____
Vision Problems	☐No	☐Yes	Who _____
Arthritis	☐No	☐Yes	Who _____
Sickle Cell	☐No	☐Yes	Who _____
Psychiatric illness	☐No	☐Yes	Who _____

Please list any other medical history that you consider important to share: _____

_____

_____

_____

_____

_____

For office use only: Scanned _____ Entered _____

Patient Privacy Form

Date

PATIENT INFORMATION

Patient's Name

Date of Birth

SHARING INFORMATION

Please CHECK the information below that you authorize Einstein Pediatrics to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

☐ Results of lab tests / x-rays ☐ Appointment information ☐ Billing information ☐ Medical Information

Name of person that has permission to receive the above patient information — Relationship to patient

Name of person that has permission to receive the above patient information — Relationship to patient

BRINGING PATIENT TO THE DOCTOR

List anyone who has permission to bring the above patient to the doctor other than the patient's parents/legal guardians.

Name of person — Relationship to patient

Name of person — Relationship to patient

COMMUNICATION

I authorize Einstein Pediatrics to leave a message regarding: *Check ONLY ONE*

☐ All Information including appointments, general information, updates, billing, etc.

☐ Appointment Information ONLY

On my voicemail on the: *Check ALL that apply.* ☐ Primary Contact Number ☐ Secondary Contact Numbers

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Einstein Pediatrics. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to: Einstein Pediatrics 2235 Cedar Lane Ste 302 Vienna, VA 22182. I understand that I have the right to refuse to sign this authorization.

I have read and received a copy of the Notice of Privacy Practices for Einstein Pediatrics.

Signature — Date — Relationship to patient

Responsible Party Signature Form

Date

RESPONSIBLE PARTY

The Responsible Party is the person who is FINANCIALLY responsible for the patient's account(s) and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies provided to me for the following patients as well as future patients registered in my name at Einstein Pediatrics.

Name of Responsible Party (PLEASE PRINT) Relation to Patient(s)

PATIENTS COVERED BY RESPONSIBLE PARTY

Child's Last Name	First Name	Date of Birth
Child's Last Name	First Name	Date of Birth
Child's Last Name	First Name	Date of Birth
Child's Last Name	First Name	Date of Birth
Child's Last Name	First Name	Date of Birth
Child's Last Name	First Name	Date of Birth

WAIVER OF LIABILITY

Responsible Party Initials

I understand that the treatment/service from the providers and physicians at Einstein Pediatrics for the patients listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

PAYMENT POLICY

Responsible Party Initials

Einstein Pediatrics is committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area. Thank you for adhering to our payment policy. Signing below indicates that you are the responsible party which means you are financially responsible for this patient and have read and understand the payment policy and agree to abide by its guidelines.

RESPONSIBLE PARTY ACKNOWLEDGEMENT

I understand that I am the responsible party for the patients listed above and future patients registered in my name at Einstein Pediatrics and I agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office at Einstein Pediatrics as well as online at www.einsteinpeds.com.

Signature of Responsible Party Date

Privacy Notice to Patients

HIPAA POLICY STATEMENT

Einstein Pediatrics Privacy Notice to Patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED BY EINSTEIN PEDIATRICS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Effective Date: September 1, 2016

Under the HIPAA Privacy regulations, Einstein Pediatrics and all similar health care providers are required by federal law to maintain the privacy of your child's protected health information (PHI) and will abide by the terms in the Privacy Notice. Please be advised that Einstein Pediatrics may use your child's PHI in rendering treatment to your child. For example, we are permitted to use your child's PHI in providing your child with medical care/treatment when your child visits our office or when we treat your child in a hospital or nursing facility. Under federal law, we may disclose your child's PHI to you or we can disclose your child's PHI to third parties for treatment. For example, if we refer your child to a specialist, we will forward your child's medical information to such specialists. We can disclose your child's PHI for payment purposes. For example, we will disclose your child's PHI to your insurance provider, your employer, Medicare, Medicaid, or other parties responsible for providing your child with health insurance coverage in order for Einstein Pediatrics to be reimbursed for our services rendered to your child. We will also use or disclose your child's PHI for health care operations. For example, we may use your child's PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your child's PHI, when required by the Secretary of the US Department of Health & Human Services. Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your child's PHI without your authorization. Our practice may use or disclose your child's PHI in accordance with the specific requirements of the HIPAA rules without Einstein Pediatrics needing to obtain your authorization if the information is:

1. required by law
2. required for public health purposes
3. required disclosures about victims of abuse, neglect or domestic violence
4. required by a health oversight agency for oversight activities authorized by law
5. required in the course of any judicial or administrative proceeding
6. required for a law enforcement purpose to a law enforcement official
7. required by a coroner or medical examiner
8. required by an organ procurement organization for research, and,
9. necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Einstein Pediatrics is permitted to disclose your child's PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission. We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail or phone, our office personnel will note your request in your chart. In the event our practice wishes to disclose your child's PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Einstein Pediatrics decided to release your child's PHI for reasons other than treatment, payment, or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your child's PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Einstein Pediatrics a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures. Please be further advised that you have the ability to access, obtain a copy, inspect and request amendment to your child's medical information that we maintain. Additionally, if you desire, Einstein Pediatrics can provide you with an accounting of all disclosures for treatment, payment or healthcare operations and pursuant to authorization. If you have a dispute with our practice regarding the use of your child's PHI or a disclosure by Einstein Pediatrics and believe that your child's primary rights have been violated, please contact Einstein Pediatrics to file a complaint or you may contact the Secretary of Health and Human Services. We welcome feedback from our patients through our website contact us form or via email at info@einsteinpeds.com. Please understand that Einstein Pediatrics will not retaliate against you in any way for filing a complaint. Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your child's PHI to carry out treatment, payment or healthcare operations or disclosures by Einstein Pediatrics of your child's PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested designation or restriction. If you request a copy of your child's PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means. Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact Einstein Pediatric's Privacy Contact. Einstein Pediatrics reserves the right to amend this notice as revised. Notices will be posted on our website (www.einsteinpeds.com) and in our offices and provided to you upon your request. Thank you and if you have any questions, please contact Einstein Pediatrics at 703-344-7330.

Payment Policy

PAYMENT POLICY

Proof of Insurance:

All patients must complete our patient information forms before seeing the provider. We must obtain a copy of your current, valid insurance card for proof of insurance. If you fail to provide us with the correct insurance information at the time of service, you may be responsible for the balance of your claim.

Co-payments and balance dues:

All co-payments and balance dues must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Claims submission:

We will submit your claims to your insurance provider and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Monthly billing statement:

After your insurance company pays Einstein Pediatrics, you will receive a monthly billing statement, which indicates your balance due and/or deductibles due. These amounts are payable to Einstein Pediatrics. The balance amount is to be paid in full within 10 days of receipt of the monthly billing statement. If you have questions about your account please call 703-344-7330.

Insurance:

We participate in most insurance plans. If you are not insured by a plan we do business with or do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Einstein Pediatrics **does not** file claims with any **secondary** insurance companies.

Coverage change:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we cannot verify active coverage; the balance will automatically be billed to you.

Non-payment:

Partial payments will not be accepted unless otherwise negotiated with the billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. You will be responsible for any collection or legal cost associated with collecting your account. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During that 30 day period, our providers will only be able to treat you on an emergency basis.

Missed appointment:

In order to achieve the best appointment availability for our patients, we have a policy for missed appointments. There will be a $50 charge added to the account for missing an appointment without an attempt at canceling. Three missed appointments within a 12 month period will result in eligibility for discharge from the practice for the family. We understand the potential for unforeseen circumstances that can arise that may cause a late or missed appointment. If this happens, please call us as soon as possible so we can change your appointment status accordingly and make it available for another patient.

Cancellations:

Our policy is to charge $50 for previously scheduled appointments that are canceled less than 24 hours prior to their scheduled date/time. These charges will be your responsibility and billed directly to you, and not your insurance company. Please help us serve you better by keeping your regularly scheduled appointments.

Non-covered services:

Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Since all insurance plans are different, please contact your insurance company or HR department for detailed information about what is covered or not covered including well child visit maximums, after-hours fees and immunizations, etc. You will be billed and responsible for all non-covered services.

Newborn Insurance:

In order for Einstein Pediatrics to file insurance for your newborn, a parent must add them to the insurance policy within 30 days of the date of birth. Once added, please notify our billing department in order to have the patient's charges filed in a timely manner. If insurance is not determined after the 30 days from birth, the patient's account will be considered self-pay and the responsible party will be billed for the balance.

Forms of payment:

Einstein Pediatrics accepts payments by cash, check, money orders, Visa, MasterCard, and debit cards bearing these logos. Payment is expected at time of service.