

New Patient Information Form

Date _____

PATIENT INFORMATION

Patient's Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's First Name	Preferred Name	Middle Initial
Date of Birth		SSN#		Primary Language <input type="checkbox"/> YES <input type="checkbox"/> NO
Email Address		Race/Ethnicity		Is patient of Hispanic Origin?

PARENT 1 INFORMATION

Last Name		First Name		Middle Initial
Address	<input type="checkbox"/> 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 above	<input type="checkbox"/> 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
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SIBLINGS

<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Last Name	First Name	DOB	Last Name	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	DOB	Last Name	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> 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 <i>*If different than parent.</i>

PREFERRED PHARMACY

Name of Pharmacy	Location/Address	Phone
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HOW DID YOU HEAR ABOUT EINSTEIN PEDIATRICS?

Who Referred you? _____

New Patient Medical History

Date _____

PATIENT INFORMATION

Patient's Name _____

Date of Birth _____

MEDICAL INFORMATION

During pregnancy, Did Mom have any medical conditions? No Yes Explain _____
Or use tobacco, drugs, or alcohol? No Yes Explain _____
Immediately after birth, did your child have any problems? No Yes Explain _____
Were they admitted to the NICU? No Yes Explain _____
Did mom breastfeed? No Yes For how long? _____
What was your child's birth weight _____ lbs. _____ oz. Born at term? Yes Early (How many weeks gestation? _____) Late
Delivery? Vaginal Cesarean In which hospital or birthing center was your child born? _____

Do you consider your child to be in good health? No Yes Explain _____
Besides birth, has your child ever been hospitalized? No Yes Explain _____
Has your child ever had: A blood transfusion No Yes Explain _____
Convulsions or seizures No Yes Explain _____
Heart problems/murmur No Yes Explain _____
Surgeries No Yes Explain _____
Serious illnesses No Yes Explain _____
Major injuries No Yes Explain _____
Does your child have any: Food Allergies No Yes Explain _____
Drug Allergies No Yes Explain _____
Are you concerned about your child's development:
Physical No Yes Explain _____
Mental No Yes Explain _____
Social/emotional No Yes Explain _____
Are you concerned about your child's attention span? No Yes Explain _____
Girls Only: Has your daughter started her menstrual cycle? No Yes At what age _____
Has she experienced problems? No Yes Explain _____

Does your child attend school? No Yes Where _____
If so, How is their behavior in school? Excellent Average Not good Explain _____
How are their grades? Excellent Average Failing Explain _____
On average, how many hours/day does your child spend in front of a screen? TV, Computer, Video Games _____ hour(s)/day
Do you have concerns about your child's weight? No Yes Explain _____
Does your child routinely exercise or engage in physical activity? No Yes Explain _____
Has your child experienced ongoing constipation? No Yes Explain _____
Has your child had any unusual feeding/dietary problems? No Yes Explain _____

Has your child experienced any of the following? If yes, please explain below.

Frequent ear infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Wheezing/Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other problems with ears or hearing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bronchitis/Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fevers	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chronic or recurrent skin problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lung/breathing issues	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nasal Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Abdominal Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Problems with eyes/vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bladder or kidney infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bedwetting 5+ yrs	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Explain: _____

Please explain any other medical or social history that you consider important: _____

List any medications that your child is currently taking: _____

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 2235 Cedar Lane, Ste 302, Vienna, VA 22182. 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

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 1st, 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

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.

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 any missed appointment. 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.

I have read and understand the Payment Policy of Einstein Pediatrics.

Signature

Date

Relationship to patient