South River PEDIATRICS

Patient Information		**Date:**
Last Name:	First Name:	MI:
Birth Date:	Sex: M F	Social Security#
Child Resides with (check one):	☐ Both Parents ☐ Mother ☐ Father ☐ Other	
Home Phone:		
Mailing Address:		
City:	State:	Zip code:
Physical Address (If not same as above):		
City:	State:	Zip code:
Email Address:		

Parent/Guardian Information		
Name:	D.O.B	
Relationship to Patient:		
Home Address:	City, State:	Zip code:
Cell Phone:	Home Phone:	Work Phone:
E-mail address:	Occupation:	

Parent/Guardian Information		
Name:	D.O.B.	
Relationship to Patient:		
Home Address:	City, State:	Zip code:
Cell Phone:	Home Phone:	Work Phone:
Email Address:	Occupation:	

Primary Insurance Information	
Insurance Name:	
Insurance Address:	
Policy Holder:	
Date of Birth:	Social Security #
Policy #:	Group #:
Employer:	Occupation:

Additional Insurance Information	
Insurance Name:	
Insurance Address:	
Policy Holder:	
Date of Birth:	Social Security #
Policy #:	Group #:
Employer:	Occupation:

It is your responsibility to notify our office immediately of any changes to the above information

Signature:_____ Name:_____ Relationship to Patient:_____

South River PEDIATRICS

Pediatric History

Practice Name: _____ Date of Entry: _____
Patient Name: _____ Date of Birth: _____
Address: _____ Phone No.: _____
_____ Emergency No.: _____
Source of Information: _____ Relationship: _____

Mother's Pregnancy/Child's Birth History: (under 2 yrs old)

Illness during pregnancy?	NO	YES
Any medications during pregnancy?	NO	YES
Alcohol/Drug Abuse	NO	YES
Problems at birth?	NO	YES

Describe: _____
Type of Delivery? Vaginal C-Section
Birth Weight: _____ Discharge Weight: _____

Did baby receive Hepatitis B vaccine?	NO	YES

Date of Hepatitis B vaccine: _____
Name of Hospital: _____

Was first PKU done?	NO	YES

Patient's Health History: Has your child ever had:

Measles/Mumps/Chicken Pox	NO	YES
Frequent ear infections	NO	YES
Vision/Hearing Problems	NO	YES
Skin Problems	NO	YES
Asthma/Allergies	NO	YES
TB/Lung Disease/Croup	NO	YES
Seizures/Epilepsy	NO	YES
High Blood Pressure	NO	YES
Heart Defects/Disease	NO	YES
Liver Disease/Hepatitis	NO	YES
Diabetes	NO	YES
Kidney Disease/Bladder Infections	NO	Yes
Handicaps/Disabilities	NO	YES
Bleeding Disorders/Hemophilia	NO	YES
Sexually Transmitted Diseases	NO	YES
Emotional Problems/Suicide Attempts	NO	YES
Hospitalizations/Surgeries	NO	YES
Physical/Emotional Abuse/Broken Bones	NO	YES
Immunizations Up-To-Date	NO	YES

Psycho-Social History:

How many living in the household? _____
Who cares for the child? _____

Are parents working:	NO	YES

Name of school: _____
Grade: _____
Behavior problems: _____
_____
Comments: _____

Family History: Has anyone in the family (parents, grandparents, aunts & uncles, sisters & brothers, cousins, etc.) had the following: Who:

TB/Lung Disease	NO	YES	_____
HIV/AIDS	NO	YES	_____
Suicide Attempts	NO	YES	_____
Heart Disease	NO	YES	_____
High Blood Pressure	NO	YES	_____
High Cholesterol	NO	YES	_____
Blood Disorders	NO	YES	_____
Diabetes	NO	YES	_____
Seizures	NO	YES	_____
Allergies/Asthma	NO	YES	_____
Mental Retardation	NO	YES	_____
Mental Illness	NO	YES	_____
Cancer	NO	YES	_____
Birth Defects	NO	YES	_____
Hearing/Speech Problems	NO	YES	_____
Kidney Disease	NO	YES	_____
Alcohol/Drug Abuse	NO	YES	_____
Stroke	NO	YES	_____
Hepatitis/Liver Disease	NO	YES	_____
Thyroid Disease	NO	YES	_____
Learning Problems	NO	YES	_____
Attention Deficit Disorder	NO	YES	_____
Family Violence	NO	YES	_____

Adolescent History: (Interview separately)

Age at first period _____ LMP _____

Sexually Active	NO	YES	# of partners ___
Sex of partners	MALE		FEMALE
Any fears of partner/other violence?		NO	YES
Smoker: NO YES	Alcohol Use:	NO	YES
Drug Use: NO YES	Working:	NO	YES
Do you think about hurting yourself?		NO	YES
Access to gun/weapon:		NO	YES

South River PEDIATRICS

Medical Power of Attorney

This power of attorney shall be effective during such period of time as we, or either of us, may for any reason not be available to give our consent to any medical diagnosis or treatment, including surgery, for our child (or children).

I _____ do hereby appoint the following individuals as our
(Name of Parent/Legal Guardian)

true and lawful attorney-in-fact, with full power loco parentis, to decide upon and consent to the rendering of any medical diagnosis, which (he or she) deems in the best interest of health and welfare of our child(ren) _____
(Name of Patient)

Name	Relationship to Patient

_____ _____
Signature of Parent or Guardian Date

South River Pediatrics

Financial Policy

INSURANCE, DEDUCTIBLES, CO-INSURANCE & CO-PAYS

South River Pediatrics currently participates with most insurance company. Please check with the staff to verify our participation in your insurance plan. The Primary Care Physician (PCP) must be selected on your child's insurance card as our practice: **South River Pediatrics** for benefits and coverage at time of visit.

The most recent insurance card must be presented at each visit to verify the information on file. Depending on your specific insurance plan, you may have a co-pay, co-insurance, and/or a deductible due at the time of your visit (some plans have a combination of two or three of the aforementioned items). Co-pay is a set dollar amount that you owe at the time of each visit. A co-insurance is an amount required by some insurance carriers that is above the deductible and co-pay amounts. A deductible is a set amount that is owed before the insurance begins paying toward the patient's services. ***Co-pays are due at the time of service.***

Any co-pays that are unpaid at the time of service due to the inability or refusal to pay for any reason are subject to an additional fee. As a courtesy, you have until 4:00pm on the same date of service to furnish payment or be charged an additional surcharge of $10 per unpaid co-pay. Please ask our front desk for more details. Any balances that you may have incurred from prior or present dates of service will be collected when you visit the office. Our office bills the patient's insurance and makes every effort possible to ensure that claims are promptly and correctly processed.

NEWBORN ENROLLMENT

After the birth of your new baby, be sure to fill out the necessary paperwork to add your baby to your insurance policy. Most insurance companies allow 30 days from the date of your child's birth to send in the paperwork. If you miss the deadline, claims filed on behalf of your newest family member may be denied and you may be financially responsible.

UNINSURED PATIENTS

For any patients determined to have no medical insurance coverage, those patients are deemed to be self-pay patients.

Effective January 2015, all self-pay patients will be placed on a discounted sliding fee schedule. In order for the patient to receive the discounted rates, payment for services must be paid in full at time of service. If you have a question about the fee schedule, please feel free to contact our billing department.

AUTO ACCIDENTS/WORKERS' COMPENSATION

Motor vehicle accidents (MVA) charges must be paid in full at the time of service. A receipt will be issued for you to submit to your auto insurance carrier. When and if we receive payment from your auto insurance we will provide you with a refund.

AFTER-HOUR CARE

Please note that there is an additional charge for services provided outside of our regularly scheduled appointments. These include requests for visits after 5:00pm, emergency walk-in visits that disrupts the regularly scheduled business day, federal holidays, and Saturday office visits. This charge will be billed to your insurance company however this may become your responsibility if the insurance company does not cover this charge.

ACCOUNT BALANCES

Any outstanding balance after 60 days may be referred to an outside collection agency. These accounts may be subject to a collection fee of 30%-40%, which will be added to the total balance due at the time of payment. Patients with continually delinquent accounts or those whose accounts have been sent to a collection agency are subject to discharge from South River Pediatrics.

Account balances may consist of any unpaid co-pays, deductibles, co-insurances or any balance that the insurance policy did not cover for a date of service. Balances are expected to be paid in full at the time of service. In the event that you cannot afford the entire balance, please contact our billing department.

COLLECTION EFFORTS

We will make every effort to work with you to make payment arrangements should your bill become outstanding. As a courtesy to you, we will file claims with your insurance carrier. You are ultimately responsible for the charges from the services provided to the patient. You will receive a monthly statement reflecting balances still outstanding from your insurance carrier for which you are responsible. In the event that the account becomes outstanding, the payments must be regimented to clear the account within a 60-day period. *If you do not meet your financial obligation and refuse to pay the balance, we reserve the right to refuse care for and all subsequent visits.*

METHODS OF PAYMENT

For your convenience, we accept cash, personal checks, money order, Visa, MasterCard, Discover, and American Express. There is a $25 fee for all returned checks. If the office receives two returned checks, we will then only accept cash or credit as a form of payment.

REFUNDS

In the case that there is a refund due to parent/policy holder, we ask that an e-mail request is sent to: Jackie@southriverpediatrics.com. Please state (a)to whom the refund is to be made out to and (b) the address to which it will be mailed to. Refund will be mailed within seven (7) days of the request.

LEGAL SERVICES

If any of our physicians and/or providers are asked to be involved in any legal matter requiring our participation pertaining to you or your child via telephone, court deposition, and/or court appearance we will charge you a fee for these services. This will include preparation time, professional time, and transportation costs. The fee for these services is three-hundred dollars ($300) per hour will be billed to the parent whose attorney is requesting the information.

I am aware that I am responsible for my bills in the event the insurance company denies any claims. I have read and understand the office policies and procedures and agree to adhere to the specific guidelines outlined above. I am aware that I do not comply with above stated guidelines South River Pediatrics reserves the right to terminate care.

Parent/Legal Guardian Name: _____

Signature _____

Patient Name: _____

Today's Date: _____

Revised 8/2015

South River PEDIATRICS

Office Policy

Thank you for choosing South River Pediatrics. Our practice was founded by Dr. Azam Baig in 1983 and we have since been committed to providing excellent medical care combined with compassion. We have five board certified physicians and two certified nurse practitioners operating in our three Maryland locations: Edgewater, Dunkirk, and Chester.

HOURS OF OPERATION & PHONE HOURS

Edgewater

Monday- Thursday	8:00am–6:00pm	Phones: 7:00am–6:00pm
Friday	8:00am–5:00pm	Phones: 7:00am–5:00pm
Saturday	8:00am–12:00pm	Phones: 8:00am–12:00pm

Dunkirk

Monday, Tuesday, Thursday, Friday	9:00am–5:00pm	Phones: 8:00am–5:00pm
Wednesday	9:00am–6:00pm	Phones: 8:00am–6:00pm

Chester

Monday–Friday	9:00am–5:00pm	Phones: 8:00am–5:00pm

*******All of our offices close for lunch daily between the hours of 12pm and 1pm*******

AFTER-HOURS & EMERGENCIES

If an emergency should arise, please call 911. For non-urgent and routine questions call **Ask-A-Nurse.** This is a service we offer through Anne Arundel Medical Center and can be reached at **443.481.4000**. Please know that our providers are on call 24 hours a day 7 days a week for issues that cannot possibly wait. You may have the doctor on-call paged at **443.481.3076** between the hours of **7:00AM to 1:00AM**. Any calls to the providers outside of these hours will be charged $10.

SATURDAY APPOINTMENTS

Please note that Saturday hours are same day sick only and are on a first come first serve basis. It is a good idea that if you are planning on scheduling a Saturday appointment, please be prepared to come to your appointment prior to scheduling. Being prepared for your appointment allows us to accommodate as many sick appointments as needed in a short period of time.

INCLEMENT WEATHER
Please note that in the event of the office closing during regular business hours for any reason (holidays, weather, emergency issues, etc.) there will be a recording on the phone in place of our regular office recording. If you reach this message it is safe to assume that we are not in the office. Please do not leave any urgent messages on the machine as they will not be checked until the next open business day.

Additional information/updates in regards to our office can be found on our Facebook page

QUESTIONS FOR THE DOCTOR
If you have a question about your child, you may leave a detailed message for your physician in regards to your child with our front desk staff.

APPOINTMENTS
Appointments are scheduled to accommodate the provider's schedule so that they may provide the best care for their patients. We recommend you schedule well visits, sports physicals, A.D.H.D. and A.D.D. reviews and consults between one to three months in advance as they do book rather quickly. Same day sick visits are given on a first come first serve basis.

WELL VISIT NOTICE
During your child's well visit for preventative care, you may be asked to complete certain screening questionnaires. We use these items to help us assess both development and health exposures during your child's growth. We feel strongly that these are necessary and important to your child's overall well-being, and we follow the guidelines for preventative health screening as set forth by the AAP and the Maryland State Board of Health.

We will submit to your insurance for these services. If your insurance does not cover these services, you will be responsible for the balance. Please feel free to discuss this with our billing department if there are any concerns or questions or your insurance carrier to inquire about coverage. Additionally, your provider can help you understand what these screenings are for and when they are most important for your child.

Don't schedule your child's physical exam on his or her birthday. Many insurance providers don't consider it a 5-year old physical until the day after the birth date. For annual physical exams, many insurance companies do not cover two physicals within a one year period. Please check with your insurance company to verify coverage for physicals if you have questions.

COMBINATION VISITS
With the changes in insurance there are certain expectations, but these are things we expect from you. Please have some respect and consideration for our time and profession:

a. No co-pays are required for most preventative care services (or care provided to Medicaid-enrolled children.)
b. Many times parents have extra concerns about their child's health or behavior that requires extra time and is not part of a routine preventative care visit.
c. For the convenience of children and families, and when schedules permit, we try to address these added problems as part of your child's well visit/check-up office visit. In this situation, as per guidelines developed by AMA and American Academy of Pediatrics, we will bill for the added office visit time.

d. Several insurance companies are now asking that we collect a co-pay from families when we address these extra problems in addition to the check-up visit.
e. If more convenient, we can also schedule a separate appointment to address these additional health concerns.
f. Our goal is to deliver the very best care to your child and family – comprehensive, convenient and fairly priced.

LATENESS, CANCELLATIONS & NO SHOWS

If you are more than 15 minutes late for your well visit or consult appointment, we reserve the right to reschedule the appointment. If you are more than 15 minutes late for a sick visit, you will forfeit the scheduled appointment time. Well visits, A.D.H.D./A.D.D. consults and reviews require no less than 24 hours' notice of cancellation. Same day sick visits require no less than 3 hours' notice. Patients who no-show for a double visit will be restricted from scheduling double appointments in the future. **With regards to no-shows/cancellations, we will charge you and not the insurance company in the event that you either miss your appointment or do not allow the amount of time required for cancelling the appointment.** The fees are as follows:

Well Visit $40 **Consult $40** **Sick/Follow-up visit $25**

PRESCRIPTIONS

South River Pediatrics processes prescription refills on weekdays only. When requesting refills, your chart has to be reviewed by your physician before a prescription can be filled. Our office requires up to **three** business days to process all prescriptions. If your child is on a medication that is refilled on a monthly basis, please plan accordingly when requesting prescriptions. Controlled substances cannot be called into the pharmacy.

FORMS

School, day care, sports physicals and other forms require 3-5 business days to complete unless presented at the time of a well-child visit. Forms dropped off, except during well child visits, require a $10 processing fee. We may fax or mail forms back to you, but we do ask for a self-addressed stamped envelope for mailing.

REFERRALS

In the event that you/your child require a referral to see a specialist, you must first schedule the appointment before one may be written. Our office requires up to **five business days** to process a referral. For referrals, please call our office, follow the prompt for the referral line and leave all pertinent information for it to be processed. We are under legal obligation to all insurance companies to process referrals according to Maryland State Law.

MEDICAL RECORDS

In the event of the transferring of care to another practitioner, medical records for your child may be requested to be copied for transfer. A Records Release Form must be signed for chart information to be released as well as a fee collected prior to copying. (Please inquire about this fee as it fluctuates per Maryland State Law). Records can either be collected in person or faxed over to the new office to which your child will be or has transferred to, as long as the information is provided on the aforementioned form.

All records are property of South River Pediatrics. We are permitted by Maryland law to charge commercial insurance companies a processing/copying fee per patient as well as a postage fee. See *www.odg.state.md.us* for additional information on this particular law. If

anyone other than the physician requests medical records, there will be an additional $22.88 fee. Our fee is .76 cents per page plus postage.

SINGLE, SEPARATED OR DIVORCED PARENTS

For single, separated, or divorced parent(s) who is/are authorized to bring the child in for treatment will be responsible for any co-payment/deductible or co-insurance balance. If there is a divorce decree requiring the other parent to pay such charges, the authorized parent will be responsible for collecting said charges from the other parent and presented at time of service.

Unless South River Pediatrics has a court order(s) that states the contrary, our office is legally obligated to disclose medical information to both parents/legal guardians. If at any time legal matters become too intrusive for our staff, we reserve the right to dismiss the patient from our practice.

PERSONAL BELONGINGS

It is understood and agreed that the practice shall not be responsible for any loss, theft, misplacement, or damage to any valuables and personal belongings while inside the premises of the practice or outside the premises in the parking lot or other areas around the professional building.

GROUNDS OF DISMISSAL

- Non-payment of patient responsible balances in a timely manner
- Multiple missed appointment
- Profane, abusive, or demeaning language to staff

South River PEDIATRICS

NEW PATIENT/NEWBORN WAIVER

I state that I have not yet provided South River Pediatrics with my child's, _____, completed insurance information. I acknowledge that no coverage is bound until I have provided South River Pediatrics with the necessary insurance information for my child.

I understand that all balances must be paid in full within one month (30 days). Further, I understand that my signature on this form establishes me, _____, as financially responsible for all patient balances.

This waiver states, therein, the signer accepts full assumption of financial responsibility for any and all unpaid charges after the one month (30 day) period has elapsed. After which, the patient is considered a self-pay patient.

Signature _____ **Date:** _____