



Patient Information		Date:	
Last Name:		First Name:	MI:
Birth Date:	Sex: M F	Social Security#	
Child Resides with (check one): <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: _____



Pediatric History

Practice Name: _____
 Patient Name: _____
 Address: _____

 Source of Information: _____

Date of Entry: _____
 Date of Birth: _____
 Phone No.: _____
 Emergency No.: _____
 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

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 _____

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

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

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: _____



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



Financial Policy

South River Pediatrics is committed to providing you with the highest quality care in a cost effective manner. Therefore, we believe that it is essential to our patients and their parents that we outline our financial aspects of your visit with our practice. We have developed these policies based on industry standards and through careful consideration. Our professional fees are based on reasonable and customary within our region. These policies are presented in order for you to understand how we interact with you, your insurance company, and some of the constraints we must follow due to contractual and/or legal requirements. If you have any questions or concerns regarding your bill please call our Billing Department at 410-956-2856.

INSURANCE

We are contracted with most insurances companies and will bill your insurance company for services provided. Please check with our staff to confirm our participation with your insurance plan. Please bring your insurance card with you to each and every office visit. Our receptionist will ask to see your insurance card every time you check in for a visit. If your child is accompanied to their appointment by someone other than the parent, please arrange for the insurance card to be presented as well. The most recent insurance card must be presented at each visit to verify the information on file is correct.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES

A **co-payment** is a set dollar amount that you owe at the time of each visit. Per our contract with your insurance company, co-pays must be collected at the time of service, including most "nurse only visits". If you are unable to pay your co-payment at the time of service, we will charge an additional \$10.00 to cover our cost of billing you for the co-pay.

A **co-insurance** is an amount required by some insurance carriers that is above the deductible and co-pay amounts. This amount is determined by your insurance plan and will be determined after our office has submitted a claim on your behalf for payment.

A **deductible** is a set amount that is owed before the insurance begins paying towards the patient's services. We will bill you for any **co-insurance** or **deductible** amounts as identified by your insurance company.

Any balance that you may have incurred from prior dates of service is expected to be paid within 20 days of the billing date and you may be asked to pay your balance at the time of your next visit.

NEWBORN ENROLLMENT

It is extremely important that you notify your insurance company immediately following the birth of your child to initiate the process of enrollment. Most insurance companies allow 30 days from the date of your child's birth to send in the necessary paperwork for enrollment. If our office is unable to verify insurance coverage with your insurance company, claims filed on your behalf may be denied and you may be financially responsible. Once you have obtained the new insurance information from the insurance company, please notify our Billing Department at **410-956-2856** so that we may retroactively submit your claims for processing.

UNINSURED PATIENTS

If a patient has no insurance, insurance that we are not contracted with, or has experienced a lapse in coverage at the time of service, we are still committed to his or her care and well-being. Our practice offers a discount to self pay patients on a sliding fee schedule. This is a discount on what we normally charge for an office visit. To benefit from the discount, **payment must be paid in full at the time of service**. If there is a lapse in coverage or we are not a participating provider, we are happy to provide you with a detailed billing summary for submission to your insurance company.

BEFORE AND AFTER-HOUR CARE

In accordance with national billing guidelines, there is an additional charge for appointments provided outside of our regular business hours. Before and After Hour services that are provided by your provider consist of but not limited to **Walk-In Hours 8:00am-9:00am** in all of our offices on designated days, **Saturdays, Federal Holidays** when our offices are open, and **Evening hours from 5:00pm-6:00pm**. This charge will be billed to your insurance company, however; not all insurance companies cover this fee. In the event that your insurance company does not cover this charge, it will become your responsibility to cover this portion of your bill. We recommend that you contact your insurance company prior to the visit to see if this is a covered service.

ACCOUNT BALANCES/PAYMENT PLANS

Our Billing Department will be happy to assist you with any previous balances owed to our practice. We can offer a payment plan if you are unable to pay your balance in full. To initiate a payment plan with our office, a minimum payment of \$50.00 or 20% of the outstanding balance (which-ever is greater) is required and a monthly payment must be paid on the remaining balance. If you do not meet your financial agreement, and you refuse to pay your balance, we reserve the right to dismiss the patient from the practice and your account will be forwarded to an outside collection agency.

COLLECTIONS

We understand that at times there are extenuating circumstances that may limit your ability to pay off any outstanding balance. Patients who have not established a payment plan with our Billing Department will be referred to an outside collection agency for balances that are over 60 days past due. These accounts will be subject to a collection fee of 33% which will be added to the total balance due. In the event your account is referred to an outside collection agency, you are subject to be discharged from the practice.

METHODS OF PAYMENT

For your convenience, you can make payments on line at www.southriverpediatrics.com or you may call our Billing Department at **410-956-2856**, Monday through Friday from 8am-4pm and someone will be available to assist you with your payment. We accept Cash, Personal Checks, Money Order, Visa, MasterCard, Discover, and American Express. There is a \$35 fee for all returned checks. In the event of two returned checks, we will only accept Cash or Credit Card as a form of payment.

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 if 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: _____



OFFICE POLICY

Welcome to South River Pediatrics. Thank you for choosing us as your health care provider for your child/children. Nothing is as precious as the health of our children and we are committed to providing your child/children with the highest quality of care.

As we begin our relationship with you, we feel that it is important that you have a clear understanding of our general office and financial policies.

We have 8 providers and 3 locations with convenient office hours to serve you. Please take this opportunity to review our office policies and procedures.

Appointments

Provider schedules fill up quickly. We encourage our patients to schedule Well Child Visits, Adolescent, Sports Physicals, and ADD/ADHD Consult (including medication follow-up) appointments up to 3 months in advance.

For regular routine care we encourage you to schedule your appointment with your child's Primary Care Provider. However, should you choose to see any available provider please inform our front office staff. You will then be given the opportunity to choose from the Provider's available appointments. **Please be aware that our Providers rotate their schedules at each of our offices.**

Same Day Sick appointments are available by appointment. If the provider of your choice is not available, we will make every effort to schedule you with another provider.

We know that your time is valuable, and we will make every effort to ensure that we see your child as scheduled with minimal wait time. Therefore, we ask that you are prepared for each visit. To ensure your child is seen as scheduled:

- Please arrive at least 15 minutes prior to your appointment to complete necessary paperwork.
- Please bring your insurance card and a valid photo ID to every appointment.
- You will be asked to confirm your demographic information and insurance at each appointment.
- Please be prepared to pay your copay at the time of your visit.

Late Arrivals/Cancellations & No Shows

We have set "Appointment Times" for our patients and do our best to see our patients on time. Please understand that unforeseen circumstances may require some patients a little extra time with the provider. If this occurs, we will do everything in our control to get your child in to see the provider in a timely manner. To prevent the providers from falling extremely behind during the day, we ask that you arrive for your appointment at least 15 minutes before you are seen to complete the necessary paperwork.

- **Late arrivals** increase the wait time for other patients. If you arrive more than 15 minutes late for a routine **Well Visit** you may be asked to reschedule your appointment. If you arrive more than 15 minutes late for a **Sick** appointment, we will see you, but you will be offered the next available appointment so that patients who arrived on time will be seen as scheduled.
- **Cancellations-Well Visit, ADD/ADHD, and Consult** appointments require a 24-hour notice to cancel the appointment without a cancellation fee. Appointments that are not canceled within 24-hour of the appointment will be charge a \$50 fee. **Sick** and **Follow-up** appointments require a 3-hour notice to cancel the appointment. If you cancel your appointment less than 3 hours of your scheduled appointment, you will be charged \$25.00 for a cancellation fee.
- **No Show**-A "No Show" appointment is an occurrence where the patient does not show for an appointment and does not cancel the appointment in advance according to our cancellation policy. If you do not show for your appointment and you do not cancel the appointment in advance, we will record in your medical record "No Show" and you will be charged a "No Show" fee of **\$50.00** for a Well Visit, ADD/ADHD, Consult or follow-up and a **\$25.00** fee for a Sick appointment.

Please be advised that failing to keep scheduled appointments can result in dismissal from the practice.

Prescriptions/Forms

Prescriptions-South River Pediatrics processes prescription refills Monday through Friday. Refill request are not completed on the weekends. For your convenience, many prescription medications can be sent electronically to the pharmacy of your choice. Please allow up to 48 hours to process all prescription refills. If your child is on a medication that is refilled monthly, please plan accordingly when requesting refills. Please be advised, that some prescription medications require pre-authorization from your insurance company and may take longer to fill request. We will not mail prescriptions. Controlled medications cannot be called into a pharmacy. **When picking up prescriptions in the office, please be prepared to show a valid photo ID.**

When requesting refills for your child's ADD/ADHD medication, please make sure your child has had a routine follow-up within the last 3 months of your request. If your child has not been seen for a follow-up, we will not refill the prescription until the patient has been seen in the office.

Forms- We will be happy to complete School, Day Care, Camp, and Sports Physical forms for you. Forms that are presented at the time of a well visit will not require a charge.

Forms that are dropped off in the office (not during a well visit) will require a **\$10.00** processing fee per form .Payment is due at the time forms are dropped off. **We will not accept FAXED forms.** Please allow 3-5 business days for completion. At your request, we may mail forms back to you, but we ask that you provide a self-addressed stamped envelope for mailing.

Before submitting your child's form(s) for completion, please make sure:

1. Your child is up to date on his/her well visits
2. You complete your portion of the form and sign before presenting to our office for completion.

Forms that are not completed and signed will not be processed and will result in a delay in completing your form(s) in a timely manner.

Referrals

If you need a referral for a follow up visit for a condition your child has been seen for, you must first schedule the appointment with the specialist before requesting a referral. When contacting our office for a referral please follow the prompts on our referral line and leave all pertinent information. You must provide all information requested at the time of your request otherwise this will cause a delay in processing your referral. **Our office requires 5 business days to process a referral.** When your referral has been completed, you will be contacted by our office. **We will not back date any referrals.**

If you are requesting a referral for a medical condition that we have not seen your child for, you will need to be seen in our office before we can issue a referral to a specialist.

Medical Records

All medical records are the property of South River Pediatrics. A signed Medical Records Release Form must be completed before records can be processed and released. We are permitted by Maryland law to charge administrative and copying fees for the process of medical records; per patient/per chart. Please call the office for current fees as the cost fluctuates per Maryland State Law. Fees must be paid before release of medical records. We

will not mail medical records unless a self-addressed stamped envelope is provided to our office and we will not fax medical records unless we are faxing records to another provider office.

Please allow 14 business days to process medical records request. For additional information, you may call our office at 410-956-6302.

Divorce, Separation, & Custody Agreements

South River Pediatrics believes that such matters should not enter into a child's medical treatment.

"Joint Custody" means that each parent has equal access to the child's medical records. Unless, we have a court order that states the contrary, our office is legally obligated to disclose medical information to both parents/legal guardians.

Please be advised of our office policy concerning this sensitive matter:

- We will **NOT** prevent either parent from reviewing their child's chart, obtaining their child's test results, or from scheduling an appointment to be seen.
- We will **NOT** call the other parent for consent prior to treatment.
- We will **NOT** fax any health information to either parent.
- We will discuss with the attending parent information pertinent to the child's history and/or present exam. It is the responsibility of the parents to communicate with each other about the patient's care, office dates/visits and any other pertinent information relevant to the care of the child.
- If there is a dispute between the parents regarding custody and a custody agreement has been reached, we will need to obtain a copy of the agreement for the child/children file. The individual who is requesting the medical treatment is responsible for the payment of the medical bills. We will collect co-pays and deductibles from the attending parent or legal guardian. It is our policy that co-pays and account balances are due at the time of service from the parent, guardian, or caretaker who brings the child in for the appointment. The parent or legal guardian who **COMPLETES** and **SIGNS** our Financial Policy Form will be considered the **GUARANTOR REGARDLESS OF INSURANCE COVERAGE.**
- If at any time legal matters become too intrusive for our staff, we reserve the right to dismiss the patient from our office.

If you have additional questions about our practice, please feel free to contact our office at 410-956-6302 or visit our website at www.southriverpediatrics.com.

Thank you for choosing South River Pediatrics.

Azam Baig, M.D., FAAP



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: _____