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 Pediatric Vaccine Policy

Patient Name: _____ **Date of birth: _____**

South River Pediatrics providers have carefully reviewed our approach to vaccines within our practice. The following statements conclude our views:

1. We firmly believe in the effectiveness of vaccines in preventing serious illnesses and saving lives.
2. We firmly believe in the safety of all vaccines.
3. We firmly believe that all children and young adults should receive all recommended vaccines according to the schedule published by the Centers for Disease control and disease (CDC) and the American Academy of Pediatrics (AAP).
4. We firmly believe, based on all available scientific literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.

The vaccine campaign is really a victim of its own success. Precisely because vaccines are so effective at preventing diseases that we have parents who have become complacent waiting. As a result of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or chickenpox, or a family member or friend whose child died as a result of these diseases. Unfortunately, health care providers within our practice have witnessed children suffering and/or dying from these vaccine-preventable diseases.

Vaccines are a crucial part of disease prevention among the general population. Vaccines benefit not only those who receive them, but also the vulnerable population who may not be eligible for vaccination due to age or other medical contraindications. While you may decide to take the risk of you or your child getting a vaccine-preventable disease, we cannot take the risk to our patients.

We're making you aware of these facts not to scare or coerce them, but to emphasize the importance of vaccinating your child. We recognize that the option to vaccinate may be emotional for some parents. We will do our best to help you better understand that getting vaccinated on schedule is the right thing to do. If in doubt, talk to your provider during your visit. Keep in mind that delaying or "breaking" vaccines to give one or two at a time goes against expert recommendations and medical advice from our providers, and can put your child at risk of serious illness and/or death.

We hope all of our patients are up to date with vaccinations for infants and young children at the age of two. We also expect all of our patients to have their recommended childhood vaccines before age six. Finally, all vaccines for adolescents and young adults should be given according to con las recomendaciones actuales del programa de los CDC y AAP.

If, despite all our efforts, you choose to refuse or reject vaccines, we ask that you find another practice that shares the same opinions.

As medical professionals, we feel very strongly that vaccinating children on time with currently available vaccines is absolutely the right thing for all children and young adults. Thank you for your time reading this policy, and feel free to discuss any questions or concerns you may have with any of us.

Sincerely,

Providers of South River Pediatrics

Parent/Guardian Signature:_____

Relationship to patient_____

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 **Saturday Hours, and Federal Holidays** when our offices are open. 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 Thursday from 8am-5pm and on Fridays from 8am-12pm; 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: _____

Revised 11/2022

OFFICE POLICY

Welcome to South River Pediatrics. Thank you for choosing us as your health care provider for your child/children. Nothing is a 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 6 providers and 2 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**-All appointments require a 24-hour notice to cancel the appointment without a cancelation fee. Appointments that are not canceled within 24-hour of the appointment will be charge a $40 fee. **Same Day** appointments that are scheduled on the same day of the appointment request will also be subject to the $40.00 cancellation fee if the appointment is cancelled.
- **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 cancelation 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 $40.00.

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, your child 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 patients 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:** _____

224 Mayo Road Edgewater, MD 21037

Medical Records From:

Name of Facility:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Fax Number:_____

Medical Records To:

Name of Facility:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Fax Number:_____

Please release medical record information and / or immunization record information for:

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

I am aware that if the medical record has information regarding substance abuse, psychiatric treatment, or communicable diseases, this information may be released.

What You Want Copied:

Records Required/ Date of Service:_____Complete Record:_____
Immunizations:_____ Other (Please Specify):_____
Purpose of Disclosure:_____
_____

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment or transfer. I further authorize South River Pediatrics to obtain medical information from another provider/ facility as deemed necessary in the course of my treatment. This authorization will expire sixty (60) days from the date of signature. In the State of Maryland, the physician who creates the patient's record is the owner of those medical records. Maryland Law states that photocopies may be released to the patient or parent upon proper written request within a reasonable period of time. I understand there is a $22.88 admission fee if sent to someone other than parent/patient and $.76 per page after that. There will be a postage fee applied if mailed. All fees must be paid upfront before copying can begin.

Patient/Parent/Guardian Signature:_____ **Date:**_____

Telephone Number: (H): _____ (W):_____

Date/Initials Completed: _____ Fee Collected: $_____