SUFFOLK PEDIATRIC, PC

NEW PATIENT REGISTRATION / REGISTRO DE PACIENTE NUEVO

PATIENT INFORMATION/INFORMACION DEL PACIENTE:

Name/Nombre:_____ Last Name/Apellido:_____

DOB/Fecha de Nacimiento: ____/____/____ Sex/Sexo: M F Race/Raza:_____

Email/Correo Electrónico:_____

Address/Dirección:_____ Apartment/Apartamento:_____

City/Ciudad:_____ State/Estado:_____ Zip/Código Postal:_____

Cell/Celular:_____ Home Telephone/Teléfono de Casa:_____

Pharmacy/Farmacia:_____ Phamacy Tel. / Tel. De Farmacia:_____

PARENTS INFORMATION/INFORMACION DE TUTOR

Mother/Madre/Guardián:_____

Father/Padre/Guardián: _____

PARENTS EMPLOYER INFORMATION /INFORMACION DE TRABAJO DE TUTOR:

Occupation/Ocupación:_____ Employer Tel./Tel. De Trabajo:_____

Address/Dirección:_____ State/Estado:_____ Zip code/Código Postal:_____

INSURANCE INFORMATION/INFORMACION DE SEGURO:

Insurance/Seguro:_____ Secondary Ins./Seguro Secundario:_____

ID #_____ ID #_____

POLICY HOLDER INFORMATION/INFORMACION DEL ASEGURADOR:

Name/Nombre:_____ DOB/Fecha de Nacimiento:____/____/____

Relationship/Relación:_____ Phone Number/Número Telefónico:_____

I certify the above information is true and accurate. I authorize the release of any medical information necessary to process a claim or continue medical treatment. I further authorize payment of medical benefits paid directly to the medical provider. I acknowledge that I am responsible for all payments not covered by my insurance.

Certifico que la información es verdadera y precisa. Autorizo la divulgación de cualquier información médica necesaria para procesar una reclamación o continuar el tratamiento médico. Autorizo además el pago de los beneficios médicos pagados directamente al proveedor médico. Reconozco que soy responsable de todos los pagos no cubiertos por mi seguro.

Signature/Firma:_____ Date/Fecha:_____

45 W. Suffolk Ave, Ste. 200. Central Islip, NY 11722 **Phone: 631-582-2228 Fax: 631-582-4881**

SUFFOLK PEDIATRIC, PC

Medical Records Release Form

Patient Name:_____ DOB_____
Last Name, Middle Name, First Name Month / Date / Year

I hereby authorize:

Facility Name:_____

Address:_____

_____

Phone:_____

Fax:_____

To release medical information to:

Suffolk Pediatrics

45 W. Suffolk Ave, Ste. 200

Central Islip, NY 11722

Phone: 631-582-2228

Fax: 631-582-4881

Information to be released: (Please check all that apply)

- ☐ Complete Medical Record
- ☐ Lab Reports
- ☐ X-RAY Report
- ☐ Immunization Record
- ☐ Consult Notes

Purpose for disclosure: (Please check all that apply)

- ☐ Changing PCP or Relocating
- ☐ Continued Medical Care
- ☐ Other:_____

Notes:

From:_____

_____

_____

_____

_____

_____

_____

_____

Authorization & Disclosure

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information. I give permission for a copy of the information listed above to be transferred/released to the above listed facility. I understand that I may revoke this authorization at any time before the transfer/release of information. This authorization will expire in 90 days after the date signed.

Signature of Patient/ Guardian_____ Date:_____

Print patient's name/Guardian_____ Relationship:_____

SUFFOLK PEDIATRIC, PC

FINANCIAL POLICY/AGREEMENT

Welcome to Our Practice!

We are dedicated to providing the best affordable quality care to your child/children and regard your complete understanding to our financial responsibilities/agreement as an essential element of your care and treatment. Thus, in order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policy. Unless other arrangements have been made in advance by either yourself or your healthcare provider, full payment is due at the time of service!

Your Insurance Company

We have made prior arrangements with many health insurance plans with which we participate with to accept assignments/payments in full for services rendered to your child or children. However, it is the subscriber's responsibility to make sure he/she understands the terms of his/her policy. Please be advised that in the event your family deductible for the year has not been met, you will be responsible to pay for the child's consultation in **full at the time of service.**

It is the office policy to collect any/all co-payments due at the time of visit/service, including payment for services/tests not covered (such as Urine Analysis, Tuberculosis Screening, and/or any vaccines not covered under your insurance terms).

All co-payments not paid at the time of service will be billed with an additional $5 to cover administrative cost. **WE DO NOT ACCEPT PERSONAL CHECKS.**

EFFECTIVE MARCH 10, 2014, A NO SHOW FEE OF $20.00 WILL BE ADDED IF YOU DO NOT CALL TO CANCEL YOU'RE APPOINTMENT WITHIN 24 HOURS OF YOUR APPOINTMENT TIME.

Managed care and HMO insurance companies have many rules and regulations. Because we participate in many plans, we can no longer be responsible for ensuring your compliance with your insurance company rules.

All HMO carriers require members/enrollees to select a PCP (Primary Care Physician). You must contact your insurance carrier and sure you have selected a provider from our office (Dr. David Sanchez, Dr. Roxane Lacy, Dr. Patricia Mena) as your child's PCP, prior to having services rendered. If a claim is denied because you failed to change your Primary Care Physician (PCP), you will be responsible for the claim(s). If you have not done so already, please inform the office staff so we may assist you in doing so. If a PCP is not selected, you will be responsible to pay (out of pocket) for today's visit in full.

In the event we are unable to confirm your eligibility status for any visits, you will be responsible to pay for the visits. Please note "any money paid for medical services rendered at Suffolk Pediatric are non-refundable". **NO EXCEPTIONS!**

In the event your health plan determines a service to be "**NOT COVERED", you will be responsible for the total charge.** Please contact your insurance carrier directly for answers and other questions. You are ultimately responsible to know your own insurance policy and their limitations.

Responsible Party: _____Date:_____

Parent/Guardian's Signature

Print Patient's Name: _____

SUFFOLK PEDIATRIC, PC

HIPAA PATIENT CONSENT FORM

OUR OFFICE OF PRIVACY PRACTICE PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THE NOTICE CONTAINS A PATIENT RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THE CONSENT. THE TERMS OF OUT NOTICE MAY CHANGE. IF WE CHANGE OUT NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURE WE HAVE ALREADY MADE IN REFERENCE ON YOUR PRIOR CONSENT. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.
- THE PRACTICE HAS A NOTICE OF PRIVACY PRACTICES AND THAT THE PATIENT HAS THE OPPORTUNITY TO REVIEW THIS NOTICE.
- THE PRACTICE RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY.
- THE PATIENT HAD THE RIGHT TO RESTRICT THE USE OF THEIR INFORMATION, BUT THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS.
- THE PATIENT MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME ANY ALL FUTURE DISCLOSURES WILL THEN CEASE.
- THE PRACTICE MAY CONDITION RECIEPT OF TREATMENT UPON THE EXECUTION OF THIS CONSENT.

This consent was signed by:_____
(Name or Representative)

Signature:_____ **Date:**_____

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PARENT CONSENT FORM FOR PHOTOGRAPHY OF CHILD/CHILDREN

As the parent of a child and/or children at Suffolk Pediatric, I agree to the following:

I understand that my child/children, whose name(s) are listed below, may be photographed at Suffolk Pediatrics for the sole purpose of patient identification/records, and used in promoting pediatric patient care services either in print or via Suffolk Pediatrics on the Internet.

Parent/Guardian Name: _____

Relationship to Child/Children: _____ Date: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

I hereby give permission for my child/children to be photographed or their images recorded for print or electronic use in promoting patient care services at Suffolk Pediatrics. Their digital images are recorded for electronic use in patient care service and record identification. I understand that this form will remain in effect as long as my child is a patient here at Suffolk Pediatrics, and there will be no payment for me or my child/children's participation.

Parent/Guardian's Signature: _____ Date: _____

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