PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Sex: M F Birthdate: _____ Home Phone: _____

Home Address: _____
Street (Apt#) City State Zip Code

FATHER'S INFORMATION

Name: _____

Social Security #: _____ Birthdate: _____ Marital Status: S M W D

Home Address: _____
Street (Apt#) City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

MOTHER'S INFORMATION

Name: _____

Social Security #: _____ Birthdate: _____ Marital Status: S M W D

Home Address: _____
Street (Apt#) City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Effective Date: _____

Insured's Name: _____ Copay/Deductible Amount: _____

ID# _____ Group #: _____

Secondary Insurance Company: _____ Effective Date: _____

Insured's Name: _____ Copay/Deductible Amount: _____

ID# _____ Group #: _____

PLEASE READ AND SIGN BELOW

INSURANCE RELEASE: I hereby authorize the physician to release to any party responsible for payment any information acquired in the course of medical examination or treatment. A Photostat of the authorization shall be considered as effective and valid as the original. I request that payment of authorized benefits be made to me or my behalf to the party who accepts assignment, for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to receive direct payment for the amount due in my pending claim for physician's services rendered. I understand that I am financially responsible for charges not covered by this authorization. A Photostat of the authorization shall be considered as effective and valid as the original.

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

(CONTINUED)

NEW PATIENT MEDICAL HISTORY

PATIENT'S FULL LEGAL NAME: _____

BIRTHDATE: _____ SEX: _____

List Hospitalizations (Including significant ER visits): _____

_____

List Surgeries: _____

_____

List Current Medications (and for which condition): _____

_____

List Current Medical Equipment (and for which condition): _____

_____

List Current Specialists (and for which condition): _____

_____

List Allergies to Medicine or Food (and nature of reaction): _____

_____

Social History

Who does the child live with (list): _____

What is the marital status of parents: _____

What school does the child attend and what grade: _____

Sports Participation: _____

Hobbies: _____

Family Medical History (circle relevant conditions and indicate relationship to patient)

Allergy
Anemia
Anxiety or panic disorder
Asthma
ADHD
Arthritis or autoimmune disorder
Autism
Bipolar
Celiac disease
Color Blindness
Crohn's disease or ulcerative colitis
Diabetes
Eczema
Epilepsy
Hearing Loss
Heart attacks before age 40
High cholesterol or triglyceride
Hypertension
Kidney stones
Migraine
Nose Bleeds
Psoriasis
Schizophrenia
Thyroid disease

Patient Name: _____

DOB: _____

Review of Systems

Please circle all symptoms that apply

Constitutional: fevers fatigue weight gain weight loss

Eyes: visual disturbances eye pain eye drainage wears glasses or contacts blindness

ENT: sinus trouble congestion nose bleeds mouth sores frequent sore throats enlarged tonsils hoarseness snoring or sleep apnea hoarseness ringing in ears hearing trouble hearing aid or cochlear implant

Respiratory: chest pain shortness of breath persistent cough asthma symptoms with exercise has a nebulizer

Cardiovascular: heart murmur palpitations high blood pressure heart surgery pacemaker

Gastrointestinal: abdominal pain constipation diarrhea vomiting nausea blood in stools encopresis (has bowel movement accidents) incontinent of stools lack of appetite food intolerance has a gastrostomy

Musculoskeletal: joint pain weakness congenital malformations significant injury uses assist devices

Psychiatric: attention issues impulsivity hyperactivity anxiety depression mood changes cutting behavior suicidal talk or actions eating disorder school problems behavioral problems

Skin: dry skin rashes eczema hives changes in moles lumps in the skin fingernail or toenail problems excessive bruising change in pigmentation

Neurological: headaches fainting seizures tremors insomnia sleep talking/walking cerebral palsy intellectual disability autism spectrum disorder speech delay developmental delay wheel chair bound other assist devices

Endocrine: poor growth or short stature poor weight gain excessive weight gain early onset of puberty excessive thirst excessive urination cold or heat intolerance

Hematology: anemia pallor excessive bleeding excessive bruising enlarged lymph nodes

Allergy: itchy eyes itchy nose sneezing postnasal drip coughing wheezing hives food allergy drug allergy hives

Genito-urinary: bed wetting day time urinary accidents incontinence (must wear diapers) frequent urinary tract infections kidney stones genital lesions abnormal periods

Any other problems you would like to address today: _____

_____

_____

Discussed with patient and reviewed by: _____ Date: _____

(CONTINUED)

Who referred you to our office? _____

Your previous pediatrician: _____

I hereby authorize Dr. Koenig and/or Associates (and their designated staff) to administer any medical treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date

Town & Country Pediatrics, PC

Financial Policy

We would like to thank you for choosing Town & Country Pediatrics, PC as your child's doctors. As one of our patients, we would like to keep you informed of our current office and financial policies. If you have any questions, do not hesitate to ask a member of our staff.

Payments: You may choose to pay by cash, check, Visa, Mastercard, American Express or Discover.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a part to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Co-payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. A $5.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.

Payment options if you have no insurance: Self-pay patients are expected to pay for services in FULL at the time of service.

Monthly Statements: If you have a balance on your account, we will send you a statement. It will show separately the balance, any new charges to the account, re-billing fee, and any payments or credits applied to your account during the month.

Re-Billing Fee: A re-billing fee of $5.00 will be imposed on each account that is not paid by the due date.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs and expenses of collection including, but not limited to our attorney's fees.

Returned Checks: There is a fee (currently $15) for any checks returned by the bank.

Missed/Late Appointment Fee: Patients who do not show up on time for an appointment, or cancel with less than a 24-hour notice will be charged a $20 fee. If you are late for an appointment, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: Our billing department will not get involved in custodial, separation or financial disputes involving or related to divorced parents of a minor child In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent bringing the child in for treatment will be held responsible for the payment due at the time of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will be happy to provide a receipt if you need to seek reimbursement from another party.

Non-covered services: Our office verifies your coverage as a courtesy but there is no guarantee until the claim is processed. It is your responsibility to understand your benefit plan with regards to, for instance, covered services and participating laboratories. For example:

a. Not all plans cover annual physicals, sports physicals, or vision screenings. If these are not covered, you will be responsible for payment.

b. Some insurances limit the number of allowable well visits per year and/or have a dollar maximum of benefits payable for well child services. If this benefit is exceeded, your insurance company will not pay and you will be responsible for payment.

c. Some insurance companies consider visits for ADD or ADHD as mental health and will not cover the claim for services rendered by a medical physician. In this case, you will be responsible for payment.

Well Exam/Sick Visit: During your well exam there may be instances where your child is also sick or presents with a problem/concern. When or if this occurs, we are contractually required to report the additional service(s) to your insurer. Therefore, there may be a copay/deductible cost due for the sick portion of the visit once the claim is processed by your insurance company.

Transferring of records: You will need to request in writing, and pay a reasonable copying fee (currently $15 for paper copies) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Print Name: _____

Signature: _____ Date: _____

Responsible Party: _____ Relationship: _____

Address (if different from patient): _____

_____

Patient Name(s): _____

_____

_____

_____

_____

HIPAA

"Health Insurance Portability Act"

PLEASE COMPLETE THE FOLLOWING FORMS:

Open Authorization to Release Protected Health Information

The purpose of this form is to authorize (if needed) anyone else to bring your child(ren) in if you are unable to do so.

Example: Spouse, grandparents, babysitter, aunt, uncle, etc.

*If your child is brought in by someone not listed on this form we will not be able to treat your child without your consent.

*This also includes if someone were to call about your child for advice, we will not be able to give advice or information, unless they are listed on this form.

Message Consent

This form gives up permission to leave messages regarding your child.

Email Consent

This form gives us permission to communicate via email.

Consent Form

This form gives us your consent to share your children's health information with your insurance company, specialists, etc.

Acknowledgement

Acknowledging that you have received our Notice of Privacy Practices

Town & Country Pediatrics, PC

NOTICE OF PRIVACY PRACTICE

This notice was published and becomes effective on April 14th, 2003.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer, Sheri at the address or phone number at the bottom of this page.

Who will follow this notice?

This Notice of Privacy Practice will be followed by:

- Any health care professional who provides treatment to you;
- All workforce members of Town & Country Pediatrics, PC; and
- All Business Associates with whom we share Protected Health Information.

Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by your attending physician or another workforce member of Town & Country Pediatrics, PC. We are required to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of this Notice that is currently in effect.

Changes to this Notice.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in our waiting room. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be asked to acknowledge in writing the receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you for ***Treatment*** (such as sending medical information about you to a specialist as part of a referral); to ***Obtain Payment for Treatment*** (such as sending billing information to your insurance company); and to support our ***Healthcare Operations*** (such as comparing patient data to improve treatment methods).
- We may use or disclose medical information about you ***without your prior Authorization*** for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for:

Required by Law	Public Health	Communicable Diseases
Health Oversight	Abuse or Neglect	Food and Drug Administration
Legal Proceedings	Law Enforcement	Coroners, Funeral Directors and Organ Donation
Criminal Activity	Inmates	Military Activity and National Security
Workers Compensation	Required Uses and Disclosures	Research (IF APPLICABLE)

- We may also contact you for ***Appointment Reminders***, or to tell you about ***Recommended Possible Treatment Options, Alternatives, Health-Related Benefits or Services*** that may be of interest to you to ***Support Marketing or Fundraising efforts***.
- We may disclose medical information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

Other Uses of Medical Information.

In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing your decision.

Your right regarding medical information about you.

- In most cases, you have the right to ***Access and/or Copy Medical Information*** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the ***Right to Request an Amendment*** to your records, by completing our request for an Amendment of Medical Records Form that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to receive an Accounting of Disclosures made for purposes other than Treatment, Payment or Healthcare Operations or where you specifically authorized a disclosure, when you complete a Request for an Accounting of Disclosures Form. All requests must be for a period less than 6 years and starting April 14, 2003. You may receive the first list request in a 12-month period for free; other request will be charged according to our cost of producing the list. We will inform you of the cost before you may incur any costs.
- You have the right to request ***Confidential Communication***, by completing a Request for Confidential Communication Form. We will attempt to comply with all confidential communications request, such as sending mail to an address other than your home.
- You have the right to ***Request Restrictions*** on how we may use and disclose medical information about you for Treatment, Payment and Healthcare Operations or to persons involved in your care except when specifically authorized by you, when required by law or in an emergency, by completing a Request for Restrictions Form. We will attempt to comply with your request but we are not required by law to accept it. We will inform you of our decision in writing.

Complaints.

- If you are concerned that your Privacy Rights may have violated, or you disagree with a decision we make about access to your records, you may contact our Privacy Officer to file a formal complaint; or
- You may send a written complaint to the Secretary or the U.S Department of Health and Human Services. Please contacts our Privacy Officer to obtain additional information on how to file this complaint.

Under no circumstances will you be penalized or retaliated against for filing a complaint.

You may contact our Privacy Officer, Sheri at 314-994-0209 extension 122 or in writing for further information concerning any of the information in this notice.

Town & Country Pediatrics, PC

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
****Please list ALL children (under 18) we will be caring for****

PATIENT NAME(S)	Date of Birth

I, _____ hereby authorize **Town & Country Pediatrics, PC** to release any and all Protected Health Information (PHI) maintained in my child's Medical Record to the following individuals, concerning my child's status as a patient, treatment or payment services provided by **Town & Country Pediatrics, PC**

NAME	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is given freely with the understanding that:

1. This authorization is valid until revoked by me.
2. I may revoke this authorization at any time, except where information has already been released, by completing Town & Country Pediatrics, PC's Revocation of Authorization Form.
3. Individuals listed on this form will be able to receive any and all information related to my child's status as a patient, treatment or payment of services provided to me by Town & Country Pediatrics, PC during the time period in which this authorization is valid.
4. Individuals not listed above will be unable to receive any information regarding treatment or payment for services provided to my child without my prior written authorization.
5. Town & Country Pediatrics, PC and its workforce members are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

_____	_____
Parent's Signature (or personal representative)	Date
_____	_____
Relationship to Patient	Witness

For office Use only

Date of Receipt		Signature	

Town & Country Pediatrics
3009 N. Ballas Road, Suite 131A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

Due to the new federal privacy regulations, we cannot leave messages with Protected Health Information (PHI) on home answering machines or with family members without written permission.

Patient name(s) _____

_____

_____

_____

_____

_____

I give Town & Country Pediatrics, PC permission to leave messages

_____ On my home answering machine/voice mail

_____ On my cell phone voice mail

_____ On my work answering machine

_____ With the person listed (name and relationship)

_____

_____

_____
Signature

_____ I do not want medical information released except personally to myself

_____
Signature

Town & Country Pediatrics, PC

EMAIL CONSENT

Email information will be added to our private email account for office updates/Immunization/Scheduling reminders only.

PRIMARY EMAIL ADDRESS:
ALTERNATE EMAIL ADDRESS (optional)

	Please check the box if you would like to sign up for our patient portal. A link will be emailed to you to create a log in and password.
The patient portal will give you access to immunization records, show any appointments scheduled-request to schedule appointments, update your childs records.	

HIPAA EMAIL CONSENT

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Town & Country Pediatrics, PC to send me personal health information via unencrypted email.

_____	_____	_____
Signature	Printed Name	Date

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

_____	_____	_____
Signature	Printed Name	Date

Patient Name(s)	Date of Birth

Town & Country Pediatrics
3009 N. Ballas Road, Suite 131A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

CONSENT FORM

I understand as part of my healthcare, Town & Country Pediatrics, PC originates and maintains health records describing my health history, symptoms, examination and rest results, diagnoses, treatment, and any plan for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have received the Town & Country Pediatrics, PC's *Notice of Privacy Practices,* which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting Town & Country Pediatrics, PC's Privacy Officer at (314) 994-0209.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting Town & Country Pediatrics, PC's Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

This consent is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as the original.

_____ _____

Print Parent's Name Date

_____

Parent's Signature (or personal representative)

_____ _____

Witness

NOTICE OF PRIVACY PRACTICES

Acknowledgement

I acknowledge that I have received a summary of Town & Country Pediatrics, PC's Notice of Privacy Practices and consent to use or disclosure of my protected health information by Town & Country Pediatrics, PC for the purpose of diagnosing or providing treatment to my child, obtaining payment for my health care bills, to conduct health care operations of Town & Country Pediatrics, PC and as required by law.

I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patients of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Town & Country Pediatrics, PC reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

_____

_____

_____

_____

_____

Name of Patient(s)

_____

Signature of Parent (or personal representative)

_____

Relationship to Patient

_____

Date

Town & Country Pediatrics
3009 N. Ballas Road, Suite 131A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

Town & Country Pediatrics patients:

You can now make arrangements for your health care bills to automatically be charged to your credit card. This means one less bill you have to write a check for.

Many patients appreciate the ease of automatic payment payments, knowing there are safeguards to protect them from misuse. Plus there is no worry about re-billing fees being added to your account because your payment arrived a few days late.

With our Automatic Credit Card Payment program, we will charge the credit/debit card of your choice each month for the previous month's activity.

Naturally, if you enjoy writing checks each month, you can continue to pay your bill just as you have in the past.

We've enclosed more information about this program plus sign-up materials.

Sincerely,

Billing/Collection Department

MAKE IT EASY ON YOURSELF

Save yourself the time and bother of writing a check and finding a stamp to make your payment.

Fill out the authorization agreement, and return to us. After that, we will automatically make your payment for you.

AUTOMATIC PAYMENT PLAN

The most commonly asked questions about Town & Country Pediatrics payment plan.

1. **What is the Automatic Payment Plan?**

   The automatic Payment Plan is a convenient way to make your payment. Town & Country Pediatrics received your payment as authorized by you by directly charging your credit card or debit card for the amount of your balance. There are no checks to write.

2. **How will I know how much will be deducted from my account and on what date?**

   The amount of your copay will be deducted on the date of service. The amount of any deductible/co-insurance will be deducted from your credit/debit card on or after the 20th of the month.

3. **What if I discover an error has been made after charges have been applied against my account?**

   You should contact Town & Country Pediatrics billing department immediately.

4. **Will I get a receipt?**

   A receipt will be emailed to you when a transaction has been made. You may receive a paper copy also.

5. **How can I be sure that there will not be any unauthorized charges against my account?**

   You are protected by federal regulations governing electric transfers which are subject to stringent safeguards.

6. **How do I sign up?**

   Return the authorization agreement and we will take care of the rest.

7. **What if I want to cancel the Automatic Payment Plan?**

   You may cancel the Automatic Payment Plan at any time be sending Town & Country Pediatrics written notice 10 days in advance.

8. **What happens if I want to charge another account?**

   You must notify Town & Country Pediatrics of the new account information.

AUTOMATIC PAYMENT PLAN

Town & Country Pediatrics
3009 N. Ballas Road, Suite 131A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

I authorize Town & Country Pediatrics to automatically charge my credit card (Visa, Mastercard, Discover, American Express) listed below for the items listed on the monthly statements for:

Patient Name	DOB
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization will remain in effect until I cancel in writing.

Please check all that apply:

	I authorize payment for office visit copay's
	I authorize payment for any remaining balance after insurance has been billed. (co-insurance, deductible, non-covered charges, etc.)
	I authorize a maximum charge of $_____
	No minimum or maximum limit

CARD TYPE	CARD NUMBER	3 DIGIT SECURITY CODE	EXPIRATION DATE
VISA			
MASTERCARD			
DISCOVER			
AMERICAN EXPRESS			

Name as it appears on the card _____

Home Telephone # _____ Cell Phone # _____

Home Address _____

Email (receipt will be emailed to you) _____

Authorized Signature: _____ Date: _____