Patient Information

Date: _____/_____/_____

Patient Name_____ D.O.B. _____/_____/_____ SSN: _____-_____-_____

Patient Name_____ D.O.B. _____/_____/_____ SSN: _____-_____-_____

Patient Name_____ D.O.B. _____/_____/_____ SSN: _____-_____-_____

Mother's Information

Name: _____

SSN: _____ - ____ - _____ Date of Birth: _____/_____/_____

Address:_____ Apt.#: _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____ - _____Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Cell Phone Carrier: _____

E-mail: _____@_____

Employer's Name: _____

Father's Information

Name: _____

SSN: _____ - ____ - _____ Date of Birth: _____/_____/_____

Address:_____ Apt.#: _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____ - _____Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Cell Phone Carrier: _____

E-mail: _____@_____

Employer's Name: _____

Insurance Information

Primary Insurance

Name of Insurance: _____

Insurance ID #: _____Group #: _____

Name of Insured: _____ Relationship to Patient: _____

Birthdate: ____/____/_____ SSN: _____ - ___ - _____ Date Employed:_____/_____/_____

Name of Employer: _____

Secondary Insurance

Name of Insurance: _____

Insurance ID #: _____Group #: _____

Address of Insurance: _____

City: _____ State _____ Zip _____

Insurance Phone: (_____) _____ - _____

Name of Insured: _____ Relationship to Patient: _____

Birthdate: ____/____/_____ SSN: _____ - ____ - _____ Date Employed:_____/_____/_____

Name of Employer: _____

Work Phone: (_____) _____ - _____

Address of Employer: _____

City: _____ State _____ Zip _____

Emergency Contacts – NOT PARENTS

1. Name: _____Relationship to patient: _____

Address:_____ Apt.#: _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____ - _____Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ E-mail: _____@_____

2. Name: _____Relationship to patient: _____

Address:_____ Apt.#: _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____ - _____Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ E-mail: _____@_____

Name of person financially responsible: _____

Relationship to patient: _____

Signature of person financially responsible: _____ Date: _____

Patient Information

Date: _____/______/______

Patient Name____ Language Spoken: _____________________________

Child currently lives with: _______________________________

Please check one:

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Race:

___ White ___ Black ___ Asian ___ American Indian ___Alaskan Native ___ Hawaiian Native or Pacific Islander

Patient Name____ Language Spoken: _____________________________

Child currently lives with: _______________________________

Please check one:

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Race:

___ White ___ Black ___ Asian ___ American Indian ___Alaskan Native ___ Hawaiian Native or Pacific Islander

Patient Name____ Language Spoken: _____________________________

Child currently lives with: _______________________________

Please check one:

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Race:

___ White ___ Black ___ Asian ___ American Indian ___Alaskan Native ___ Hawaiian Native or Pacific Islander

Pharmacy Information

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

Preferred Method of Contact – Please Check

Medical Issues: __ Cell Phone __ Email __Home Phone

Reminders: __ Cell Phone __ Email __Home Phone

Billing statements: __ Email __Standard Mail to home address

Cell Number: ________________________________ Email ____

Home Number_______________________________ Address: ______________________________________

Do we have your permission to submit your child's immunization record electronically to the National Vaccine Registry? ____YES _____NO

FAMILY MEDICAL HISTORY
(Please Print)

This form is to gather a family medical history. This helps us to anticipate and help with health problems your child might inherit. This information is, of course, part of your child's confidential medical record.

Patient Last Name Patient First Name Date

_____ _____

Biological Mother Name: _____DOB:_____

Biological Father Name: _____DOB:_____

Maternal Grandmother Name: _____

Maternal Grandfather Name: _____

Paternal Grandmother Name: _____

Paternal Grandfather Name: _____

Siblings

Name: _____DOB:_____

Name: _____DOB:_____

Name: _____DOB:_____

Name: _____DOB:_____

Please indicate if there is a family history of any of the following.

Check all that apply	Relationship to patient and age	Other important information
_____Premature heart disease		
_____Premature high blood pressure		
_____ Eye problems/lazy eye		
_____ Kidney disease		
_____ Juvenile diabetes		
_____ Cancer		
_____ Seizures		
_____ Tuberculosis		
_____ Thyroid disease		
_____ Mental Illness (depression, schizophrenia, etc.)		
_____ Birth defects		
_____Premature death		
_____Intestinal problem		
_____Other ailments		

Premier Pediatrics, Inc.
John Bennet II, M.D.

(OVER)

Please list the ages, health statuses, and any medical problems of your child's grandparents.

_____
_____
_____
_____
_____
_____

Please list any other health concerns about your family medical history.

_____
_____
_____
_____
_____
_____

This from is to gather medical history. This helps us to anticipate and help with health problems your child might inherit. This information is, of course part of your child's <u>confidential</u> medical record.

PREMIER PEDIATRICS INCORPORATED

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Without specific written authorization we are permitted to use and disclosure health care records for the specific purposes of treatment, payment, and health care operations.

- **For Treatment**: Treatment generally means the provision coordination or management of health care and related services among health care providers or by a health care provider with a third party consultation between health care providers regarding a patient for the referral of a patient from one health care provider to another.
- **For Payment:** Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of our health plans to obtain premiums to fill their coverage responsibilities and provide benefits under the plan and to obtain or provide reimbursement for the provision of health.
- **For Health Care Operation**: Health care operations and certain administrative financial, legal and quality improvement activities of a covered entity that is necessary to run its business and to support the core functions of treatment and payment.
- To contact you as a reminder that you have an appointment for a treatment or medical care.
- To tell you about recommended possible treatment options or alternatives that may be of interest to you.
- To tell you about health-related benefits or services that may be of interest to you.
- To contact you in an effort to raise money for the practice and its operations.
- To inform a friend or family member, who is involved in your medical care.
- Under certain circumstances, we may use and disclose medical information about you for research purposes.
- When required to do so by Federal State of Local Law.
- When necessary to prevent serious threat to health and safety or the health and safety of public or another person. Any disclosure however would only be to some one able to help prevent the threat.
- If you are an organ donor to organizations that handle organ procurement, or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- If you are a member of an armed forces as required by military command authorities, we may also release medical information about foreign military personnel to the appropriate foreign military authority.
- For worker's compensation or similar programs that provide benefit for work-related injuries or illness.
- For public health activities including to prevent the control of disease, injury or disability to report birth and death, to report child abuse or neglect, to report reactions to medications or problems with products. To notify people of refills and products they may be using, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by laws, to a health over side agency for activities authorized by law. These over side activities include for example audits, investigations, inspections and licenser. These activities are necessary for the government to monitor the health care system, government programs and compliance with Civil Rights laws.

- If you are involved in a law suite or dispute in a response to a court or administrative order, we may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.
- If asked to do so by law enforcement or so in response to a court order, if penal warrant, summons or similar process. To identify or locate a suspect fugitive material for the same person. About the victim of crime if under certain eminent circumstances, we are unable to obtain the person's agreement about death, we believe may be the results of her criminal contact. About criminal contact at the hospital and in emergency circumstances to report a crime. The location of the crime or victims or their identity, discussion or location of the person who committed the crime.
- To a coroner and medical examiner or funeral director is necessary to carry out their duties.
- To authorized federal officials for intelligent, counterintelligence and other national security activities by law.
- To authorized federal officials, provide protection to the President, other authorized persons or foreign heads of State for contact special investigation.

YOUR RIGHTS

We have the following rights regarding medial information we may obtain from you:

- **The Right to Inspect and Copy**: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. But does not include psychotherapy notes. To inspect and copy medical information that may be used to make a decision about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that denial to be reviewed. Another license health care professional chosen by the hospital for review your request and the denial. The person conduction the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend:** If you feel your medical information, we have about you is incorrect or incomplete you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted. In addition, you must provide a reason to support your request.
  We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  Was not created by us, unless the person or/and to see who created the information is no longer available to make the amendment:
  It is not a part of medical information kept by for the practice.
  It is not part of the information, which he would be permitted to inspect and copy or
  It is accurate and complete.
- **Right to an Accounting Disclosure:** You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures you much submit a request in writing. Your request must state the time, period which you may not be longer than six years and may not include dates before April will amend that date. Your request should indicate in what form you want the list. For example on paper or electronically. The first list your request within the 12-month period will be free. For additional list, we charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions:** You have the right request restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit of the medical information we disclose about you to someone who is involved in your care or the payment for your care by the family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required

to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **To request restrictions**, you must make your request in writing. In your request, you must tell us (1) what information you want to limit. (2) whether you want limit or use disclose or both. (3) to whom you want the limits to apply, for example disclosures to your spouse.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you ask that we only contact you at work or by mail. To request confidential communication, you must make your request in writing. We will not ask you the reason for your request. We will accommodate any reasonable request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of this Notice:** You have a right to a paper copy of this notice. You may ask us to give your copy of this notice at anytime. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact our office.

OUR RESPONSIBILITIES

We reserve the right to change this notice. We reserve the right to make the revised or change notice affective for medical information we already have about you, as well as information we receive in the future. We will post a copy of the current notice in hospital. The notice will contain on this first page in the top right hand corner, the effective date. In addition, each time you register at or admitted to the hospital for treatment for health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and provide you with a notice of legal duties in privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms and Notice of Privacy Practices currently in effect. We reserve the right to change terms of our notice of privacy practices and to make a new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted from the effective date and you may request a written copy of the revised notice from this office.

You have the right to file formal written complaint with us at the address below or the Department Of Health And Human Services Office or Civil Right in the event you feel your privacy right had been violated. We will not retaliate against you for filing a complaint.

For information about our Privacy Practices, please contact:
Office Manager – Beth Turk
Premier Pediatrics, Inc.
26040 Detroit Road, Suite 7
Westlake, OH 44145
440-871-1717

For information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201
877-696-6775

Acknowledgement of Receipt of Privacy Practices

I have received a copy of **Premier Pediatrics, Inc.** Notice of Privacy Practices with an effective date of Notice of Privacy Practices.

_____

Name of Patient/Guardian

_____

Address of Patient/Guardian

_____

Signature of Patient/Guardian

_____

Date

Premier Pediatrics, Inc. – Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Please initial on each line and sign at the bottom recognizing that you have read and agree to each line item

_____On arrival, please check in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

_____While the filing of insurance claims is a courtesy that we extend to our patients; **all charges not covered by your insurance company are your responsibility**.

_____According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and any charges not covered by your plan.

_____It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

_____If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.

_____If you have no insurance, payment for an office visit is to be paid at the time of the visit. There is also a $21 charge per vaccine if you are uninsured.

_____Co-payments are due at time of service. A **$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the business day.

_____Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. All **balances are due upon receipt** of your bill.

_____If previous arrangements have not been made with our billing office; any account balance outstanding greater than 30 days will be charged a $10 late fee. Any balance over 60 days will be forwarded to a collection agency. If forwarded to a collection agency you will be responsible for any and all collections fees assessed.

_____We require 24-hour notice for canceling any appointments. There is a **$75** charge for any appointment if it is not canceled OR if 24-hour notice is not given. You are responsible for this charge regardless of insurance.

_____A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

_____To copy or transfer medical records we charge **$2.73 per page for the first 10 pages; $.57 per page for pages 11-50; $0.23 per page for pages 51 and higher**. Ohio Law states that Premier Pediatrics has 30 days after the receipt of your request to provide you with your medical record.

_____If your child has school, camp, or sport forms to be completed, there is no charge for the first form. We have a 3 to 5 day turnaround time for all forms. If a form is needed sooner than 3 days, there is an additional **$10** rush fee.

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.

Patient Name(s) _____

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date

PATIENT COPY

Premier Pediatrics, Inc. – Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

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- While the filing of insurance claims is a courtesy that we extend to our patients; **all charges not covered by your insurance company are your responsibility**.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and any charges not covered by your plan.
- It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
- If you have no insurance, payment for an office visit is to be paid at the time of the visit. There is also a $21 charge per vaccine if you are uninsured.
- Co-payments are due at time of service. A **$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the business day.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. All **balances are due upon receipt** of your bill.
- If previous arrangements have not been made with our billing office; any account balance outstanding greater than 30 days will be charged a $10 late fee. Any balance over 60 days will be forwarded to a collection agency. If forwarded to a collection agency you will be responsible for any and all collections fees assessed.
- We require 24-hour notice for canceling any appointments. There is a **$75** charge for any appointment if it is not canceled OR if 24-hour notice is not given. You are responsible for this charge regardless of insurance.
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Premier Pediatrics, Inc.

John B. Bennet II, M.D.
Allison McConville, CPNP

Westlake
26040 Detroit Road, Suite 7
Westlake, OH 44145
Fax: 440-871-3098
440-871-1717

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient: _____ Date of Birth: _____ /_____ /_____

Current Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____

I hereby authorize _____ to release the health information indicated below that is contained in my, or my child's, patient records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient psychotherapy notes (defined as notes that document private, joint, group or family counseling sessions that are separated from the rest of a patient's medical record). Release of psychotherapy notes requires a separate authorization.

Mail to: Premier Pediatrics, Inc. OR Fax: 440-871-3098

Street: 26040 Detroit Road, Suite 7

City: Westlake State: OH ZIP: 44145

Reason for Disclosure:
_____
(Reason for disclosure must be completed prior to processing.)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____. Unless otherwise revoked, this authorization will expire one year from the date of authorization written below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and I understand that my, or my child's, health care will not be affected by whether or not I sign this authorization. I can revoke this authorization at any time, except to the extent that action has been taken. Once my, or my child's, health care information is released, redisclosure of my, or my child's, health care information by the recipient may no longer be protected by law.

If I have questions about disclosure of my, or my child's, health information or this authorization, I can contact:

_____.

_____ _____ /_____ /_____
*Signature of Patient/Patient's Personal Representative** *Date Signed*

_____
Printed Name

_____
Relationship, if not Patient

{4583435:} **If not the patient's signature or a parent signing for a patient under 18 years old, a copy of a legal document verifying the patient's personal representative must be attached.*