New Patient Demographics - Millburn Pediatrics

Patient Name:	Date of Birth:	Gender:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Contact

Primary Contact: _____ Primary Contact DOB: _____
Prim. Contact Relationship: _____ Prim. Contact Cell #: _____
Primary Contact Street Address/City/State/Zip Code: _____
_____
Primary Contact Email Address: _____
Primary Contact Occupation & Employer: _____

Secondary Contact

Secondary Contact: _____ Secondary Contact DOB: _____
Sec. Contact Relationship: _____ Sec. Contact Cell #: _____
Secondary Contact Street Address/City/State/Zip Code: _____
_____
Secondary Contact Email Address: _____
Secondary Contact Occupation & Employer: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____
Pharmacy Street Address: _____

Insurance Information

Insurance Name: _____ Insurance Member/Policy #: _____
Insurance Group Number: _____ Insurance Copay: _____
Responsible Party: _____ Rest. Party DOB: _____

159 Millburn Avenue
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973 912 0155

Understanding Your Insurance

Millburn Pediatrics Providers strongly agree with the AAP recommendations that your child should receive regularly scheduled checkups which may include routine labs, and testing of hearing and vision.

Insurance companies have recently changed what they will cover during a well visit. Our billing office often has calls from parents with questions regarding their bills for charges incurred during a "checkup" that are not covered under routine child care. We have created this "Checkup Primer" to educate families about what is routinely covered at the preventative care visits and what may result in additional charges. We ask that you sign below stating that you understand and agree.

DURING CHECKUPS:

- Measure height, weight and head circumference (depending on age) and plot them using a growth chart. A body mass index (BMI) is calculated for all children older than 3 years.
- Thoroughly check body parts and systems
- Discuss age related anticipatory guidance (screenings)
- Discuss safety issues
- Discuss nutrition appropriate for age
- Discuss development and growth
- Discuss schooling (if age appropriate)
- Refill Medications

Other concerns that are more complicated and involve more time or expertise such as chronic (prolonged duration) headaches, stomach pains, psychological/school problems, or other medical issues usually require a separate code and charge in addition to the checkup. We practice medicine based on guidelines from the American Academy of Pediatrics. Occasionally, some things such as blood work, other labs, prolonged discussions of topics at the time of the checkup and hearing & vision tests are either not covered by your insurance or are put towards your deductible. It is up to your insurance and specifically your medical plan as to if and how they will pay for these charges. We always suggest you check with your insurer or HR department prior to your visit to know just what is covered and what is not by your plan. Like you, we are contracted with the insurance companies and are required to charge you for all copays and patient responsibility charges. There are many different insurance companies. Each company has its own rules, forms, pre-requisitions, fee schedules, reimbursement rates and many other unique things for us to do to get paid. There are variations within each plan. Please make sure you know your plan, so there are no surprises as you are responsible for payment of charges not covered by your plan. The care we provide during these encounters is done in the interest of your child's current and future health regardless of insurance/payment issues. Your signature below verifies that you agree to have the testing done, and know that there may be an added expense for which you will be responsible.

Print Patient Name (s) _____

Parent Signature _____Date _____

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Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents not covered by insurance.

Your insurance may **not** reimburse the doctor for lab services done in our office. These include strep, lead, hemoglobin, urine, mono, influenza, blood sugar, occult blood or specimen handling. They may have a contract that requires you to use LABCORP or QUEST LABS. If you would like the test done here, you may be charged.

I am responsible to call my Insurance Carrier and name Millburn Pediatrics as my Primary Care Physician.

I have received the Millburn Pediatrics, PA Privacy Standards Notice of Health Information Practices (effective 4/14/2003.) I understand that Millburn Pediatrics, PA may disclose certain health information to a family member or caregiver because they are involved in my child's health care or payment relating to my health care unless I specify their name in writing Please see our divorce policy if applicable.

_____ _____

Signature of Parent/Guardian/Adult Patient Date

PLEASE DO NOT RELEASE ANY INFORMATION TO:

NAME: _____

ADDRESS:_____

PHONE: _____

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have questions or concerns, please ask a member of our staff.

Appointments

1. We value the time we have set aside to see and treat your child. We do not double book well appointments. If you are unable to keep a Well Visit appointment, we require 24 hours notice. There is a **$50** fee for **MISSED** appointments on **WEEKDAYS** and **$75** on **WEEKENDS** due to these visits being fewer in number but higher in demand.
2. If you are late for your visit (>15 minutes) we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We do appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit. This differs by insurance company, please read your policies carefully.
5. Prior to seeing your physician, you will be required to provide a copy of your up to date insurance card as well as a valid form of ID (this is a government program to protect against identity theft.) We thank you in advance for having these readily available for us to copy and place in your child's chart.
6. There is an additional charge for visits on Saturdays/Sundays/Holidays/Walk-ins that is billed to your insurance company.

Initial_____

Insurance Plans - *Please understand*

1. It is your responsibility to keep us up-to-date with your most current insurance information. *If the insurance information is incorrect, you will be responsible for the charges and payment of the visit.*
2. If your plan requires you to select our practice as your PCP, make sure it appears on your card prior to any visits. *If your insurance company has not been informed that our practice is your PCP, you may be financially responsible for your current visit.*
3. It is your responsibility to understand your benefit plan with regards to covered services and participating laboratories.
4. Not all plans cover annual visits that are made less than 365 days from the last hearing and screenings. If these are not covered, you will be responsible for payment.
5. Your insurance may not pay for in-office testing, such as (but not limited to) hemoglobin, lead, strep, covid, mono, urine dips, molecular tests, covid antigen test, blood sugar and stool occult blood testing. They may prefer you to go to a contracted lab, such as Labcorp or Quest. *If you choose to have these tests done in the office and our insurance does not cover the testing, you will be responsible for the cost*

Initial_____

Referrals

1. It is your responsibility to know if a referral is required to see a specialist, whether a pre authorization is required before a procedure, and what services are covered.
2. Advance notice is needed for non-emergent referrals, typically 3 to 5 business days. Please make this request through the portal and advise the requirements needed to complete the referral.
3. It is your responsibility to know if the selected specialist is in your plan

Initial_____

Vaccines

1. The physicians at Millburn Pediatrics adhere to the American Academy of Pediatrics guidelines on immunizations. Our goal is to complete your child(ren)'s primary vaccine series by the time they are 2 years of age. Then work to ensure that all subsequent vaccines are given on time.
2. IF YOU CHOOSE NOT TO VACCINATE YOUR CHILD(REN), WE ARE NOT THE PEDIATRICS PRACTICE FOR YOU.

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Prescription Refills

1. For ANY medication refills, we require one week's notice.
2. It is YOUR responsibility to make ADHD medication check-ups every three months, we will NOT refill child(ren)'s prescription without an appropriate appointment.

initial_____

Financial

1. As contracted with our insurance company, you are responsible for any and all co-payments, deductibles and coinsurances.
2. CO-PAYMENTS are at time of service. Payments can be made through your portal or the BILL PAY link we provide prior to your visit. We now offer AUTO-PAY. A $10 service fee will be added to your copay if the co-payment is not paid by the end of the business day.
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. For scheduled appointments, prior balances must be paid prior to the visit. Patient balances are available in your portal. An invoice for outstanding balances will be added to your portal on a monthly basis. Your remittance is due within 30 days. Account balances outstanding longer than 30 days will be paid with the credit card on file. If there is no contact made to the office regarding a payment plan and the credit card is declined, a $30 re-bill fee will be added for each monthly cycle.
5. If you have a high deductible plan, you will be responsible for the balance. If you are not able to pay the balance all at once, please make arrangements with our billing manager.
6. We expect balances to be paid by the parent present at your child(ren)'s appointment. We are not responsible for mediating who is responsible for payment.
7. We accept cash, checks and major credit cards. A $25 fee will be charged for any returned checks due to insufficient funds.

Initial_____

Forms

1. If you request forms to be filled out, there is an annual $20 form fee per child. This is a one time a calendar year charge. This fee must be paid prior to completing the form. No exceptions.
2. Please upload your form request to the portal. Make sure your child's name is on all pages and your portion of the form is completed. We cannot clear a child to participate in sports without reviewing the HISTORY PAGE filled out by the family.
3. Please plan ahead. We ask for 7-10 days to complete all forms.

Initial_____

Transfer of Records

1. Please request transfer of records for each child through your portal.
2. If you are transferring to any practice/physician, we will provide a copy of your child(ren)'s immunizations, growth charts and last well visit notes for free, as a courtesy to you. Please give us a week to complete the request.
3. There is a fee for your child(ren's) complete record, $1 per double sided page up to $50.00. The cost to mail the chart is $5-10 depending on the size of the chart.
4. We provide records for visits (including consultations from specialists while your child(ren) was a patient . All PREVIOUS records must be requested from the prior physician.

Initial_____

I have read and understand Millburn Pediatrics office policy and agree to comply and accept the responsibility for any/all payments that become due as outlined above.

Print Patient Name (s) : _____

Parent Signature _____Date _____