PATIENT REGISTRATION FORM

GRACE PEDIATRICS

Today's Date _____

Child's Name: _____
First Middle Last

Child's Birth Date: _____ Sex (circle one): **M** **F**

Address: _____

City: _____ State: _____ Zip: _____

PARENT Information - MOTHER or Legal Guardian

Name: _____ Birth Date: _____
First Middle Last

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

PARENT Information - FATHER or Legal Guardian

Name: _____ Birth Date: _____
First Middle Last

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

OTHER CONTACT Information - NOT parent

Name: _____ Relationship to Patient: _____
First Last

Home Phone: _____ Cell Phone: _____

Siblings (Name and Birthdates)

#1: _____

#2: _____

#3: _____

Health Plan / Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID #: _____ ID #: _____

Group #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Relationship to Patient: _____ Subscriber's Relationship to Patient: _____

Name of Person Completing this form: _____
First Last

_____ _____ _____
Signature Relationship to Patient Date

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Review of Symptoms (current symptoms) 현 증상:

Please circle any of the following that your child is currently experiencing: (please note that if your child is here for well child check-up or annual physical, you might be asked to make a separate visit in the near future to address these concerns. If these symptoms/concerns are required to be addressed during today's visit, there will be separate charges in addition to the well child check-up or annual physical fee).
아이의 현재 증세를 동그라미 쳐 주세요. 혹 오늘 영유아 검진, 소아 정기검진으로 방문을 오셨다면 조만간 따로 예약을 하고 오시기를 권장드립니다. 만약 오늘 아래의 증세에 관해 진료를 받으시면, 정기검진 이외의 추가 비용이 나오실 수 있습니다.

Constitutional	fever (발열), fatigue(피로), dizziness(어지러움), recent unexpected weight loss or gain(최근 체중 변화)
Eyes	eye discharge(눈 분비물), recent changes in vision(최근 시력 변화)
Ear, Nose, Throat	ear pain(이통), ear discharge(귀분비물), hearing disturbances(청력 장애), nasal stuffiness(비폐색), runny nose(콧물), nose bleed(비출혈), sore throat(인후통), hoarseness(쉰소리)
Respiratory	cough(기침), sputum(가래), shortness of breath(호흡 곤란)
Cardiovascular	chest pain(흉통), palpitation(feeling of increased heart rate) (두근거림)
Hematologic	easy bruising(쉽게 멍듬), hard to stop bleeding
Gastrointestinal	abdominal pain(복통), vomiting(구토), heartburn(속쓰림), diarrhea(설사), constipation(변비), bloody stool(혈변), black stool(흑색변)
Genitourinary	difficult/painful urination (배뇨 곤란), frequent urination(빈뇨), blood in urine(혈뇨)
Musculoskeletal	joint pain(관절통), joint swelling(관절 부종)
Skin	rashes(발진), changes in pigmentation(색소 변화)
Neurologic	headache(두통), seizure(경련), loss of consciousness
Psychiatric	depression(우울), hallucination(환청)

Past Illness / Conditions 병력

Please check any of the following that your child has or has ever had in the past:

Y	N		Y	N	
☐	☐	ADHD	☐	☐	High cholesterol(고지혈증)
☐	☐	Asthma(천식)	☐	☐	Heart disease(심장병)
☐	☐	Anemia(빈혈)	☐	☐	Kidney disease(신장병)
☐	☐	Atopic Dermatitis(아토피)	☐	☐	Liver disease(간질환)
☐	☐	Autism	☐	☐	Pneumonia(폐렴)
☐	☐	Broken bones(골절)	☐	☐	Seasonal allergies(알레르기성 비염)
☐	☐	Cancer(암) type(종류):	☐	☐	Sexually transmitted disease(성병)
☐	☐	Developmental delay	☐	☐	Thyroid disorder(갑상선 질환)
☐	☐	Diabetes(당뇨)	☐	☐	Tuberculosis(결핵)
☐	☐	High blood pressure(고혈압)			

If you marked yes to any of the above or there are any other medical conditions that we need to know about your child, please explain in more detail below:

_____

_____

_____

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Surgical Procedures/ Hospitalizations (수술 / 입원 병력)

Procedure	*Year*

Medical problems that run in your family (e.g., diabetes, heart problems, cancer) 가족병력

Medical problem	*Family member*

Known allergies (including medication/food allergies) 알레르기 (약물과 음식 알레르기 포함)

☐ No known allergies

Allergies	*Symptoms(증상)*

Prescription and over-the-counter medications you are currently taking 복용약

(continue on reverse if necessary): 공간이 부족하면 뒷장에 쓰세요.

Medications	*Dosage(용량)*

Birth History 출생력

Birth weight (출생 시 몸무게) : _____ kg/lbs

Birth By(분만 종류): ☐ NSVD(자연분만)
☐ C-section(제왕 절개)

Gestation(임신기간): ☐ preterm, < 38 weeks (조산)
☐ full term, 38-41 weeks (만삭)
☐ post term, > 41 weeks (과숙)

Any complications during the pregnancy(임신중 이상)? ☐ Yes ☐ No

Any complications during and after delivery (분만 중/후 이상)? ☐ Yes ☐ No

Immunizations 예방 접종

☐ Up-to-date (필요한 예방 주사를 모두 맞음)

☐ Behind (필요한 예방 주사를 모두 맞지 못함)

Social History

Who does your child live with? 현재 같은 세대에 거주하는 사람은 ?

Does anyone in your household smoke? 현재 동거하는 사람들 중에 흡연하는 사람이 있습니까? Yes ☐ No

PATIENT REGISTRATION FORM ***GRACE PEDIATRICS***

Office Policies

Please read and initial on each line

_____ *(initial)* **Well Check-ups are Required**

At Grace Pediatrics, we feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the following ages:

- ◊ Newborn period
- ◊ 2 weeks of life
- ◊ 1 month of age
- ◊ 2 months of age
- ◊ 4 months of age
- ◊ 6 months of age
- ◊ 9 months of age
- ◊ 12 months of age
- ◊ 15 months of age
- ◊ 18 months of age
- ◊ 24 months of age
- ◊ 30 months of age
- ◊ 3-21 years of age – on a yearly basis

We expect parents to follow these guidelines so that we may continue to provide quality healthcare to your children. Failure to do so may result in being discharged from the practice. We request that *only* primary caregivers bring children in for well check-ups.

_____ *(initial)* **Mutual Respect of Time**

We pride ourselves on punctuality at Grace Pediatrics. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We may have to reschedule if you arrive more than 15 minutes late.
2. If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time with you and your children.
3. We will provide you with all the time that you need, but when making the appointment, you must tell us ALL of the reasons you would like your child to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.
4. If you are running late, please call the office. We may be able to accommodate you with advanced notice.

_____ *(initial)* **Minors**

A minor must be accompanied by a parent or legal guardian during each visit. If someone other than the child's parent or legal guardian (i.e. grandparent, other family member, etc.) accompanies your child, the parent or legal guardian must complete the Treatment of Minor form before their appointment.

_____ *(initial)* **Insurance Changes**

It is your responsibility to let us know if there are any changes to your insurance. Although we check for your child's eligibility as a courtesy before their appointment, the insurance company's systems do not always display up-to-date information on your plan. Please let us know about these changes before your appointment.

_____ *(initial)* **Notice of Privacy Practices**

I acknowledge that I have read a copy of the Grace Pediatrics Notice of Privacy Practices and have had an opportunity to review it. I understand a written copy will be provided to me at any time upon my request and understand that Grace Pediatrics has a link to the Notice of Privacy Practices on the practice website (irvinegracepediatrics.com). I understand that privacy practices described in the Notice of Privacy Practices may change over time. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

PATIENT REGISTRATION FORM

GRACE PEDIATRICS

_____ ***(initial)*** **Consent for purposes of Treatment, Payment, and Healthcare Operations**

I understand that, as a condition to my child receiving treatment from Grace Pediatrics, Grace Pediatrics may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of Grace Pediatrics. I permit the employees, the doctor, and all other persons caring for my child to treat them in ways they judge are beneficial to them. I understand the physician will explain to me the nature of my child's condition, his or her recommended treatment, and any associated risk involved. I also understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that *no guarantees can be made to me about the outcome of this care.*

I understand that I have the right to revoke/withdraw this consent, in writing, at any time. Provision of future treatment may be withdrawn if I withdraw my consent.

I have read and understand the Grace Pediatrics Office policies and agree to all provisions outlined herein.

First Name Last Name

Signature Relationship to Patient Date

PATIENT REGISTRATION FORM ***GRACE PEDIATRICS***

Financial Policies

Please read and initial on each line

Thank you for choosing Grace Pediatrics as your health care provider. We are committed to quality patient care at the lowest possible cost. Parents are required to pay for their child's health care at the time services are provided. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be noncovered services that are not considered reasonable and necessary by your insurance carrier. Our office cannot tell you in advance whether or not your charges will be covered by your insurance plan. It is your responsibility to familiarize yourself with your own insurance plan and coverages.

_____ *(initial)* **Insurance**

Although we will try our best to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. You are responsible for any and all co-payments, deductibles, coinsurances, and/or any charges that are not covered by your insurance plan. Our office checks your insurance eligibility at the time of your visit as a courtesy; however, coverage is not always guaranteed.

Patient balances are billed after our office receives an explanation of benefits (EOB) from your insurance. Your remittance is due within 30 days of receiving your invoice. Any outstanding account balances that remain unpaid past 30 days will be paid with the credit card on file (see the Credit Card on File Policy). If the credit card on file is declined and no contact is made to the office about a payment plan, the account will be charged a $30 re-bill fee for each monthly cycle. Any outstanding balances that remain unpaid for more than 90 days will be forwarded to a collection agency. If the account is sent to collections, a collection fee of 50% of the outstanding balance will be added to the charge, and the patient will receive a letter of dismissal from Grace Pediatrics.

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT.

_____ *(initial)* **Covered/Non-Covered Services**

Grace Pediatrics is not responsible for knowing your insurance policy coverage. It is your responsibility for any balances that may be due to the provider as a result of:

- Coinsurance or copayments
- Annual deductible amounts
- Non-covered services
- Out-of-network charges
- Terminated coverage
- Exhausted benefits
- No insurance coverage
- Failure to respond to insurance company correspondence or inquiries
- Failure to list our provider as your primary care provider

_____ *(initial)* **Patients Without Insurance Coverage**

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, payments are required at the time of service.

PATIENT REGISTRATION FORM

GRACE PEDIATRICS

_____ ***(initial)*** **Tests recommended during well visits (yearly physicals)**

We pride ourselves on providing only the highest quality care for your child and do this by following recommendations from the American Academy of Pediatrics clinical guidelines. However, tests that are recommended by the American Academy of Pediatrics may not be covered by your insurance plans. Most insurance plans provide coverage for these services; however, it is the patient's responsibility for any charges not covered by insurance. As prompt and appropriate treatment of your child is of primary importance to us, please be aware that we will perform screenings, tests, and non-covered services that we, your trusted providers of care, deem necessary.

Our office DOES NOT CHECK for the following individual coverages (extra cost is indicated below in case those are not covered by insurance)

- Eye/vision screening exam ($10)
- Hearing screening test ($10)
- Developmental screening for young children ($10)
- Depression screening for teens ($10)
- Hemoglobin test for anemia ($20)
- Urine test ($20)
- Blood draw fee ($10)
- Blood test (TBD)
- Lead test (TBD)

_____ ***(initial)*** **Separate sick and well child (checkups) visits**

We understand that other medical issues might come up during your well child visits, and we would like to take care of these issues for your convenience. However, most of the time, your insurance plan will not cover both issues (well and other medical issues/illness). Our recommendation is to address the illness and/or medical issues during a separate sick visit. However, if we discuss and treat medical issues during the well child visit (due to the nature of the illness or per the parent's request), you will be responsible for the charges that are not covered by your insurance plan (copayment, deductible, coinsurance, or the full charge amount).

_____ ***(initial)*** **Tests and Procedures during sick visits**

Tests and procedures that are necessary for accurate and timely diagnoses become the patient's responsibility if insurance plans do not fully cover for those items and/or they fall under the deductible.

Common procedures/test that are performed in our office are listed below. We DO NOT CHECK for the following individual coverages:

- Ear wax removal/cleaning
- Umbilical stump cauterization
- Wart removal
- Removal of a foreign body
- Wound care
- Nebulizer respiratory treatment
- Lung function test
- Blood test
- Urine test
- Rapid Strep test (throat swab)
- Rapid Flu test (nasal swab)
- Rapid RSV test (nasal swab)
- Other tests and procedures that are deemed necessary during each visit.

_____ ***(initial)*** **Tests sent to laboratory and/or imaging centers**

All tests that are sent to a laboratory and/or imaging centers will be billed separately from other facilities. You may be partially or fully responsible for these tests, depending on your medical insurance plan. We DO NOT HANDLE the billing for these tests/studies.

PATIENT REGISTRATION FORM

GRACE PEDIATRICS

_____ ***(initial)*** **Missed Appointment Fee ($50)**

Missed appointments represent a cost to us, you, and to other patients who could have been seen during the time set aside for you. Cancellation notifications are required 1 business day prior to the appointment.

- Appointments not cancelled 1 business day in advance will result in a “No Show” fee of $50.
- If you cancel an appointment that was made on the same day, it will result in a $50 fee.
- If we have to reschedule your appointment because you were late, a $50 fee will be charged.
- This fee must be paid before any future appointments are scheduled.
- Patients with **3** missed appointments within a 12-month period will be asked to transfer their care to another practice.
- Your child’s appointment time will be confirmed via text, email, or phone call prior to their appointment.

_____ ***(initial)*** **Returned Checks**

A $50 fee will be charged for any checks returned for insufficient funds.

_____ ***(initial)*** **Divorce Decrees**

Our office cannot be a party to your divorce decree. The responsibility of the bill for minors is with the parents or legal guardian. It is our policy to *collect payment at the time of service from the parent, guardian, or caretaker who brings the child in for the appointment.* Our primary responsibility is to provide medical care for your child and not handle billing or insurance coverage disputes between separated or divorced parents.

_____ ***(initial)*** **Medical Records**

We will forward your child’s medical record free of charge if we can fax it to a physician’s office directly. However, if you would like to obtain the record for yourself and/or require that a physical copy be mailed to a physician’s office, there will be a fee.

Your child’s immunization records can be printed out at any time at no extra cost to you

_____ ***(initial)*** **Medical Forms**

We provide the service of completing medical evaluation forms (i.e. school forms, sports physical, etc.) for your child. You must notify our office before your child’s appointment that you require a form to be filled out. Please bring the form with you to your child’s appointment to avoid a separate fee.

If you do not bring the form on the day of the appointment, there is a charge of $15 to complete the form. Medical form requests will typically be processed in 2-3 business days. If you require the form to be completed on the same day that is requested, we will try to accommodate it for an additional fee of $30.

_____ ***(initial)*** **Authorization to pay benefits to physician/clinic**

I authorize payment to be made directly to Grace Pediatrics by my insurance company for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I accept financial responsibility for all services not covered by my insurance.

_____ ***(initial)*** **Authorization to release information**

I authorize release of any medical care information acquired during the course of my child’s examination or treatment to their referring physician and/or insurance company. I have requested medical services from Grace Pediatrics on behalf of myself and/or my dependents and understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized.

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_____ ***(initial)*** **Guarantee of Payment**

I understand that filing a claim with my insurance company or other third-party payers does not relieve me, under any circumstance, from my responsibility for payment of all charges. I further acknowledge that I am responsible for payment of all charges for service rendered by Grace Pediatrics to me or my child.

I have read and understand the Grace Pediatrics Financial policies and agree to all provisions outlined herein.

First Name Last Name

Signature Relationship to Patient Date

PATIENT REGISTRATION FORM ***GRACE PEDIATRICS***

Credit Card on File Policy

Grace Pediatrics requires that a valid credit card be kept on file.

This policy is designed to:

- Help avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your children and their medical care

How the policy works:

1. At the time of your registration or check-in, you will be asked for your credit card information to be electronically stored in our secure system.
2. We will bill your insurance carrier as a courtesy for all charges related to the visit.
3. When we receive an explanation of benefits (EOB) from your insurance, we will send you a statement. If we have not received payment by the due date (30 days after invoice), we will charge the credit card on file for the balance due (on statement).
4. If we attempt to use your card and it is declined or expired, we will send you a new statement with a note attached asking for current credit card information. If no contact is made to the office about a payment plan, the account will be charged a $30 re-bill fee for each monthly cycle.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our office as soon as possible. If a mistake has been made, we will reverse the charges.

Until further notice, I ,_____, authorize Grace Pediatrics to charge the patient-responsible balances on my child's account to the following credit card:

_____ _____

Print Name as it appears on your credit card Phone # of Cardholder

_____ _____

Credit Card # Expiration date (mm/yyyy)

_____ _____

Billing Address (Street Number) Billing Zip Code

I have read and understand the Grace Pediatrics Credit Card on File policies and agree to all provisions outlined herein. I agree to provide my credit card information to Grace Pediatrics for the sole purpose of payment for my child(ren)'s medical care. I have the right to cancel this process and use another form of payment.

_____ _____

Signature of Authorized User Date