

Patient Registration

CHILDREN OF JOY
PEDIATRICS



Patient Information

Patient First Name: _____ Patient Last Name: _____
Date of Birth: _____ Sex: _____ E-mail Address: _____
Patient Address: _____
Primary Phone: _____ Day Phone: _____ Mobile Phone: _____
Emergency Contact: _____ Emer. Phone #: _____
Language: _____ SSN: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: Asian Black White Hawaiian Hispano **Who referred you?** _____
Pharmacy Name: _____ Pharmacy Phone: _____

Method of Contact:

Medical Contact: Mail Cell Phone Text Email General Notice: Mail Cell Phone Text Email
Reminders: Mail Cell Phone Text Email Patient Portal: Mail Cell Phone Text Email
Recalls: Mail Cell Phone Text Email

Parent Information

Mother's First Name: _____ Mother's Last Name: _____
Date of Birth: _____ Sex: _____ E-mail Address: _____
Parent Address: _____
Primary Phone: _____ Work Phone: _____ Mobile Phone: _____
Employer: _____ Employer Phone #: _____
Language: _____ Social Security: _____
Civil Status: Single Married Widowed Separated Divorced Common Law
Race: Asian Black White Hawaiian Hispano Ethnicity: Hispanic or Latino Not Hispanic or Latino

Father's First Name: _____ Father's Last Name: _____
Date of Birth: _____ Sex: _____ E-mail Address: _____
Parent Address: _____
Primary Phone: _____ Work Phone: _____ Mobile Phone: _____
Employer: _____ Employer Phone #: _____
Language: _____ Social Security: _____
Civil Status: Single Married Widowed Separated Divorced Common Law
Race: Asian Black White Hawaiian Hispanic Ethnicity: Hispanic or Latino Not Hispanic or Latino

Insurance Information

Primary Insurance Card Holder: _____ Rel. to Patient _____
D.O.B: _____ Sex: _____ Insurance Name: _____
Subscriber ID#: _____ P.O. Box: _____

Secondary Insurance Card Holder: _____ Rel. to Patient _____
D.O.B: _____ Sex: _____ Insurance Name: _____
Subscriber ID#: _____ P.O. Box: _____

We need expressed written permission from you if your child is not accompanied by a parent when visiting Children of Joy Pediatrics. If you expect someone other than a parent will accompany your child (i.e. a grandparent, aunt, uncle, etc.) to his/her appointments or sick visits, please provide their full name and date of birth below. They will need to bring a valid form of identification to the visit.

1. _____ 2. _____ 3. _____

If someone other than the person(s) listed above or a parent accompanies your child on his/her visit to Children of Joy Pediatrics, please be sure to provide us with express written permission permitting them to accompany your child to his/her visit and to have access to your child's confidential medical information.

The information provided above is complete and accurate to the best of my knowledge. If any changes occur I will advise the office.

Patient / Guardian Signature: _____ **Date:** _____

Patient History



Patient Name: _____
Completed By: _____

Date of Birth: _____
Relationship: _____

(Please circle "Y" (yes) or "N" (no) or explain where required. Write N/A if not applicable)

Prior Pediatrician: _____	Last Dental Visit: _____	Last Eye Exam: _____
PREGNANCY & BIRTH Mother age at pregnancy: _____ Mother's any illness: _____ (Medication/Alcohol/Smoking): _____ Birth Place: _____	FAMILY MEDICAL HISTORY: List all blood relatives of your child who have: (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother. (FF) Father's Father, (A) Aunt, (U) Uncle	
Birth Age (Early/Late/On time): _____ Type of Delivery: Vaginal ___ C/S ___ Birth weight: _____ Problems at birth: Breathing? _____ Problems after birth: NICU? _____ Jaundice: Bilirubin level? _____ Hearing test: Passed ___ Failed ___ Hep. B shot given (date): _____ Discharge date: _____ Discharge weight: _____ Feeding: Breast ___ Formula ___ Both ___	Asthma _____ Allergies (Seasonal) _____ Allergies to Food _____ Diabetes _____ Epilepsy/Seizures _____ Heart Disease _____ High Blood Pressure _____ High Cholesterol _____ Tuberculosis _____ HIV/AIDS _____ Migraines/Headaches _____ Respiratory Problems _____	Birth Defects _____ Brain Paralysis _____ Early Deafness _____ Anemia/Blood Disorder _____ Mental Retardation _____ Cancer _____ Cystic Fibrosis _____ Arthritis _____ Muscular Dystrophy _____ Drug Addiction _____ Alcoholism _____ Kidney Disease _____

CHILD'S PAST MEDICAL HISTORY
 Allergic Reactions to (if so, what kind)?

- Medicine: Yes No
- Food: Yes No
- Animals: Yes No
- Insect Bites: Yes No

Immunizations up-to-date? Yes No
 Do you have a record? Yes No
 Medications taken on regular basis? Yes No

Hospitalizations? Yes No
 When? _____ Where? _____
 Why? _____

Serious Injuries/ Surgeries? Yes No
 When? _____ Why? _____

Recurrent Infections?

Ear: <input type="checkbox"/> Yes <input type="checkbox"/> No	Throat: <input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia: <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with hearing: <input type="checkbox"/> Yes <input type="checkbox"/> No
Bed wetting: <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEVELOPMENT & BEHAVIOR
 Age at which child:
 Sat alone _____ Walked _____
 Used sentences _____ Toilet Trained _____

Is Development normal for his/her age? Yes No
 How are grades in school? _____
 Problems in school? Yes No

Behavior problems? Yes No

FEEDING & NUTRITION
 Breastfed? Yes No
 Number of months: _____
 Formula fed? Yes No
 How much a day? _____
 Milk intake: Bottle _____ Cup _____
 Vitamins? Yes No
 Do the vitamins have Fluoride? Yes No
 Special diet? Yes No

Social/ Physiological Issues:

- Divorced
- Death of a loved one
- School
- Family challenges

List all brothers & sisters & their ages:

Other Significant History:

General Consent Form



SECTION A: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Soc Sec#: _____

SECTION B: GENERAL CONSENT TO TREATMENT

I do hereby authorize Children Of Joy Pediatrics and the assistant/s that she may designate to perform the treatment/procedure(s) that are reasonable, necessary, and advisable. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk, and possible consequences involved.

Understanding this, I authorize Children of Joy Pediatrics to perform such examinations, treatment, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent, at any time, to the extent permitted by law.

SECTION C: CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

SECTION D: INSURANCE AUTHORIZATION

I hereby authorize direct payment of medical benefits to Children of Joy Pediatrics for services rendered by any provider in person or under Dr. Miranda's supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-insurance amounts, deductibles and co-pays.

SIGNATURE: _____ Date: _____

SECTION E: PATIENT RESPONSIBILITY AGREEMENT

RESPONSIBLE PARTY (GUARANTOR)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Children of Joy Pediatrics. **This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below.**

Name: _____ Relationship to Patient _____
Home Address: _____
E-mail address: _____ Occupation: _____
Social Security Number: _____ Phone (Home) _____ (Cell): _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. **I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of being made responsible. Furthermore, I agree to pay any collection cost and legal fees incurred by this office with respect to these charges.**

Signature: _____ Relationship To Patient: _____ Date: ___/___/___

CHILD ADVOCACY

As advocates for our young patients, Children of Joy Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

Name: _____
Signature: _____ Relationship To Patient: _____ Date: ___/___/___

**HIPPA (HEALTH INSURANCE INFORMATION & PORTAVILITY ACT)
RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORMS TO PATIENTS:**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY CHILDREN OF JOY PEDIATRICS PHYSICIANS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

Effective 9/23/2013

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulation, Children Of Joy Pediatrics and all similar health care providers are required by federal law to maintain the privacy of your protected health information ("PHI") and will abide by the terms in this Privacy Notice.

Please be advised that CHILDREN OF JOY PEDIATRICS may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you with medical care/treatment when you visit our office, or we treat you in a hospital. Under federal law, we may disclose your PHI to you, or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist, we will forward your medical information to such specialist. We can disclose your PHI for payment purposes to you insurance provider, employer, Medicare, Medicaid or other party responsible for providing you with health insurance coverage for CHILDREN OF JOY PEDIATRICS to be reimbursed for our services rendered to you. We will also use or disclose your PHI for health care operations. For example, when we engage in quality assurance and medical chart reviews. We may also disclose your PHI when required by the Secretary of Health & Human Services. Unless disclosure is required under federal, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with specific requirements of the HIPAA rules without CHILDREN OF JOY PEDIATRICS needing to obtain your authorization if any of the following instances occur:

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect or domestic violence
4. Required by health oversight agency for oversight activities authorized by law
5. Required in the course of any judicial or administrative proceeding
6. If disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
7. Required for a law enforcement purpose to a law enforcement official
8. Required by a coroner or medical examiner
9. Required by and organ procurement organization, for research, or

Additionally, if you are a member of the armed forces, CHILDREN OF JOY PEDIATRICS are permitted to disclose your PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission.

We may also contact you via mail, or phone to remind you of appointments with our office or to discuss treatment alternatives.

In the event our practice wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if CHILDREN OF JOY PEDIATRICS desires to release your PHI for reasons other than treatment, payment or for our practice's operations. For example, if we desire to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you will have the ability to revoke such authorization at any time by sending CHILDREN OF JOY PEDIATRICS a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures only.

Please be further advised that you can access, copy, inspect and amend your medical information that we maintain. Additionally, if you desire, CHILDREN OF JOY PEDIATRICS can provide you with an accounting of all disclosures that we have made of your PHI to third parties, except disclosures for treatment, payment or health care operations and pursuant to authorization.

If you have a dispute with our practice regarding our use of your PHI or disclosure by CHILDREN OF JOY PEDIATRICS and believe that your primary rights have been violated, please contact the Secretary of Health and Human Services to file a complaint. Please understand that CHILDREN OF JOY PEDIATRICS will not retaliate against you in any way for filing a complaint.

Please be advised that you have the right to request restrictions on certain use and disclosures of your PHI to carry out treatment, payment or health care operations or disclosures by CHILDREN OF JOY PEDIATRICS to a family member, relative or close friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you also can request that we send it to an alternative location (different address) and by alternative means.

If you have received this notice in an electronic form and you would like a paper copy, please contact our office. CHILDREN OF JOY PEDIATRICS reserves the right to amend this Notice as revised. Please sign below acknowledging receipt of the CHILDREN OF JOY PEDIATRICS disclosure.

Patient or Representative Signature:

Date _____

Our Policy

Please take a moment and review Children of Joy's office policies and sign below. By signing you understand the policies; if you have any questions feel free to ask any of the staff members.

New Patients

1. If patient's insurance eligibility is unable to be verified on the date of service, you will be obligated to pay the visit (1st visit is \$100.00 sick or well) (2nd or more visits is \$60.00 for sick and \$ 100.00 for well) NOT including VACCINES. After we receive the claim and we are able to verify that it has been paid, we will then reimburse you with a check by mail.
2. **COPAYS must be paid before being seen by the doctor. If the co-pay is unable to be paid at day of service a 3 day grace period is given. After the 3 days there will be a \$5.00 late fee**
3. Patient with balances will be discussed before seeing the doctor.
4. A Payment plan is available and should be arranged if balance is not paid off completely; otherwise patient will not be seen on next visit.

Insurance

- 5 **WE DO NOT ACCEPT MEDICAID WITHOUT AN HMO. A HMO MUST BE CHOSEN. WE ONLY ACCEPT** (Amerigroup, Horizon NJ Health, Americhoice/UHCP, Aetna)
- 6 We accept almost all PRIVATE insurances such as (AETNA, CIGNA, Horizon BCBS, Magnacare, Qualcare, UMR, United Healthcare, Oxford, GHI/ Emblem, Anthem, Alicare, Tricare and SOME Locals, etc.)
- 7 Mothers with newborns and **PRIVATE** insurance have a **30 day grace period** (60 days for Federal Employees only) where the baby will be covered ONLY IF the insurance was notified of baby's birth. On day 31/61 the baby must have coverage.
- 8 Mothers with newborns and **MEDICAID** insurance: If baby was born under mom's HMO (Horizon NJ or Amerigroup) a temporary ID is mandatory prior to the visit otherwise waiting time will be longer.
- 9 **Account balances will be discussed before seeing a provider.** Payment plans are available and should be arranged with a credit or debit card, if balance is not paid in full. Otherwise, we will be unable to be see you on your next visit. (After a 90 Days balances will be transferred to collections)

Appointments

- 10 All visits in the office are by appointment only, we STRONGLY discourage walk-ins.
- 11 All appointments should be cancelled within 24 hour notice prior to the scheduled appointment. Otherwise a **service fee of \$25 for preventive or sick/consults** will apply. For sick visit appointments scheduled the same day, it is your responsibility to call at least 2 hours prior to the appointment otherwise you will be responsible for the service fee.
- 12 Only 2 well-exams per family will be given for the same day at the same time, and with the same doctor. If you have more than two kids the third or the fourth will be seen another day. For sick visit appointments there are no limits per family in one day.
- 13 If patient is late to their appointment; it will be considered as a "no show" when patient comes in, then will be considered a walk-in and will be seen after the rest of the patients in the waiting area have been seen with the next available provider.
- 14 The latest appointment time for a well exam will vary depending on the provider.
- 15 All children under 18 must be present to discuss labs (If co-pay applies, co-pay is due.)
- 16 On most instances wellness visits don't have co-pays but if your child comes and is sick or needs some other medical attention besides a well-exam, they will be liable for any patient responsibility that the insurance applies, (includes co-pays, deductibles, co-insurance)

PCP

- 17 Please, keep in mind; the office has multiple providers. Dr. Miranda will not be available to see your child for every visit. We suggest to set up appointments with your preferred provider ahead of time prior to the child's well exam without any cancelations/reschedules.

Forms

- 18 Referrals are given by the provider ONLY and will not be released at the last minute or while the patient is at the specialist's office. Please, make sure when the provider refers you to a specialist you redeem the referral at the front desk. If your child was seen at the end of the day and the front desk staff have left. Please give us a call the next day and we will make sure we have it ready for you to pick up
- 19 It is not our responsibility to check if the referred specialist accepts your insurance. Please make sure they do if they don't call your insurance and they will assist you with a specialist around your area and that accepts the insurance. If not, you may/will get a bill.
- 20 Physical forms will be filled out within a week from the day it was dropped off at the office. Only if the physical exam, immunization and blood results are up-to-date. If not, time may vary.
- 21 WIC forms and medication (asthma) forms will be filled out within 3 or 4 days.
- 22 If for any reason you decide to transfer your records to another pediatric office there is a transfer fee of \$10.00 per child record. Any open balance will need to be paid in full in order to release any medical records.

Signature: _____

Date: _____

We appreciate all appointments cancelled 24 hours in advance. If in any case an appt. is given for the same day; please, advise us at least 2 hours before.

No Show/ Late Cancellation fee- \$25.00

Missed Co-pay (After 3 Days) - \$5.00

Late Fee on Payment Plan- \$10.00

Ear piercing - \$65.00 (Gold) \$50.00 (Silver)

Record Transfer - \$10.00 per child