Patient Registration

CHILDREN OF JOY PEDIATRICS

Referred by_____

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

CHILDREN OF JOY PEDIATRICS

Patient Name: _____ **Date of Birth:** _____
Completed By: _____ **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? _____

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
_____
Day Care:

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

Recurrent Infections?
Ear: □Yes □No
Eczema: □Yes □No
Seizures: □Yes □No
Anemia: □Yes □No
Asthma: □Yes □No
ADD/ADHD? □Yes □No
Bed wetting: □Yes □No

Throat: □Yes □No
Pneumonia: □Yes □No
Seasonal Allergy: □Yes □No
Skin infection: □Yes □No
Problems with vision: □Yes □No
Problems with hearing: □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

CHILDREN OF JOY PEDIATRICS

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: ___/____/____

CHILDREN OF JOY PEDIATRICS

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 JOYP 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

CHILDREN OF JOY PEDIATRICS

Patient: _____**DOB**_____**Chart**_____

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 a patient's insurance eligibility is unable to be verified on the date of service, you will be obligated to pay the visit (new patient 1st visit is $175.00 for well) (2nd or more well visits $150.00, 1st initial sick visit is $130.00, 2nd or more sick visits $100.00), Tele-Health visits $50.00. These fees DO NOT include VACCINCES, we charge an admin fee of $24.23 for each vaccine. After we receive the claim and we can 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 on the 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 BH).

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 the 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 the balance is not paid in full. Otherwise, we will be unable to be see you on your next visit. (After 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 for 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 a 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 setting 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 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 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 to release any medical records.

Signature: _____ Date:_____

CHILDREN OF JOY
PEDIATRICS
55 & 134 Summit Avenue
Hackensack, NJ 07601
Off. 201-525-0077/Fax 201-525-0072

Parents, Legal Guardian Consent, Companion

Patient:_____ DOB_____

General consent to treatment

I _____authorize Children Of Joy Pediatrics and any/all of its medical providers to perform an examination, treatment/procedure (s), allergy test, laboratory tests that are necessary for my child. I have been informed of the reason for the treatment/procedure (s), along with the expected benefits, risk, and possible consequences involved. Children Of Joy Pediatrics will bill appropriately and send claims to current insurance on file, or is applied to a deductible, or if my insurance is retro terminated I am aware that I will be responsible to pay for the visit.
If a specimen is collected and needs to be performed outside the office such as a laboratory, I give permission to Children of Joy Pediatrics to send the specimen to be tested, and additional expenses may apply if the laboratory does not participate with my insurance, or if my child does not have insurance at the time of the visit and I may receive a statement from the laboratory directly.
Children Of Joy Pediatrics is not responsible for such charges.
I understand I may withdraw my consent, at any time, to the extent permitted by law.

_____
Parent Signature:

_____ _____
Name of Person (allowed to bring child) *Relationship*

Authorization – Non-Parent/Guardian to Accompany Patient

I_____ give permission to_____ accompany, discuss, and share medical information about my child. I further authorize her/him to see all necessary medical records and make health care decisions of a routine nature and determined at the sole discretion of the provider. I also give authority to speak to the doctor, give authorization of treatment, vaccinations, medication, and certain procedures and make general health decisions if I cannot be reached or be present. I am aware that an ID will be required at the time of the visit and a copy will be filed in my child's medical record.

_____ _____
Name of Person (allowed to bring child) *Relationship*

CHILDREN OF JOY PEDIATRICS

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. *I hereby authorize (Name of Provider)_____ Tel_____*

   Fax_____

2. *To disclose information from the health Records of:*

   Print Name_____ Date of Birth_____

   Print Name_____ Date of Birth_____

   Print Name_____ Date of Birth_____

   Print Name_____ Date of Birth_____

Patient Address:_____ ***Patient Phone#***_____

_____

3. *Information to be disclosed:*

   ( ) Complete health record
   ( ) Immunization Record
   ( ) X-Ray/Radiology Report
   ( ) Laboratory Tests
   ( ) History &Physical Examination
   ( ) Consultation Reports
   ( ) Progress Notes
   ( ) Other_____

I understand that this will include information relating to (Check if applicable)

   ( ) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
   ( ) Behavioral health services/psychiatric care
   ( ) Treatment for alcohol and/or drugs abuse

4. *At the request of the patient, this information is to be released to:*

   CHILDREN OF JOY PEDIATRICS
   DR. ROSA J. MIRANDA
   134 SUMMIT AVENUE
   HACKENSACK. NJ 07601
   OFF. 201-525-0077

   PLEASE FAX TO: 201-525-0072

5. *I understand this authorization may be revoked in writing at any time, except to the exent that action has been taken in reliance of this authorization. Unless otherwise revoked, this authorization will expire in 6 months from the date signed. I also understand I may refuse to sign this form that my health care and payment will not be affected Initials_____*
6. *The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the exent indicated and authorization herein.*
7. *I may request a copy of this form after signing Initials_____*

*Patient Parent's Signature:*_____ *Date*_____

*Legal Repfresentative Signature:*_____ *Date*_____

Our Service Fees

CHILDREN OF JOY PEDIATRICS

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