NEW PATIENT INFORMATION

Child's Name:_____DOB:_____ Male or Female

Child's Name:_____DOB:_____ Male or Female

Address:_____

Street Apartment #

_____

Town Zip Code

Parents/Guardians Names: _____

Contact Numbers:

Primary:	Secondary:	Other:

Ethnicity:_____ Preferred Language:_____(Required per State)

May we send statements and reminder cards to your home? **YES** **NO**

May we call you at work? **YES** **NO**

May we call you at home? **YES** **NO**

Who can we call? **Mom only** **Dad only** **Either Parent**

May we leave messages (including lab results) on a voicemail? **YES** **NO**

May we contact you via E-mail? **YES** **NO**

Email: _____

May we speak to other family members regarding your child's treatment? **YES** **NO**

This includes any one who may bring your child in for treatment:

Name:	Relationship:
Name:	Relationship:

_____ _____

Signature of Parent/Responsible Party Date

Relationship to Patient: _____

INITIAL HISTORY QUESTIONNAIRE

Household- please list all those living in child's home

Name	Relationship to child	Age	Health problems

Are there siblings not listed? If so, please list their names, ages and any health problems.

If mother and father are not living together or if the child does not live with the parents, what is the child's custody status? Please note, court documentation may be required.

Previous Doctor:_____

Preferred Pharmacy:_____

Emergency contacts: OTHER THEN PARENT OR GUARDIAN

Name	Relationship to child	Phone

Do any family members smoke inside or outside the home?

_____

Are there guns in the house? _____ If yes, are they locked up? _____

Parents' occupation and place of employment:

_____

INSURANCE INFORMATION

Primary Insurance: _____

Ins. Name ID# Group#

_____

Cardholder's Name Date of Birth

Secondary Insurance if applicable: _____

Ins. Name ID# Group#

I request that payment of Authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Private insurance, and other health insurance to Manchester Pediatric Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance including all reasonable costs and expenses, including attorney's fees incurred in pursuing collections of such charges. I authorize my physician to release any information related to an illness, injury, care or treatment to my insurance company. I hereby authorize as assignee to all necessary information to secure payment.

_____ _____

Signature Date

_____

Printed Name

INSURANCE DISCLOSURE

Our practice accepts most major health plans including CT Medicaid, however, it is your responsibility to ensure that your child has active health insurance at the time of his or her visit. The insurance that we have on file at the time of your visit is the insurance that will be billed.
Your insurance policy is a contact between you and your insurance company. It is your responsibility to understand your coverage and benefits including: waiting period time frames, preventative care limits and maximums (including immunizations, labs, etc.) deductibles and co-pays. We will work very hard to assist you in receiving the maximum benefits available under your policy. While many insurance companies will cover the cost of the entire visit, some do not and certain services may be your responsibility to pay through your deductible. We are unable to tell you what will and will not be covered under your specific insurance policy until a claim has been filed and a response given by the insurance company.

You are responsible for full payment of any charges not covered under your insurance plan. If your insurance plan has a co-payment or is a high deductible plan, the office staff is obligated to collect this at your visit. We accept all forms of payment including check, cash or credit card. Self-pay patients are required to pay at the time of service.
All co-payments and deductibles are due at the time of service.

We will assist you, in your insurance plan requirements, for referral, pre-certification, or authorization to see another doctor or specialist other than your Primary Care Physician (PCP). However, once requested, we require 5-7 business days to fulfill such requests.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the billing department promptly for assistance in the management of your account. If you have not contacted us or paid on your balance for 60-90 days your account ill be reviewed for the collection agency process. All accounts sent to collection will incur a flat, one-time fee of $50.00 administrative service fee.

Returned checks will result in a $25.00 fee that will be posted to your account.
Appointments not cancelled 24 hours prior to scheduled appointment will result in a $25.00 fee. 15 minutes late to an appointment is considered a no-show and will result in a $25.00 fee.

Please feel free to discuss any insurance or financial issues or concerns with the office manager/billing department at any time. Thank you!

I, the under signed, accept and agree to the above stated terms of the Financial Agreement.

_____ _____

Signature of Parent/Responsible Party Date

MANCHESTER PEDIATRICS POLICIES

Late Policy

Manchester Pediatric Associates strives to provide excellent care to all of our patients while making every effort to run on schedule, as we know parents' time is limited and precious. In order to help us see our patients promptly and to avoid inconveniencing patients scheduled for later in the day, patients who arrive more than 10 minutes late for a non-urgent appointment may need to be rescheduled to the next available appointment. A patient who is more than 10 minutes late for a same day sick visit may be asked to see another provider or come back later in the day.

School Forms and Records

Manchester Pediatric Associates will provide a record of the physical or school form at every well child visit within 24 hours of the parents' request. In recognition of the amount of time required by the staff to complete a school form, if a school form is lost or a duplicate required, there will be a $5 charge. All school forms will need to be picked up, we are unable to send school forms via fax. Additionally there is a $0.50 per page fee for any records or print outs requested.

Immunization Policy

Childhood vaccines are one of the most powerful tools in pediatric healthcare. We are now able to prevent many childhood illnesses that once devastated children and families. Manchester Pediatric Associates feels that one of our most important responsibilities in caring for your child is to provide routine vaccinations as per the guidelines set by the American Academy of Pediatrics and the Center for Disease Control. We believe that children should be immunization according to the schedules set by these organizations in order to provide protection against serious, life-threatening preventable illness.

Additionally, Manchester Pediatric Associates recognizes our ethical obligation to protect patients who are either too young to receive vaccines, have a medical problem that prevents them from receiving vaccines, or who have compromised immune systems either through disease or chemotherapy. Ensuring that all patients are vaccinated helps to protect all the patients that come through our doors.

Please do not hesitate to contact us regarding any questions about vaccines or your child's vaccine schedule.

Student Policy

Manchester Pediatric Associates is proud to be a teaching facility. We ask that you please be respectful and open to our students learning in this environment. A provider will always see your child in conjunction with a student.

I, the under signed, accept and agree to the above stated terms of the policies.

_____ _____

Signature of Parent/Responsible Party Date

Financial Policy

At Manchester Pediatric Associates we are committed to providing you with the highest quality medical care. This goal is best achieved if everyone is aware of our policies.

At every visit you are required to present the following:

- Insurance card
- Picture ID (driver's license preferred) for verification of identity and address
- Any change in address or phone number

If you do not have your child's insurance card upon check-in and we cannot verify coverage, you will be considered a self-pay patient.

Initial:_____

APPOINTMENT CANCELATION AND NO SHOW POLICY

Missed appointments for routine/preventative care are very disruptive to our office and deprive others from an appointment with the doctor.

- Appointments not cancelled 24 hours prior to scheduled appointment, will result in a $25 fee for each child.
- Any appointments that are not cancelled and are "No Showed" will result in a $25 No Show Fee.
- 10 minutes late to an appointment is considered too late and the patient will be rescheduled

Initial:_____

CO-PAYMENT/ DEDUCTIBLES

All co-pays and deductibles are due at the time of service. It is your responsibility to know the limits and coverage of your health insurance policy. If you have any questions regarding the payment allowance by your insurance company, please contact your insurance company before the visit.

Initial:_____

BILLING

MPA is required and will submit claims to your insurance company corresponding to your appointment and the services provided to you. You must present your insurance card and any changes in contact information at each appointment in order to ensure proper billing of your claims. Failure to provide accurate information on the date of service may result in an out-of-pocket expense. Your insurance company may charge a copay or deductible as stated in your insurance policy. For vaccinations provided outside of a well visit, you may owe a copay as per your insurance policy. Any balance remaining after your insurance company has completed the claim is your responsibility. This balance may include your deductible, co-insurance and any and all charges not covered by your insurance company. Please be aware that during your wellness exam things may be discussed or performed that are not considered preventative per your insurance guidelines and may result in patient responsibility.

Initial:_____

High Deductible Insurance Plans

If you have a high deductible insurance plan, you will be required to make a payment of $95 per child at the time of the visit. Any remaining balance after the insurance claim has been completed will be billed accordingly. Should the patient responsibility fall under $95, a credit will be applied to your account.

Initial:_____

Balance and Past Due Accounts

Patient balance is due upon receipt of your billing statement. After the second statement, there is a $5.00 fee that will be added to the unpaid balance of each month until resolved. MPA billing department will make every attempt to contact you regarding your account balance. In the event a bill goes unpaid without contacting our billing department to discuss payment options, the account will be turned over to a collection agency. All accounts sent to collection will incur a flat, one-time administrative fee of $50.00, which will be added to the balance of the account. Returned checks will result in a $25.00 fee that will be posted to your account.

Initial:_____

School Forms and Records

MPA will provide a record of the physical or school form at every well child visit within 48 hours of the parents' request. In recognition of the amount of time required by the staff to complete any additional school forms, there will be a $5 per form charge. To avoid this additional charge, we encourage you to make a copy for your records. There will be no charge for records sent directly to another doctor, however there will be $0.50 per page fee for any print out of records requested from parent.

Initial:_____

Outside Services

When Labs, x rays or other tests are ordered by MPA providers, you are responsible to know the limits and coverage of your insurance policy. MPA will not be responsible for any charges resulting from the use of an outside service.

Initial:_____

Please feel free to discuss any insurance or financial concerns with the office billing department at any time.

I, the undersigned, accept and agree to the above terms of the Financial Agreement.

_____ _____ _____

Signature of Parent/Guardian Relationship to the patient Date

Pediatric Health History

Child's Name:_____ DOB:_____ M or F

Answer the following questions (Check Yes or No and fill in the blanks)

1. Where was your child born?_____
2. Were there any problems during pregnancy? If so, please explain?_____
3. During pregnancy did you Smoke? Yes or No; Consume Alcohol/Drugs? Yes or No; Medicines? Yes or No
4. Vaginal or C Section? Any problems?_____
5. What was your child's birth weight?_____height?_____
6. Does your child have a dentist? Yes or No Who?_____
7. Does your child take any medications? Please list_____
8. Has your child ever been hospitalized? Yes or No Why?_____
9. Has your child had any surgeries or serious injuries? Yes or No Please explain:_____
10. Does your child have any allergies to medications? Yes or No _____
11. Does your child have any allergies to food, asthma, hives, eczema or hay fever?_____

Has your child had or currently have had any of the following? (Check Yes or No)

1. problems walking Yes or No
2. problems toilet training Yes or No
3. problems with colic Yes or No
4. problems in school Yes or No
5. problems with sleeping Yes or No
6. problems with bedwetting Yes or No
7. problems with nail biting Yes or No
8. problems with weight/height Yes or No
9. Nursed as an infant? Yes or No For how long?_____
10. problems with diet Yes or No
11. nightmares yes or no
12. discipline or behavior problems Yes or No
13. Ever seen a psychologist yes or no
14. Speech therapist yes or no

For females only (Check yes or no)

1. At what age did your child start her first period?_____
2. Does your child have difficult menstrual periods? Yes or No
3. Is your child taking birth control? Yes or no
4. Has your child had any miscarriages or abortions? Yes or No

Has your child had or currently have any of the following problems? (Check Yes or No)

1. Head Yes or No
2. Eyes Yes or No
3. Ears/nose/throat Yes or No
4. Heart/murmur/high blood pressure Yes or No
5. Stomach/Constipation Yes or No
6. Wear glasses or contacts Yes or No Last Eye Exam?_____
7. Kidney/Bladder Yes or No
8. Lungs/asthma/pneumonia/bronchitis Yes or No
9. Bones/muscles/joints Yes or No
10. Anemia Yes or No
11. Skin/Rashes Yes or No
12. Wear dental bridges/plates/braces Yes or No

- Hepatitis Yes or No
- Chickenpox Yes or No
- Dizzy or passed out during exercise Yes or No
- Diabetes Yes or No
- Had a seizure Yes or No
- Been unconscious / Had a concussion Yes or No

Family History (Check Yes or No)

Maternal family health issues:_____
Paternal family health issues:_____

Any family history of? (Check Yes or No)

1. Diabetes Yes or No
2. Allergies Yes or No
3. TB Yes or No
4. Aids / HIV Yes or No
5. Convulsions Yes or No
6. Heart Disease Yes or No
7. Cancer Yes or No
8. Hepatitis Yes or No

Other Information (Check yes or no and fill in the blanks)

Are you or your children exposed to domestic violence or abuse? Yes or No

Does your child have any other diseases or medical condition not listed on this form? If yes, please explain:

_____

_____

Is your child able to perform activities of daily living? If no, please explain:_____

_____

Any special information about your child or family we should be aware about?

_____

_____

Do you have any religious, cultural, physical or other factors that influence your care? If so, please list:_____

_____

If you have just moved here to the area, where did you previously live?_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any changes in my health or medications as they arise.

Parent or Guardian signature_____Date:_____