



Riverside Pediatrics LLC

1171 East Putnam Avenue, Bldg 2

Riverside, CT 06878-1426

203-629-5800 Fax 203-629-7960

Riverside Pediatrics After Hours Registration Forms

Patient Name _____ Gender _____ Date of Birth _____

Primary Care Doctor _____ Doctor's Phone Number _____

Guarantor Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Email _____

How did you hear about us?

Referral from Dr. _____ Relative/Friend _____ Day Care/School _____ Internet _____ Newspaper/Magazine _____

Yellow Pages _____ Other _____

Insurance Information

Check here if you have medical insurance _____

Name of primary insurance company
Insurance company address/PO box
Responsible party name
Responsible party's date of birth
Member ID _____ Group Number _____
Signature of responsible party

Emergency contact/Name of nearest relative not living with patient

Name _____ Phone Number _____

I understand that if I do not pay as services rendered, a service charge may be added each month if there is an outstanding balance. Should this account become delinquent, I understand that I am responsible for any and all legal fees, court cost and collection fees involved as a result of any collection activity.

I hereby authorize Riverside Pediatrics, LLC to treat and furnish information to insurance carrier concerning the diagnosis and treatment of (Patient Name) _____ . I understand that I am responsible for all charges, regardless of insurance coverage. I also understand that payment copays are due at the time of service and that I am responsible for any cost transferred over to the patient by my insurance carrier.

Signature of Parent or Guardian _____ Date _____

**Riverside Pediatric After Hours
Physician On Call Waiver**



I understand that the physician treating my child is not his/her primary pediatrician and that once Riverside Pediatrics After Hours is closed, I will contact my child's primary pediatrician for any and all medical concerns.

Signature of parent or caregiver _____

Date _____

Riverside Pediatrics, LLC
Official Financial Policies
Payment Agreement

*All patients are required to bring a valid insurance card and credit card to each visit.

Credit cards will be used for any deductible or other medical expenses not covered by insurance that are not paid while in the office and remain unpaid 30 days after patient bill date. *

IF YOU HAVE A MANAGED CARE PLAN IN WHICH WE DO PARTICIPATE:

1. You are responsible for providing us with CURRENT and ACCURATE insurance information at each visit. Notify us IMMEDIATELY of any insurance changes. We will bill your insurance company directly for our services. Your child's name should appear on your insurance card and if a doctor's name is required on the card as your Primary Care Physician, it must be a name of a Riverside Pediatrics, LLC doctor, otherwise full payments may be due at the time of each visit.
2. Copays must be paid at the time of service. If you cannot pay while in the office, payment must be paid by the end of the business day. Failure to do so will result in an additional charge of \$25.00.
3. You may be responsible for fees if routine services provided are not covered by your insurance plan, or if your insurance company denies payment for covered services. You are also responsible for fees incurred if we do not have your current insurance information AT THE TIME OF SERVICE.

IF YOU HAVE A PRIVATE INSURANCE IN WHICH WE DO NOT PARTICIPATE

1. Professional services rendered are charged to the patient, not your insurance company. Payment is expected as services are rendered. We accept cash, checks, Master card, Visa, and American Express. Your insurance company should reimburse you for your payments.
2. You will receive a superbill for each visit. We will submit your initial claim to your insurance plan on your behalf, as a courtesy, and reimbursement will be paid to you directly. If you wish to file a charge with your company yourself, you must obtain a claim form from your carrier. Complete your portion of the form (Part 1 of Part A), attach a copy of the superbill and submit to your insurance company according to their directions. The doctor's signature, which appears on the superbill, verifies the services rendered. Whether we file a claim initially for you, or you file directly, your balance on account with us will remain a patient responsibility and will be collected as such.
3. You will receive a monthly statement if you have a balance due. Payment for services is the patient's responsibility even if the insurance company wrongfully denies the claim. Our office will not collect your insurance payment or negotiate a settlement on a disputed claim. If your claim is denied, you should communicate directly with your insurance company.

IF YOU DO NOT HAVE INSURANCE COVERAGE (SELF-PAY)

1. If you do not have medical coverage, payment in full is due at the time of service. We accept cash, checks, Master Card, Visa, and American Express for your convenience.

COLLECTION/OVERDUE PAYMENT POLICIES

1. We require an active credit card be left on file for all families at Riverside Pediatrics. The credit card you provide will be charged for copays/balances not paid within 30 days of being billed.
2. If we must refer your account to a collection agency or law firm to collect an unpaid balance, you will be required to pay the cost of collection as well as the unpaid balance.
3. There is a \$25 fee in addition to any bank charges associated with checks not honored by our bank.
4. We cannot schedule any non-urgent child care appointments if there is an outstanding patient balance for more than 30 days. Also, completed forms will not be released for patients with an outstanding account balance over 30 days.
5. Patient balance more than 60 days overdue will be subject to a cost of collection of 18% of the principle balance.
6. Patient failure to pay balances for more than 60 days is reason for termination of the physician-patient relationship at Riverside Pediatrics.

MISSED VISITS

Well visits not cancelled 24 hours prior to the scheduled appointment will be subject to a \$100.00 charge. Sick visits not cancelled at least 2 hours prior to the scheduled appointment will be subject to a \$100.00 charge.

We value our patients and their families' time. Please come on time to your appointment so that we are not delayed in seeing other patients. If you are more than 15 minutes late arriving, patients may not be able to be seen by the physician and therefore, will be subject to the missed visit fee.

FORM FEE - \$20 per form

MEDICAL RECORDS - \$0.65 per page

Parent/Guardian Signature: _____

Date: _____

Riverside Pediatrics, LLC
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Riverside, CT 06878

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below.

Reason: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Riverside Pediatrics, LLC
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Credit Card Authorization

Family Name

Name of Child/Children

Visa

Master Card

American Express

Expiration Date

CVV Number

Please print the name as it appears on the credit card

Authorization Signature

Date

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____

AGE _____

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

Lives with adoptive parents Joint custody Single custody

Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

During pregnancy, did mother

Use tobacco Yes No

Drink alcohol Yes No

Use drugs or medications Yes No Used prenatal vitamins

What _____ When _____

Was the delivery Vaginal Cesarean If cesarean, why? _____

Was initial feeding Formula Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

Yes No Explain _____

General DK = don't know

Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to medicine or drugs? Yes No DK Explain _____

Do you feel your family has enough to eat? Yes No DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss Yes No DK Who _____ Comments _____

Nasal allergies Yes No DK Who _____ Comments _____

Asthma Yes No DK Who _____ Comments _____

Tuberculosis Yes No DK Who _____ Comments _____

Heart disease (before 55 years old) Yes No DK Who _____ Comments _____

High cholesterol/takes cholesterol medication Yes No DK Who _____ Comments _____

Anemia Yes No DK Who _____ Comments _____

Bleeding disorder Yes No DK Who _____ Comments _____

Dental decay Yes No DK Who _____ Comments _____

Cancer (before 55 years old) Yes No DK Who _____ Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of first period _____	
Any other significant problem _____				

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.*

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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