Riverside Pediatrics LLC

1171 East Putnam Avenue, Bldg 2
Riverside, CT 06878-1426
203-629-5800 Fax 203-629-7960

Karen Beckman, MD Beth Rosenberg, MD Alejandro Mones, MD

Today's Date:	New Patient: Yes_____ No______
Name of Obstetrician:	Delivered at:
Family Last Name:	

Mother's Name:	Mother's Date of Birth:
Home Address:	Home Phone:
City:	Cell Phone:
State:	Home Fax:
Zip Code:	Email:
Mother's Employer:	Business Phone:
Business Address:	Business Fax:
	Business Email:

Father's Name:	Father's Date of Birth:
Home Address:	Home Phone:
City:	Cell Phone:
State:	Home Fax:
Zip Code:	Email:
Father's Employer:	Business Phone:
Business Address:	Business Fax:
	Business Email:

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 cared 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 communicated 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 changes 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
1171 E. Putnam Avenue, Bldg. 2
Riverside, CT 06878

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPAA"), 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
1171 E. Putnam Avenue, Bldg. 2
Riverside, CT 06878

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
____

List all children including patient:

Last Name	First Name	Sex	Date of Birth	Major Illness	Lives w/patient
		M F			Yes No
		M F			Yes No
		M F			Yes No
		M F			Yes No
		M F			Yes No
		M F			Yes No
		M F			Yes No

Insurance Information

Check here if you do not have medical insurance ________

Name of primary insurance company:
Insurance company address/PO Box:
Responsible party name:
Responsible party's date of birth:
Member ID number:
Group number:
Signature of responsible party:

Name of secondary insurance company:
Insurance company address/PO Box:
Responsible party name:
Responsible party's date of birth:
Member ID number:
Group number:
Signature of responsible party:

Riverside Pediatrics, LLC
1171 E. Putnam Avenue, Bldg. 2
Riverside, CT 06878

I, ____________________________ legal guardian of ____
give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including but not limited to examinations, injections, immunizations, and/or diagnostic procedures including x-rays or laboratory analysis.

I understand that myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except immunization) of my teen (16 years of age or older) without requiring the presence of an adult. However, if my teen needs immunizations, and comes in alone, a parent/guardian must be available by phone for verbal consent.

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

I understand that any person bringing the patient for treatment not listed above must have a letter of consent or treatment may be refused or delayed. I understand that, in an emergency, efforts will be made to contact me prior to rendering of medical treatment, but medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have provided he above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Riverside Pediatrics, LLC of any changes as to the health status of my children or the above information.

Who may we contact in case of an emergency?

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Completed by (print name): ____

Signature:____

Date:____

Well Visit Schedule

Age:	Vaccine/Test Done at Well Visit
2 weeks of age	Weight Check
1 month of age	Weight Check
7 weeks of age	Pentacel #1 Prevnar #1 Rotateq #1
3 months of age	Hep B #1 (if not given in hospital) Hep B # 2 (if given in hospital)
4 months of age	Pentacel #2 Prevnar #2
5 months of age	Rotateq #2
6 months of age	Pentacel #3 Prevnar #3 Flu #1* Vision Screaning
7 months of age	Hep B#2 (if not given in hospital) Hep B # 3 (if given in hospital) Rotateq #3 Flu #2*
9 months of age	Hep B #3 (if not given in hospital)
12 months of age	Hep A #1 MMR #1 Test: Hgb/lead/ppd
15 months	Prevnar #4 Varicella #1
18 months	Pentacel #4 Hep A #2 Vision Screaning
24 months	Test: Hgb/Lead
2.5 years	Growth and developmental check
3 years of age	Vision Screaning
4 years of age (must be at least 4 years of age for this visit)	Kinrix (Dtap#5/Polio#5) Test: Hgb
5 years of age	MMRV (MMR#2/Varivax#2) Test: PPD
10 years of age	Cholesterol Screaning
11 years of age	Start HPV- 3 dose series Menactra TDAP Test: PPD
16-18 years of age	TDAP booster Menactra booster Start Trumemba 3 dose series (meningococcal B)* Test: PPD

*Yearly well visits are recommended

*Flu vaccine only given during flu season

* All Meningococcal vaccines should be completed before college

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?

Condition					
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

Condition	Yes	No	DK	Who	Comments
Liver disease	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Kidney disease	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Obesity	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Drug abuse	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Developmental disability	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ____	Comments ____
Tobacco use	☐ Yes	☐ No	☐ DK	Who ____	Comments ____

Additional family history ____

Past History DK = don't know

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

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

Has had first period ☐ Yes ☐ 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.

Copyright © 2010 American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.

HE0328

9-223/0109