NEW PATIENT PACKET

*****If multiple children have differing parents, insurance or addresses please complete a separate form for each.**

Child #1:
First Name: ______________________ Middle Initial: ____ Last Name: __________________________
DOB: _____/______/________ Sex: M F _______ Mobile # (>14yr) _____________________________
Languages spoken: ______________________________ Ethnicity: Hispanic Non-Hispanic Other
Race: _______________________ Primary Physician: ____

Child #2:
First Name: ______________________ Middle Initial: ____ Last Name: __________________________
DOB: _____/______/________ Sex: M F _______ Mobile # (>14yr) _____________________________
Languages spoken: ______________________________ Ethnicity: Hispanic Non-Hispanic Other
Race: _______________________ Primary Physician: ____

Child #3:
First Name: ______________________ Middle Initial: ____ Last Name: __________________________
DOB: _____/______/________ Sex: M F _______ Mobile # (>14yr) _____________________________
Languages spoken: ______________________________ Ethnicity: Hispanic Non-Hispanic Other
Race: _______________________ Primary Physician: ____

Child #4:
First Name: ______________________ Middle Initial: ____ Last Name: __________________________
DOB: _____/______/________ Sex: M F _______ Mobile # (>14yr) _____________________________
Languages spoken: ______________________________ Ethnicity: Hispanic Non-Hispanic Other
Race: _______________________ Primary Physician: ____

Guardian #1 information:
First and Last Name: ____________________________________ DOB: _____________ Sex: M F U
SS#_____-_____-_________ Phone#:________________________ Relation:______________________
Email:______________________________ Appointment reminders: Email Text None
Address: ____
Resides With? Yes No
Custody: Joint Exclusive None Other:
____
If exclusive or None please provide court orders*

Guardian #2 information: (If applicable)
First and Last Name: ____________________________________ DOB: _____________ Sex: M F U
SS#_____-_____-_________ Phone#:________________________ Relation:______________________
Email:______________________________ Appointment reminders: Email Text None
Address: ____
Resides With? Yes No
Custody: Joint Exclusive None Other:
____
If exclusive or None please provide court orders*
Are parents: Married Single Divorced Separated Widowed
Other/additional information: ______________________________
Living arrangements: Both Parents Father Mother Parent and Step Parent
Other/additional information: ____
Preferred Pharmacy name and location: ____

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

I hereby authorize the following people to bring my child(ren) to appointments without a parent or guardian present. I authorize them to consent to all examinations, tests, procedures, and treatments deemed necessary by the provider. The providers may discuss diagnosis or treatments with the authorized person(s) listed below. I realize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice.

Full Name	Relationship to Patient	Phone Number

Emergency Contact	Relationship to Patient	Phone Number

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Ocean Pediatrics. will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Ocean Pediatrics within this period, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS AND RELEASE MEDICAL INFORMATION

- I authorize Ocean Pediatrics to file insurance claims for services and supplies provided to my child(ren).
- I authorize Ocean Pediatrics to release my child(ren)'s medical and billing information to referring or consulting physicians and to the patient's insurance company. This information may be transmitted electronically.
- I authorize that all third-party benefits payable to me be paid directly to Ocean Pediatrics.
- I assign to Ocean Pediatrics all payments for medical services and supplies provided to my dependent child(ren). I understand that I am financially responsible to Ocean Pediatrics for the above-named patient(s).

AGREEMENT TO POINT OF SERVICE CO-PAYMENTS, DEDUCTIBLES, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

- I understand that Ocean Pediatrics cannot bill for co-payments. Any payments or payments for non-covered services are due at the time of medical services being provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid for by my insurance plan.
- I understand that if my insurance plan has a deductible amount, a $100 payment will be collected at the time of service. This amount is an estimate and will be applied toward my deductible. Any remaining balances after insurance processing will be billed to the insurance subscriber.
- If my insurance company fails to fully compensate Ocean Pediatrics any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third-party payer within 45 days from the date of service. If I fail to pay within 30 days, from statement date, Ocean Pediatrics has the right to charge my payment card that I have on file with them. In the event Ocean Pediatrics refers my account to an attorney to collect any monies owed to Ocean Pediatrics. Ocean Pediatrics shall be entitled to recover reasonable attorney's fees and costs of litigation.

***I acknowledge that I have received or reviewed a copy of the following: 1) Notice of Privacy Practices and 2) Ocean Pediatrics Office Policies Please initial. __________

Parent/Guardian Signature ____ Date_________________

Pregnancy and Birth History

Problems during pregnancy	No	Yes
Medications	No	Yes
Smoking/Alcohol/Drug	No	Yes
Diabetes	No	Yes
Illness during pregnancy	No	Yes

Other ________________

Delivery: Vaginal Cesarean Section
Reason for C/S:________________________________
Full Term Premature # weeks: _______
Birth Weight __________Birth Length __________

Problems immediately after birth:

Infection	No	Yes	____________
Breathing Difficulty	No	Yes	____________
Jaundice	No	Yes	____________
Home with mother	No	Yes	____________

Other__________

Medical History

Current Medication(s)
____
Medication Allergies
____
Food Allergies
____
Hospitalizations
____

Previous infections/problems:

Anemia	No	Yes
Asthma	No	Yes
Bedwetting	No	Yes
Bladder or kidney infection	No	Yes
Chicken pox	No	Yes
Constipation	No	Yes
Convulsions or seizures	No	Yes
Ear infection	No	Yes
Eczema	No	Yes
Hay fever	No	Yes
Hearing problems	No	Yes
Learning problems	No	Yes
Sleep problems	No	Yes
Speech	No	Yes
Transfusion	No	Yes
Vision problems	No	Yes
Weight problems	No	Yes

Developmental History

Child was able to do the following at what age:

Smile	_______	Sit Alone	_______
Roll Over	_______	First Words	_______
Toilet trained	_______	Crawl	_______
Walk alone	_______		

Family History

Alcohol or drug problems	No	Yes	________
Allergies	No	Yes	________
Asthma	No	Yes	________
Birth defects	No	Yes	________
Blood diseases	No	Yes	________
Blindness	No	Yes	________
Cancer	No	Yes	________
Convulsions	No	Yes	________
Elevated cholesterol/trig	No	Yes	________
Deafness	No	Yes	________
Death in childhood -incl. SIDS	No	Yes	________
Diabetes	No	Yes	________
Headaches/migraines	No	Yes	________
Heart defects -incl. congenital	No	Yes	________
Heart attacks	No	Yes	________
If yes, at what age?			________
Hip dislocation	No	Yes	________
Hypertension	No	Yes	________
Immune deficiency -incl. AIDS	No	Yes	________
Learning problems	No	Yes	________
Liver disease	No	Yes	________
Lung disease	No	Yes	________
Mental retardation	No	Yes	________
Psychiatric disorders	No	Yes	________
Thyroid disease	No	Yes	________
TB test—positive results	No	Yes	________

Conditions that run in the family Social History

Exposure to passive smoke	No	Yes	________
Smoker in the household	No	Yes	________

Household Parent/Caretaker:
Name Age Employer
____
____
Married Divorced Separated Widowed Other
Others in the home:
Name Age Relation to Patient.
____
____
Others important in child's life:
Name Age Relation to Patient.
____
____
Completed by: ______________________________

Date: ______________________________
This information has been reviewed with the guardian(s)

Provider Signature: __________Date: __________

Ocean Pediatrics Office Policies

Please check or initial each policy and sign and date at the bottom of the next page to confirm your understanding.
If you have any questions, please ask our staff.

☐ **Deductibles, Co-payments, and Coinsurance**

All applicable copays, coinsurance, and deductible amounts are due at the time of service. If a deductible applies, Ocean Pediatrics will collect an estimated $100 for the office visit. Any remaining balance will be billed to the guarantor. If your plan includes coinsurance for preventive visits, an estimated patient responsibility amount will be due at the time of service.

☐ **Coverage Terms**

Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your policy's terms and conditions. Ocean Pediatrics will attempt to verify eligibility and benefits as a courtesy, but we cannot obtain exact payment details until the claim is processed.

☐ **Outstanding Balances**

Outstanding balances for all family members must be paid before the physician's visit. Ocean Pediatrics reserves the right to refuse non-urgent medical services if balances are not paid in full before the scheduled visit.

☐ **Insurance Updates**

You are responsible for providing updated insurance information. If charges are denied due to outdated insurance information, the guarantor will be responsible for any unpaid balances.

☐ **Billing Policy**

Ocean Pediatrics will bill your insurance for all procedures performed at the time of service. Once the Explanation of Benefits and insurance payment are received, your account will be credited. Any remaining patient responsibility will be due upon receipt of a statement or at your next appointment, whichever comes first.

☐ **Insurance Company Disputes**

It is the plan holder's responsibility to negotiate payments with their insurance company. Ocean Pediatrics bills your insurance as a courtesy.

☐ **Collection Policy**

If payment is not made upon receiving the billing statement, you may be responsible for interest and penalties. Ocean Pediatrics uses an outside collection agency for unpaid debt. If your account goes to collections, you will be responsible for attorney fees, interest, and penalties. Ocean Pediatrics cannot remove an account from collections once it has been sent. If any family member is sent to collections, the entire family will be discharged from the practice.

☐ **Financial Hardship**

If you encounter financial hardship, Ocean Pediatrics will consider a payment arrangement.

☐ **Walk-ins**

Ocean Pediatrics discourages walk-in appointments as we are better prepared to serve you with advanced notice. If a patient arrives without an appointment, we will triage the situation to determine if urgent care is needed. We will do our best to accommodate the patient in our schedule. A $45.00 walk-in fee will be billed to your insurance. This fee is your responsibility if the insurance does not cover it in full.

Ocean Pediatrics Office Policies – continued

☐ **Check as Form of Payment and Returned Checks**

Checks are not accepted as up-front payment for visits that include vaccines; only cash or credit card will be accepted. A $35.00 fee will be applied for any returned check to cover the bank charge. If a check is returned, checks will no longer be accepted as payment, and only cash or credit will be accepted.

☐ **After hours and weekends**

A $45.00 after hour/weekend fee will be billed to your insurance as a courtesy. Coverage varies by insurance. This fee is your responsibility if the insurance does not cover it in full.

Normal Office Hours

(Last visit is scheduled 15 minutes prior to close)
Monday-Friday: 8:00am to 5:00pm

After Hours and Weekend Hours

(Last visit is scheduled 15 minutes prior to close)
Monday-Thursday: 5:00pm-5:45pm

☐ **No Shows and Cancellations**

If an appointment is missed or not cancelled 24 hours in advance, a $50 fee will be applied to the patient's account. This fee is not covered by insurance and will not be billed to insurance.

☐ **Copy of Medical Records**

A written request must be received before the release of each medical record. Ocean Pediatrics charges a $20.00 clerical fee for each patient's medical records. We have 14 days from the time of the written request and payment in full to provide the records.

☐ **Vaccine Policy**

Ocean Pediatrics strongly advocates for vaccinating children to prevent diseases. We only accept patients who are vaccinated. If you choose not to vaccinate your child, we recommend finding another pediatric group that aligns with your preferences.

☐ **Authorization to Treat a Minor**

Ocean Pediatrics cannot treat any minor (under 18) without a parent or legal guardian present. A minor may be treated in the presence of an adult other than the parent or legal guardian with proper written consent.

Patient Name: ____ D.O.B.__________________

Patient Name: ____ D.O.B.__________________

Patient Name: ____ D.O.B.__________________

By my signature below, I state that I have read and understand the policies of Ocean Pediatrics.

SIGNATURE____ DATE: ______________________

Account #: ___________

Ocean Pediatrics Payment Card on File Agreement

Dear Parent or Guardian,

To streamline our collection process, we ask you to provide a payment card to be securely held on file. Accepted payment cards include debit, credit, FSA, HSA, or HRA cards. Rest assured, your payment card information is stored securely by an encrypted merchant service, and Ocean Pediatrics only has access to the last four digits of your card.

You will have ample time to review and question your insurance company's determination of benefits. If you decline to provide a payment card on file and your account becomes delinquent, a payment card on file will become mandatory.

Please note: It is your responsibility to update any expired cards on file to ensure uninterrupted service.

I authorize Ocean Pediatrics to charge the payment card on file for outstanding patient balances for the following patients:

Patient Name:____________________________________ D.O.B____________________

Patient Name:____________________________________ D.O.B____________________

Patient Name:____________________________________ D.O.B____________________

Patient Name:____________________________________ D.O.B____________________

Last 4 Digits of payment card: ___________________

Authorized Signature: ______________________________Date: _____________________

Printed Name: ____

Account #: __________

Authorization for Ocean Pediatrics to Release Test Results for Patients Under 18 Years of Age

To efficiently communicate lab results, test results, and other important information, Ocean Pediatrics requests that you provide secure telephone number(s) where our staff can leave messages regarding test results. This will help prevent delays in conveying pertinent information about your child. If you have not received lab or test results from Ocean Pediatrics, please contact our office.

I, (parent/guardian) ______________________________, give Ocean Pediatrics permission to leave messages regarding my children results on the numbers listed below.

Primary Contact Name: ___________________________________ Phone: (____) __________________

Secondary Contact Name: _________________________________ Phone: (____) __________________

Signature: ______________________________ Date: _____________________________

Account #: __________