NEW PATIENT PACKET

*** If Children have differing parents, addresses or insurance please fill out an individual packet

Child #1:
First Name: _____ Middle Initial: ____ Last Name: _____
DOB:____/____/_____ Sex: _____ Mobile # (>14yr) _____
Languages spoken: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other
Race:_____ Primary Physician: _____

Child #2:
First Name: _____ Middle Initial: ____ Last Name:_____
DOB:____/____/_____ Sex:_____ Mobile # (>14yr) _____
Languages spoken: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other
Race: _____ Primary Physician: _____

Child #3:
First Name: _____ Middle Initial:____ Last Name: _____
DOB:____/____/_____ Sex: _____ Mobile # (>14yr) _____
Languages spoken: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other:
Race: _____ Primary Physician: _____

Child #4:
First Name: _____ Middle Initial:____ Last Name: _____
DOB:____/____/_____ Sex:_____ Mobile # (>14yr) _____
Languages spoken: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other
Race: _____ Primary Physician: _____

Guardian #1 information:
First and Last Name: _____ DOB:_____ Sex:
SS#____-____-_____ Phone#:_____ Relation:_____
Email:_____
Address: _____

Resides With? ☐ Yes ☐ No
Custody: Joint Other:

_____
If exclusive or None please provide court orders*

Guardian #2 information: (If applicable)
First and Last Name: _____ DOB:_____ Sex:
SS# Phone # Relation:
Email:_____

Resides With? ☐ Yes ☐ No
Custody: Joint

_____
If exclusive or None please provide court orders*
Are parents: Married
Other/additional information: _____

Living arrangements: Both Parents
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, a $100 payment will be collected at the time of service. If my insurance plan has a co-insurance, a $30 payment will be collected at the time of service. These amounts are an estimate and will be applied toward my balance. 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 30 days from the date of my statement. If I fail to pay within 45 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 a collection agency to collect any monies owed to Ocean Pediatrics. Ocean Pediatrics shall be entitled to recover reasonable costs of penalties and interest.

***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
Medications	NO
Smoking/Alcohol/Drug	NO
Diabetes	NO
Illness during pregnancy	NO

Other _____

Delivery: ☐ Vaginal ☐ Cesarean Section

Reason for C/S:_____

Full Term Premature # weeks: _____

Birth Weight _____Birth Length _____

Problems immediately after birth:

Infection	NO	_____
Breathing Difficulty	NO	_____
Jaundice	NO	_____
Home with mother	NO	_____

Other_____

Medical History

Current Medication(s)

_____

Medication Allergies

_____

Food Allergies

_____

Hospitalizations

_____

Previous infections/problems:

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

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

Conditions that run in the family Social History

Exposure to passive smoke	NO	_____
Smoker in the household	NO	_____

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. For deductible plans, an estimated $100 will be collected; for coinsurance plans, $30 will be collected. If your plan includes coinsurance for preventive visits, an estimated amount will also be due. Any remaining balance will be billed to the guarantor.

☐ **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, including balances for all family members must be paid prior to the scheduled visit. Ocean Pediatrics reserves the right to refuse non-urgent medical services if balances remain unpaid.

☐ **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 submit insurance claims for all procedures performed at the time of service. After receiving the Explanation of Benefits and insurance payment, your account will be updated accordingly. Any remaining balance is due upon receipt. If payment is not received after two statements, Ocean Pediatrics will process the outstanding balance using the credit card securely stored on file.

☐ **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 reasonable attorney fees, interest, and penalties. Ocean Pediatrics cannot remove an account from collections once it has been sent. If your account is sent to an outside collection's agency your account and any family member in the practice will be discharged from the practice and requested to find a new physician.

☐ **Financial Hardship**

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

☐ **Walk-ins**

Ocean Pediatrics discourages walk-in appointments, as advanced notice allows us to provide better care. If you arrive without an appointment, we will triage to determine if urgent care is needed and accommodate you as best as possible. A $45.00 walk-in fee will be billed to your insurance; any uncovered amount is your responsibility.

Ocean Pediatrics Office Policies – continued

☐ **Accepted Payment Methods**

Ocean Pediatrics accepts payments via debit, credit cards HSA and HRA only. We accept all major credit card providers including Visa, MasterCard, American Express and Discover.

☐ **After Hours, Weekend and Holidays**

A $45.00 fee applies to visits after hours, on weekends, or holidays. This charge will be billed to your insurance; however, coverage may vary. Any uncovered amount is the patient's responsibility. Please note: our last appointment is scheduled 15 minutes before closing.

Office Hours

Monday-Friday: 9am-5pm

☐ **No Shows and Cancellations**

If an appointment is missed or not canceled 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. After three No Shows your account may be subject to discharge from our practice.

☐ **Copy of Medical Records**

Ocean Pediatrics has 14 days from the written and signed record request to provide the records. An applicable administrative fee may be applied.

☐ **Vaccine Policy**

At Ocean Pediatrics we believe in the importance of vaccinations to protect children from preventable diseases. To ensure the health and safety of all our patients, we require that all children in our care are vaccinated. Our physicians will work with guardians on an alternative schedule, if appropriate. If you prefer not to vaccinate your child, we kindly ask that you seek another pediatric practice that better aligns with your preferences.

☐ **Vaccine Billing**

For all vaccines other than the flu vaccine, our policy requires that each patient be examined and evaluated by a clinician to ensure they are healthy enough to receive the vaccine and that the correct vaccine is administered at the appropriate time. Vaccine schedules are complex, and incorporating alternative schedules can increase the risk of errors. This process is designed to prioritize safety and accuracy. The visit will be billed as appropriate.

☐ **Authorization to Treat a Minor**

Ocean Pediatrics cannot treat minors (under 18) without a parent or legal guardian present. Treatment may occur in the presence of another adult only if proper written consent from the parent or legal guardian is provided.

Patient Name: _____ D.O.B._____

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 require a payment card to be securely kept on file for all commercial accounts. Accepted payment cards include debit, credit, FSA, HSA, or HRA cards. Your payment card information is stored securely through an encrypted merchant service, and Ocean Pediatrics only has access to the last four digits of your card.

You will have sufficient time to review and address any questions regarding your insurance company's determination of benefits before your card on file is charged.

Please note: It is your responsibility to update any expired cards on file to avoid interruptions in service.

I authorize Ocean Pediatrics to charge the payment card on file for any copays, deductibles, co-insurances and/or 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_____

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 #: _____