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New Patient Registration

Patient(s) Information: Please list ALL children who will be seen in this office. Use the back if additional space is needed.

Name: First Middle Last	Date of Birth (dd/mm/yyyy)	M/F	Social Security Number

Address: _____

City: _____ State: _____ Zip: _____

How would you like to be reminded of your child's appointment? ☐ Text ☐ Phone Calls ☐ E-Mail

---

Parent/Guardian: _____

Birthdate: _____/_____/_____

SS#: _____-_____-_____

Address: ☐ Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Choose your relation to the patient:

◯ Mother/Father ◯ Step-parent ◯ Foster Parent ◯ Guardian

Parent/Guardian: _____

Birthdate: _____/_____/_____

SS#: _____-_____-_____

Address: ☐ Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Choose your relation to the patient:

◯ Mother/Father ◯ Step-parent ◯ Foster Parent ◯ Guardian

Emergency Contact	Relationship	Phone Number

121 Golfview Dr. NE, Arab, AL 35016
Phone: (256) 931-5437
Fax: (833) 753-1386

www.kidsruspediatrics.com
kidsruspediatrics@gmail.com

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Primary Insurance Information (if insurance is provided, please complete the information below)		
Insurance Name	**Policy ID #**	**Group #**
Claims Address	**Phone #**	**Patient Relationship to Subscriber:**
Subscriber's Name		**DOB:**
Subscriber Address (if different than guarantor)		**Subscriber Employer**
Secondary Insurance Information (if insurance is provided, please complete the information below)		
Insurance Name	**Policy ID #**	**Group #**
Claims Address	**Phone #**	**Patient Relationship to Subscriber:**
Subscriber's Name		**DOB:**
Subscriber Address (if different than guarantor)		**Subscriber Employer**

Consent For Treatment: I consent to necessary treatment, including drugs, medicine, performance of operation and to conduct x-ray, or other studies that may be used by the treating physician, nurse or staff. Initial: _____

Authorization For Release Of Information: I authorize Kids R Us Pediatrics to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. Initial: _____

Assignment of Benefits: I hereby authorize release of information necessary to file a claim with my insurance company and assign payment of all medical benefits to Kids R Us Pediatrics. In addition, I authorize the release of my child/dependent's medical information by or between my treating physician and my insurer, HMO, health benefits payer, or any other entity (including but not limited to third party administrators, management companies, and provider networks) included in the administration of my child/dependent's health benefits. Initial: _____

Guarantee of Account: For services furnished by Kids R Us Pediatrics I hereby guarantee the payment of all accounts for services rendered**. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney's fee and a collection fee of 50% of the balance due.** Initial: _____

Signature: _____ Date: _____

☐ By checking this box I consent to the use of my e-signature on this form.

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Delegation of Consent To Treat Minor(s)

I/We as the parent(s), conservator(s), or legal guardian(s) of the minor child(ren) named above hereby appoint the individuals listed below in order of appearance to act on my/our behalf to consent to the above specified medical treatment(s)/procedure(s) when I/we am/are reasonably unavailable to grant such consent. If I choose to terminate this delegation, I must contact my practice.

Name of Individual	Relation to Patient (Minor Child)	Contact Information

Statement of Medical Treatment(s)/Procedure(s) to be Given and Purpose of Treatment.

Additional pages may be added if necessary, to describe specified medical procedure(s); it must be signed and dated by parent/conservator/legal guardian. Initial to consent for the following treatments.

Initial Below

_____ Routine pediatric well care including immunizations.

_____ Medical evaluation and management of pediatric outpatient illnesses including both acute and chronic diseases.

_____ Minor in-office procedures

Initial Below

_____ I/We understand that in the event that I/we am/are unavailable to grant consent on behalf of my minor child, the consent of the individual identified above, who I/we have granted authority to consent on behalf of my minor child too, will be considered sufficient for the specified medical treatment(s)/procedure(s) specified above.

_____ I/We will indemnify and hold harmless, from any expense or claim of any nature, any entity that provides or causes to be provided examination, treatment, or hospital care under this Delegation of Consent (except to the extent such entity is negligent therein). I understand that I am responsible for payment of all charges that result from care provided by Kids R Us Pediatrics, including amounts not covered by my health plan.

By signing below, I consent to the use of my e-signature on this form and acknowledge that I have read, understand, and agree to this Delegation of Consent.

_____ _____

Parent/Conservator/Legal Guardian Date

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Office Information and Policies

We have regular hours of operation
We are open Monday through Thursday 8 am to 4 pm and on Fridays 8 am to 12pm. We are closed for lunch from 12pm-1 pm. We are closed on the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, Day after Thanksgiving, Christmas Eve, Christmas Day. We will be open New Year's Eve until noon. Acknowledge ☐

We are available after hours when you need us
We understand that kids get sick at night, on weekends, and on holidays! Our pediatric triage nurse is always available when the office is closed. If the triage nurse cannot offer advice, Dr. Miller is always on back-up call. In addition to our triage nurse, we have a symptom checker and dose calculator available to all of our patients on our website that we encourage you to use.

Patients should not use text messaging, Facebook messenger, or any other social media to contact us regarding patient issues as these are not HIPAA compliant. Our patient portal is available for non-urgent after-hours questions and is HIPAA compliant. Acknowledge ☐

We are a vaccinating practice
Vaccines are one of the most important services we offer as a pediatric practice. We follow the schedule endorsed by the American Academy of Pediatrics and Centers for Disease Control. We understand there may be times when you have questions or are hesitant about certain vaccines and we are here to help! We will gladly answer all of your questions about vaccination. If you ultimately decide that vaccines are not right for your family, we will ask you to find a different pediatric medical home. Acknowledge ☐

Well child care is a priority and required of our patients
We do not only want to see you when your child is sick! Well child visits are vital to maintaining the health of children. At well visits we are looking at weight, height, conducting vision, hearing and developmental screenings, which are necessary to ensure proper growth. Well child visits are required at the following ages: newborn, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years and every year annually until age 18. Failure to maintain regular well child exams will result in dismissal from the practice. Acknowledge ☐

We offer same day sick appointments
We understand that when your child is sick, you'd like for them to be seen in a timely manner. We are not a walk-in clinic, but we offer same day sick appointments during our regular office hours. Please call us to schedule a same day appointment. Acknowledge ☐

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We prescribe antibiotics only when needed. We do not routinely prescribe antibiotics over the phone.
Antibiotics treat bacterial infections, but not all illnesses are caused by bacteria. In fact, most illnesses in children are caused by viruses. Our promise to you is that we will use our pediatric diagnostic and exam skills to determine if your child needs an antibiotic, and if they do, we will prescribe the correct one and the correct dose. We do not routinely prescribe antibiotics over the phone. Acknowledge ☐

We use our patient portal for your convenience
We want you to have access to care plans, medication doses, and forms when you need them. These will always be available on our patient portal for your convenience. You may also request non urgent appointments and refills via the patient portal. Acknowledge ☐

We refer to specialists when needed
Most pediatric concerns can be diagnosed and managed in our office. However, if your child needs specialized care we will discuss this with you and coordinate the referral for you. We require a visit with our practice before any referrals are made. Acknowledge ☐

We strive to be on time
We know that life is busy and that all of us have many obligations every day. We understand the need to stay on time, and we strive to do so. On occasion there are unexpected issues that arise which cause us to be behind. Usually these are related to patient care- for example, a patient prior to your visit needed more time for a complex issue or needed to be seen urgently because they had breathing difficulties. We will do our best to communicate with you if we are significantly behind so that you are never left wondering.
Acknowledge ☐

We value mutual respect.
We ask that you communicate with us if you are going to be late or need to cancel an appointment. Arriving more than 15 minutes late may result in the need to reschedule your visit. Multiple missed appointments will result in dismissal from the practice. With few exceptions, we will not reschedule patients who miss their first appointment with our practice without notifying us. Acknowledge ☐

We do not tolerate verbal or physical aggression towards our staff
All of our staff is committed to providing to the best possible care to your children. Any family/parent/representative/caregiver, ect. who yells, becomes verbally or physically aggressive, makes threats to our staff, or uses profanity will be dismissed from the practice without exception. We want our office to be a safe place for patients and employees alike. Acknowledge ☐

Signature_____ Date_____

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FINANCIAL POLICY

Our main focus is to provide first class medical care to our patients. In order to do this, we must receive prompt payment. A financial policy has been developed for the following reasons:

1. To meet financial obligations of the practice
2. To follow terms set forth in insurance contracts
3. To help families understand their financial responsibilities for the services provided by us

INSURANCE CARDS: Please bring your child's **current** insurance card with you to each visit. This helps ensure that the proper information is processed, and the appropriate insurance is billed for that day's visit. If your insurance changes, it is your responsibility to update information as necessary.

CO-PAYS: If your insurance requires a co-pay, it must be paid at each visit. The co-pay must be paid by the person who brings the child in for the visit, via phone prior to the visit, or via **easy pay agreement** (strongly encouraged). A $15 late fee will be added to any co pay that is not paid on the day of service.

DEDUCTIBLES: If your insurance plan has a "deductible", **this amount is your financial responsibility.** We are able to verify the majority of deductible amounts on the date of service and expect payment for this amount **on the date of service. A minimum of $75 will be collected on the day of service.**

PAYMENT TERMS:

1. Payment of co-pays ***AND*** outstanding balance is required at each visit.
2. Outstanding balances must be paid within 30 days
3. To any balance over 30 days that has been determined to be your responsibility, a **rebill fee of $25** will be applied
4. **Easy-Pay**: We offer a convenient option to keep a credit card on file (info stored securely, offsite, we will not have your number). Please refer to our accompanying easy pay agreement. We strongly encourage our patients to take advantage of this option.
5. Payment plans can be set up to avoid collection accounts. Contact us for details. However, failure to adhere to the plan will result in being sent to collections and dismissed from the practice.

RETURNED CHECK FEE: There will be a $35 fee for a returned check. In addition, all future payments will need to be made with either cash or credit card.

NEWBORNS: Insurance companies generally allow only *30 days* to add your newborn to your insurance plan. Please call ASAP to get this done. Once you receive your child's card, please provide us with a copy. If you fail to add the baby to the plan, you will be financially responsible for any visits.

DIVORCE SITUATIONS: Since we are not a party to your divorce, we cannot be involved in the financial arrangements determined by your divorce decree. The parent who brings the child to the office is responsible for payment due AT THE TIME OF SERVICE. We ask that you provide us a copy of the custody agreement. This protects us, you, and your child in terms of HIPPA compliance. If your child has a legal change of name, we must have a copy of the legal document.

TRANSFERRING RECORDS: You are entitled, by AL law, to one free copy of your child's medical records. Any additional copies will be assessed a fee of $1.00 per page. A legal guardian must sign the record release. By law, our office has 30 days to copy the record. We may require that you pick up the record, as they often get "lost" when sent to other practices. If you are unable to pick them up, we do reserve the right to charge a $5.00 processing fee.

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WAIVER OF NON-COVERED SERVICES: All insurance plans are different. Some plans do not cover standard of care screenings such as vision, hearing, objective developmental screenings, etc. When this occurs, the charges may become patient financial responsibility.

LETTERS AND FORMS: There is a charge for all forms not requested at a regular well child check. The charges are as follows:

1. Sports form/Camp form: $10.00
2. School form: $10.00
3. Same day sports or school form: $25.00
4. FMLA forms: $50.00

ONE school/sports/immunization form will be provided per year, given at the well child visit, at no charge. The school and sports form will be saved to your child's 'patient portal. We will not send or fax these to the school, nor will we send immunization records. Since all are available in the patient portal, you can forward them to the school at your convenience.

No well child exams will be done with an outstanding balance on the account.

SICK COMPLAINTS DURING WELL VISITS: Insurance companies require us to file all services offered at a visit. Well child care and sick child care are separate codes for the insurance. We may complete visits at the same time for your convenience, but at times this may result in a co-pay at your well visit just as it would if the sick visit were being completed without a well child visit occurring at the same time.

I have read and agree to the terms of this financial policy. I will be provided a copy for my records, shall I so desire.

Name-printed: _____ Date: _____

Signature: _____

Names of children: _____

_____

_____

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EASY PAY AGREEMENT

This service will allow you to pay co-pays, deductibles, and balances easily and conveniently.
With this service you authorize Kids R Us Pediatrics to use this credit card as the form of payment for balances accrued, including lab test, co-pays, coinsurances, and deductibles.

What might my card be charged for?
Co-Pays: Co-pays are due at the time of the office visit.

Outstanding Balance: After your insurance provider has paid their portion of your bill [or any other patient you have listed on this form] if there is still an outstanding balance owed less than $50.00, we will automatically charge the credit card on file, and mail you a statement and receipt of payment. For any balance over $50.00, we will contact you for permission to charge the total amount or set-up payments with the card on file. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. If your insurance company sends us a corrected payment at a later date, reducing your responsibility, we will refund or credit your account.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on the expiration date listed below**. The card holder may revoke this consent at any time in writing.

Visa ☐ **MasterCard** ☐ **Discover** ☐ **American Express** ☐

Credit Card Holder's Name: _____ DOB: ___ / ___ / ____
(Please Print)

Last Four Digits of Account Number: _____

Expiration Date: _____

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: _____ DOB: ___ / ___ / ____
(Please Print)

Patient Full Name: _____ DOB: ___ / ___ / ____

Patient Full Name: _____ DOB: ___ / ___ / ____

Credit Card Holder's Signature: _____ Date: _____

☐ By checking this box I consent to the use of my e-signature on this form.

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NOTICE OF PRIVACY PRACTICE

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Kids R Us Pediatrics may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at KRUP or the hospital. For example, we may disclose medical information about you to people outside of KRUP who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run KRUP and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other KRUP personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes KRUP' policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other KRUP personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at KRUP. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by KRUP, whether made by KRUP personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. A request form may be obtained at the front desk. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, KRUP. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. A request form may be obtained at the front desk. We may deny your request for an amendment.

Right to Request Removal from Fundraising Communications: You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan: You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which you have paid out of pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. A request form may be obtained at the front desk.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. A request form may be obtained at the front desk.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. A current copy will be available at the front desk.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Kids R Us Pediatrics or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Dusty Miller, (256) 931-5437, 121 Golfview Dr. NE, Arab, AL 35016. All complaints must be submitted in writing. A complaint form is available upon request. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (Last, First, MI): _____

Address: _____

Phone Number: (_____) _____ Date of Birth: _____

This Authorization applies to the following information:

***All* Information/Complete Medical Record.**

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.

Only the following records or types of information: _____

Treatment Dates: From (month/day/year) _____/_____/_____ To (month/day/year) _____/_____/_____

The Information may be released as follows:

From **Kids R Us Pediatrics**
121 Golfview Dr. NE
Arab, AL 35016

To: _____
_____
_____

OR

From _____
_____
_____

To: **Kids R Us Pediatrics**
121 Golfview Dr. NE
Arab, AL 35016

Purpose of the release:

☐ Continuity of Treatment ☐ Other *(Please specify):* _____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

_____ _____
Patient/Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date

_____
Patient Signature if 18 or older Date

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