GLENDALE PEDIATRICS, P.C.
PATIENT INFORMATION SHEET

DATE: ______________________________

First Name: ____

Last Name: ____

DOB: __________________ MALE: ________ FEMALE: ________

SS# __________________ Place of Birth (country and city)______________________

Race: __________________ Ethnicity: ______________ Primary Language:_____________

MOTHER/LEGAL GUARDIAN

NAME: ______________________________

DOB______________________________

HOME ADDRESS: ____________________

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CITY STATE ZIP

HOME PHONE__________________________

WORK PHONE__________________________

CELL PHONE__________________________

FATHER/LEGAL GUARDIAN

NAME: ____________________________

DOB____________________________

MAILING ADDRESS: ________________

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CITY STATE ZIP

HOME PHONE______________________

WORK PHONE______________________

CELL PHONE______________________

*****PLEASE INDICATED WHICH TELEPHONE NUMBER YOU WOULD LIKE US TO CONTACT YOU AT*****

MARITAL STATUS:
SINGLE__ MARRIED__DIVORCED__WIDOWED

MARITAL STATUS:
SINGLE__MARRIED__DIVORDED__WIDOWED__

HAS CUSTODY? BOTH__ FATHER__ MOTHER__ OTHER: ______
WHICH PARENT WILL BRING IN PATIENT MOST OFTEN? BOTH__ FATHER__ MOTHER__

INSURANCE INFORMATION
****PLEASE NOTE YOU'LL BE ASKED FOR YOUR INSURANCE CARD AT *<u>EVERY</u>* VISIT****

PRIMARY INSURANCE
INSURANCE COMPANY: ____________________

EMPLOYEE'S NAME: ______________________

EMPLOYEE'S DOB: _______________________

EMLOYER'S SS # _________________________

EMPLOYER: ____________________________

SECONDARY INSURANCE
INSURANCE COMPANY: ______________

EMPLOYEE'S NAME:__________________

EMPLOYEE'S DOB: __________________

EMPLOYER'S SS # ___________________

EMPLOYER: ________________________

EMPLOYERS NAME AND ADDRESS:____

OCCUPATION:____
EMERGENCY CONTACT (OTHER THAN PARENT)

NAME: ________________________________ RELATIONSHIP: ________________

HOME PHONE: ______________ CELL PHONE: ___________WORK PHONE:______________

GLENDALE PEDIATRICS P.C.
73-09 MYRTLE AVENUE
GLENDALE, NY 11385
(718) 821-4200

Name ________________________________ Birth Date ______________
Race _________________ Sex ___________ Insurance ____
Hospital ________________________________ Address ______________________ Phone ______________
Obstetrician _____________________________ Address ______________________ Phone ______________
Referred by ____
Father's Name ___________________________ Address ______________________ Phone ______________
Mother's Name___________________________ Address ______________________ Phone ______________

FAMILY HISTORY

ALLERGIES

	AGE	Environmental/Food	Type of Allergy
Mother			
Father			
Sibling			
Sibling			

OTHER

Miscarriage_________ Month _____Cause __________
Tuberculosis ___________ TBC Contacts ___________
Diabetes ___________Convulsive Disease _________
Mother's Blood Type _______________RH ________
Baby's Blood Type _______________________________

BIRTH AND DEVELOPMENT

Term ___________________ Delivery _________________________ Birth Weight _______________________
Condition at Birth ____ Apgar score ___________________
Condition 1st Week ____
Feeding ____ Cyanosis __________________________
Convulsions ____ Jaundice __________________________
Sat Up _______________ Stood ________________ Walked ________________ Words ___________________
Short Sentences ________________ First Teeth ____________ Bladder ___________ Bladder _____________

FEEDING HISTORY

Breast ______________________ Formula ______________________ Vitamins _________________________

Primary Drinking Water Supply: ☐ Well ☐ City/Municipal ☐ Bottled

Area Water Fluoride Level: ☐ Inadequate ☐ Adequate ☐ Unknown

Fluoride Supplements: *Topical* ☐ Rinse ☐ Gel ☐ Paste *Systemic* ☐ Vitamin/Fluoride Supplement ☐ Fluoride Only Supplement

Soft Food ___________________ Present Diet ____________________ Feeding Habits ______________________
Appetite ______________________ Likes _________________________ Dislikes ____________________________
Vomiting ______________ Stools ________________ Sensitivity ________________ Hives ________________

ILLNESSES

TYPE	DATE
PERTUSSIS	
MEASLES	
RUBELLA	
T and A	
MUMPS	
CHICKENPOX	
SCARLET FEVER	
DIPTHERIA	
OPERATIONS	
ALLERGY	

TYPE	DATE
APPENDIX	
GLANDS	
RHEUMATIC FEVER	
OTITIS	
COLDS	
TONSILITIS	
CONVULSIONS	
CONSTIPATION	
DIARRHEA	
ASTHMA	

GLENDALE PEDIATRICS, P.C.

Is there anything that you feel is important for the doctor to know about your child that is not mentioned in the above questions?

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FINANCIAL POLICY

Welcome to Glendale Pediatrics, P.C.!! We are glad you've chosen us as your child's pediatrician and strive to give your children the best in medical care. We understand that in addition to feeling comfortable with your child's physician, many parents have concerns about the financial polices of the practice. This information is designed to answer frequently asked questions.

CONTRACTED INSURANCE FILING:
We currently have contracts with the following insurance companies/plans:

AETNA
BCBS
Oxford
United Healthcare
MagnaCare
CIGNA
Multiplans
Emblem
TriCare
Fidelis
HealthFirst
United Health Care Community plan
CareConnect
1199

<ins>**WE DO NOT ACCEPT STRAIGHT MEDICAID**</ins>*

REGARDING NEWBORNS UNDER HEALTHFIRST, FIDELIS, AMERICHOICE AND NEIGHBORHOOD, THE NEWBORN IS COVERED UNDER THE MOTHER'S INSURANCE FOR 31 DAYS ONLY!!!

FURTHERMORE, FOR **ALL** INSURANCES IT IS THE PARENTS RESPONSIBILITY TO INFORM THEIR INSURANCE CARRIER REGARDING NEWBORNS AND ADDING THEM ONTO THEIR PLAN WITHIN 30 DAYS AFTER THE CHILD'S DATE OF BIRTH.

Glendale Pediatrics, P.C. company policies regarding our participation with these contracted plans are as follows:
--Glendale Pediatrics, P.C. has agreed to file insurance for patients who participate with these plans. In order to do this as accurately as possible, we MUST see your child's insurance card at each visit and if you participate with a managed care program, our physician's name must appear on the card.

<ins>IF YOU DO NOT HAVE YOUR CHILD'S INSURANCE CARD AT EACH VISIT OR ANOTHER PHYSICIAN NAME APPEARS ON THE CARD, YOU MAY BE ASKED TO SIGN A WAIVER AND LEAVE PAYMENT AT THE TIME OF VISIT</ins>.

--We will, in some cases, accept a paper copy of online eligibility at Check-In as long as it includes: patient's name, proof of eligibility for medical services on the date of service and online address of contracted insurer. We will NOT verify coverage by telephone or internet when you present for a visit. It is the parent's responsibility to have this information available to whoever is presenting the child for a visit (spouse, grandparent, nanny, etc.)

--We collect all co-payments at the time services are rendered and file insurance on a daily basis.

--Any services that are deemed to be family responsibility (additional copays, coinsurance, deductible, etc.) or that are considered non-covered by your insurance will be put to the patient balance and are due immediately.

--Any services that we file with your insurance that are not responded to any time after 90 days from the date of service may be transferred to patient balance. This balance will remain the responsibility of the family until payment is received or written correspondence is received by the insurance company verifying that payment is forthcoming from them.

--A monthly statement will be sent to you detailing unpaid charges. If you have questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company or employer as benefit packages vary by employer.

NON-CONTRACTED INSURANCE OR SELF PAY:
If we do not participate with your insurance plan, we ask that you pay in full at the time services are rendered. We will provide you with a form of suitable for filing with your insurance company. You need only to fill out your portion of the insurance claim form, attach our encounter form and mail to your insurance company.

SEPARATED/DIVORCED FAMILIES:
For those families where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible to us for payment. All payments are due when services are rendered.

In the case of contracted insurance only, copay is due at the time services are rendered. Subsequently all charges deemed parent responsibility by the contracted insurer are due to Glendale Pediatrics, P.C. by the parent who authorized treatment.

If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Glendale Pediatrics, P.C. will not act as a mediator in collecting our payments.

If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.

GLENDALE PEDIATRICS, P.C.

RESPONSIBLE PARTY STATEMENT

DEFINITION: The Responsible Party is the person(s) who present and/or authorize the patient to Glendale Pediatrics, P.C. for treatment and completes this form.
Responsible Party Authorizes:
--Glendale Pediatrics, P.C., to furnish information to insurance carriers concerning patient's illness and treatments.

RESPONSIBILITIES:
--**ALL CHARGES** are due at the time that services are rendered unless patient is a member of an insurance plan with which Glendale Pediatrics, P.C. participates. Glendale Pediatrics, P.C. only allows contractual adjustment for plans with which our physicians currently have a contract.

--If patient is covered by a plan with which Glendale Pediatrics, P.C. participates the following will apply:
--**COPAYS** are due at the time of service unless the copay is a percentage of allowable charges. In this case, copay will be due immediately after insurance has processed claim with a dollar amount as copay.
--**ALL CHARGES** deemed patient responsibility after insurance has processed the claim are due immediately. This includes copays, deductibles, coinsurance and non-covered services.
--Financially responsible for all charges whether or not covered by insurance.
--A valid patient's insurance card must be presented at each and every visit.
--Glendale Pediatrics, P.C. must be notified immediately of coverage changes. Failure to provide us with timely insurance information or change in coverage could result in the responsible party being held liable for the total charges.
--Any services filed with your insurance that are not responded to any time after 90 days from the date of service may be transferred to the patient balance and will become the responsibility of the family.

RIGHTS:
--Glendale Pediatrics, P.C., will file claims promptly for patients who participate with contracted insurance plans.
--A copy of the charge/payment history for account as requested.
--A copy of this statement may be given upon request to the person(s) who have signed or who have been authorized by the Responsible Party to receive a copy.
--This statement will be valid unless rescinded in writing by one at a later date.

PLEASE DO NOT SIGN THIS STATEMENT IF YOU ARE NOT THE LEGAL GUARDIAN OF THE PATIENT.

By my signature I understand and agree to the conditions outlines in this statement and those in the Financial Policy.

______________________________ ______________________________
PRINTED NAME SIGNATURE

DATE:_________________________ __________________STAFF INITIALS

GLENDALE PEDIATRICS P.C.
73-09 MYRTLE AVENUE
GLENDALE, NY 11385
(718) 821-4200

In 1996, Congress passed the Health Insurance Portability and Accountability Act, more commonly known as HIPAA. The goal of this legislation is basically twofold: simplifying electronic health care transactions by implementing national standards and protecting patients' personal health information by implementing security and privacy standards.

Our policy has always been to protect the personal health information of our patients. However, under the new HIPAA regulation, we are required to formalize our policies by putting them in writing and providing our patients with a copy of said practice.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. We're required by law to protect the privacy of your health information and to provide you with this notice describing our privacy practices.

Please review it carefully. If you have any questions, please contact our office administrator.

We are required to obtain a onetime consent from you before we use or share your health information with others. Such disclosure will be for the sole purposes of providing treatment to you, obtaining payment for our services and running our business operations. You may revoke this consent at any time by contacting our office administrator. We are also required to obtain a written authorization from you for the use or disclosure if your health information for purposes other than those stated in the consent. However, written authorization is not required in the following situations.

YOUR HEALTH INFORMATION MAY BE DISCLOSED TO:

- Physicians or medical personnel who are involved in your care or physicians to whom you have been referred for further treatment
- Insurance companies, in order to obtain reimbursement for medical services rendered or for pre-approval for treatment
- Business associates who need this information to assist us in obtaining payment or carrying out our daily business operations
- Family involved in your care; such as a parent or guardian
- Authorized public health officials to carry out their public health activities
- Government agencies authorized to conduct audits, investigations and inspections of our facility
- FDA regulated company or person
- Law enforcement officials, authorized federal officials, or if you're in the Armed Forces, to military command authorities
- Medical examiner or organization investigation investigating organ donation or transplantation

WE MAY ALSO DISCLOSE YOUR INFORMATION UNDER CIRCUMSTANCES IN WHICH:

- You require emergency treatment or if we are required by law to treat you but are unable to obtain written consent
- We're ordered to do so by a court hearing a lawsuit or other dispute

•It is necessary to prevent a serious threat to your health or safety, health or safety of another and safety of the public
•For worker's compensation or similar programs that provide benefits for work related injuries
•We've received any information that has the potential to identify you or that this information is "disidentifying"
•We need to evaluate the performance of our staff in caring for you or to educate our staff in how to improve the care provided to you
•We need to remind you of appointments, to recommend possible treatment alternatives or to inform you of health related benefits that may be of interest to you

YOUR RIGHTS AS OUR PATIENT

1. You have the right to request a copy of this notice
2. You have the right to request a copy of any services to this notice
3. You have the right to request and obtain a copy of your health information, including medical and billing records for as long as we maintain this information in our records
4. You have the right to correct your health information if you believe it is incomplete or incorrect
5. You have the right to receive an "accounting of disclosures" that is, to whom we have disclosed your health information
6. You have the right to request that we further restrict the use of disclosure of your health information
7. You have the right to request that we communicate with you about your medical conditions in a more confidential manner
8. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information
9. You have the right to file a complaint if you believe your privacy rights have been violated

All requests must be made in writing and sent to the attention of our office administrator. If we deny part or your entire request, we will provide you with a written notice that explains our reasons for doing so.

I hereby state that I have read the above notice of the privacy practices of Apostolis Tsoumpariotis, M.D. Abe Roa M.D. Nikolas Papaevagelou M.D. carefully. As such, I give consent to Apostolis Tsoumpariotis M.D. Abe Roa M.D. Nikolas Papaevagelou M.D. to use and share any health information for the purpose of treating me, obtaining payment for services and for daily business operations. I understand that I must authorize the use and disclosure of my health information in any circumstances not covered by this consent. I further understand that there are special situations where authorization is not requited. I know that I have the right to object to any use or disclosure of my health information and I understand that all requests I make must be made in writing, as well as any decisions to terminate this consent.

______________________________	________________________
Patient Name	Signature
______________________________	________________________
Signature of Patient Representative	Relationship to Patient

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Effective Date