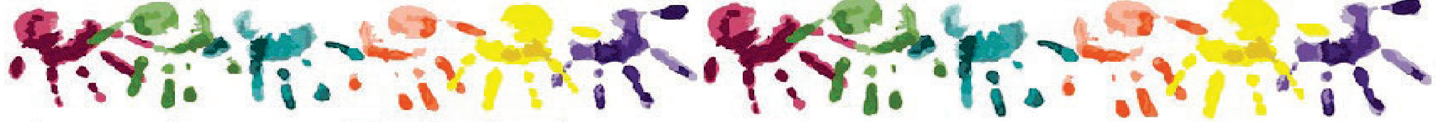


Lansdowne Park Pediatrics

PATIENT(S) INFORMATION:

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

INSURANCE NAME:____

***PLEASE PRESENT INSURANCE CARD(S) TO FRONT DESK SO A COPY CAN BE PLACED IN CHILDS CHART.**

GUARDIAN INFORMATION: (RESPONSIBLE PARTY)

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

RELATIONSHIP TO PATIENT:______________ SOCIAL SECURITY NO:______________

STREET ADDRESS:______________________________ APT. NO:__________

CITY:______________ STATE:__________ ZIP CODE:______________

HOME PHONE:__________ CELL PHONE:______________ WORK PHONE:__________

OTHER GUARDIAN:

NAME:______________________ DATE OF BIRTH:______________ GENDER: M F

RELATIONSHIP TO PATIENT:______________ SOCIAL SECURITY NO:______________

STREET ADDRESS:______________________________ APT. NO:__________

CITY:______________ STATE:__________ ZIP CODE:______________

HOME PHONE:__________ CELL PHONE:______________ WORK PHONE:__________

DELEGATION OF POWER:

I give my consent to allow person(s) named below to accompany and oversee my child for appointments, to discuss and share medical information about my child. This authorization gives the person permission to authorize treatment, vaccinations, medication and make general health decisions. The person must be over 18 and present photo identification at the time of service.

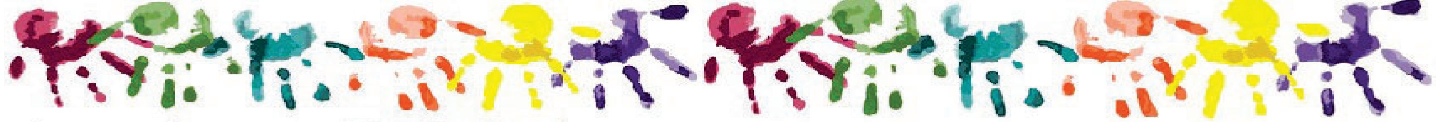
NAME: ______________________ RELATIONSHIP: ______________

NAME: ______________________ RELATIONSHIP: ______________

NAME: ______________________ RELATIONSHIP: ______________

______________________________ SIGNATURE OF PARENT/GUARDIAN

______________ DATE



AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the following patient(s):

PATIENT NAME: ____DATE OF BIRTH: __________________

PATIENT NAME: ____DATE OF BIRTH: __________________

PATIENT NAME: ____DATE OF BIRTH: __________________

PATIENT NAME: ____DATE OF BIRTH: __________________

THE PURPOSE OF THIS RELEASE IS: TO CONTINUE MEDICAL CARE

INFORMATION TO BE RELEASED: ENTIRE MEDICAL RECORD INCLUDING IMMUNIZATION RECORD

THIS INFORMATION MAY BE RELEASED TO:

LANSDOWNE PARK PEDIATRICS
1503 LANSDOWNE AVE, SUITE 3002
DARBY, PA 19023
(P) 610-237-4995 (F) 610-237-7311

THIS INFORMATION SHOULD BE RELEASED BY:

NAME: ____

ADDRESS: ____

PHONE NO.: __________________________FAX NO.:____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

____ ________________________

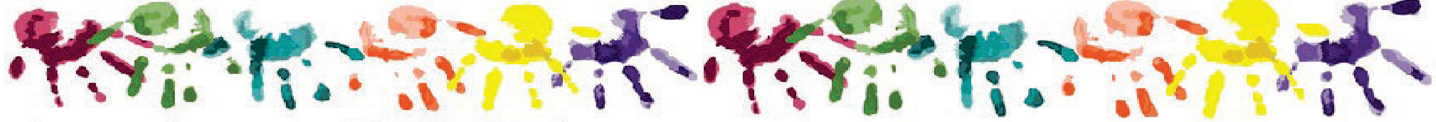
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

____

PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

____

RELATIONSHIP TO PATIENT



TEXT MESSAGE AUTHORIZATION:

☐ I authorize Lansdowne Park Pediatrics to deliver the following types of messages by text message:

- Appointment reminders
- Due for visit
- Seasonal service suggestion (flu shot)
- Balance due reminders

☐ I do not authorize Lansdowne Park Pediatrics to send me text messages of any kind.

____ _____________________________

SIGNATURE OF PARENT/GUARDIAN DATE

FOR GOVERNMENT STATISTICAL PURPOSES ONLY

Please indicate your child's race. Please select one or more race categories as applicable to your child. For Federal Statistics reporting compliance, the categories are defined as follows:

______ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation Or community attachment.

______ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

_______ **Black or African American.** A person having origins in any of the black racial groups of Africa.

_______**Native Hawaiian or other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

_______ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_______ **Prefer not to disclose**.

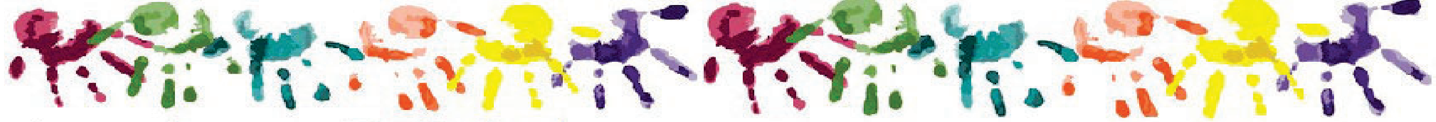
Which term describes your child best?

_______**Latino Or Hispanic**. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

_______**Non-Latino or Non-Hispanic**

_______**Prefer not to disclose.**

Preferred Language: ____



Lansdowne Park Pediatrics

HIPAA INFORMATION AND CONSENT FORM:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a “friendly” version. A more complete text is posted in the office.

What is this all about? Specifically, there are rules and restrictions on who may see or be notified of a patient’s individually identifiable information, also referred to as Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Dept. of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient charts are filed in-house, in a secure file room. The normal course of providing care means that such records will be visible, at least temporarily, on computer screens in administrative areas such as the front desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone/answering machine message, U.S. mail, or any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and reviews of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

5. Your confidential information will not be used for the purpose of marketing or advertising of products, goods, or services. We agree to provide patients with access to their records in accordance with state and federal laws.

6. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

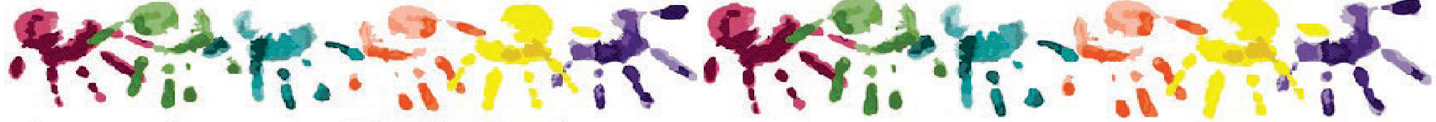
7. You have the right to request restrictions in the use of your PHI and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your requests.

8. By signing and dating this form below you certify that you do hereby consent and acknowledge your agreement to the terms set forth in this form posted in the office, as well as any subsequent changes in office policy. You understand that this consent will remain in force from this time forward.

9. **VACCINATION RECORD:** Patient immunization records may be released to any school, and day care program, any physician office, any medical clinic, any hospital, and government offices.

____________________________________ ____________________

SIGNATURE OF PARENT/GUARDIAN DATE



FINANCIAL POLICIES:

1. All co-payments, co-insurance and other patient responsible payments are due at the time of service.
2. A schedule of our fees is available at the front desk. You may or may not be reimbursed by your insurance company for these fees. While we do our best to be knowledgeable of insurance plans, it is your responsibility to know your specific insurance plan coverage, limitations and benefits. Specific coverage you should be aware of is well child care, immunization and lab services.
3. Failure to keep a scheduled appointment will result in a **$20 missed appointment fee** and/or limited appointment availability. 24 hours' notice is expected if unable to keep an appointment. Charges assessed cannot be billed to your insurance company and must be paid in full prior to scheduling future appointments.
4. We see patients by appointment only and will make every effort to provide same day appointments when necessary. If you arrive at the office without a scheduled appointment, we may not be able to accommodate you, or you may need to wait much longer than usual before you can be seen. In addition, arriving at the office without a scheduled appointment will result in a **$10 walk-in fee**.
5. We realize that temporary financial problems may affect timely payment of your account. If such a problem occurs, we encourage you to contact us promptly for assistance in managing your account. Without communication from you, the account will be frozen. Frozen accounts are unable to schedule well visit appointments, have forms filled out and may be sent to collection. Once sent to collection, a patient may be discharged from our practice.
6. State supplied Vaccines for Children are available free of charge for children without insurance or immunization coverage up to age 18. If your insurance does not provide immunization coverage, you should let us know at the time of the visit. For each immunization given there is a **$10 administration fee**. This fee is due at the time of service.
7. We cannot be involved in divorce/separation disputes. The parent/guardian accompanying the patient is responsible to pay all fees due at the visit as well as any previous monies due on the account.
8. Our providers are not experts on insurance and are not aware of the financial status of accounts. Please discuss all financial arrangements with the office staff, not the provider.
9. Any check returned to us by our bank, for any reason, will incur a **$30 fee** in addition to the amount of the returned check. A returned check may also prohibit us from accepting checks in the future on any family account.

VACCINATION POLICIES:

We immunize children and adolescents according to the current Immunization Schedule for the United States. This schedule is published by the Department of Health and Human Services and the Centers for Disease Control and Prevention. It is updated every year and is approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. We can provide you with a copy of the Immunization Schedule upon request. You can also find it online at http://www.cdc.gov/vaccines/schedules/index.html

Most insurances cover immunizations. Please check with your insurance and if you have no immunization coverage, let us know at the time of check in. The State of Pennsylvania provides free vaccines for children up to 18 years of age who have no immunization coverage or no insurance. You may still be responsible for a nominal administration fee. Please check with our staff if you have any questions.

We will keep a record of your child's immunizations and will provide you with a free copy upon request. If your child has received vaccines elsewhere, we need a copy of his or her vaccine record in order to update our file. You can get a copy of your child's vaccine record from his or her previous doctor, school or day care.

Prior to giving vaccines, we will discuss them with you or a person 18 years of age or older who is accompanying your child. If your child is 18 years or older, we will discuss the immunizations directly with him or her. We will address any questions or concerns that you may have. However, we will no longer require a parent's signature prior to each immunization.

I understand and accept the above stated policies.

________________________________ ____________________

SIGNATURE OF PARENT/GUARDIAN DATE