MERCER ISLAND PEDIATRICS, INC. P.S.

REGISTRATION FORM

Last Name______________________________ First Name_____________________ Middle_____________

Date of Birth_________ **Sex** ☐ M ☐ F **Gender Identity** _____________ **Orientation** ________________

SSN__________________ Phone___________________

Address____ City______________ State____ Zip_______

Race: ☐ Caucasian ☐ African/Amer. ☐Native Amer/Alaskan ☐ Pac. Islander ☐ Other___________

Ethnicity: ☐ Non-Hispanic ☐ Hispanic **Preferred Language:** ☐ English ☐ Other: _________

Preferred Method of Contact: ☐ Email ☐ Text ☐ Call

Please list all Children in the Family

Name: DOB:

Name: DOB:

Name: DOB:

PARENT INFORMATION					
PARENT #1			PARENT #2		
Last Name:	First Name:	DOB:	Last Name:	First Name:	DOB:
Address (If different from patient): Send bills to this address? ☐ Yes ☐ No			Address (If different from patient): Send bills to this address? ☐ Yes ☐ No		
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:
Employer:	Occupation:		Employer:	Occupation:	
Email Address:			Email Address:		
Relationship to Patient:			Relationship to Patient:		
HOW DID YOU HEAR ABOUT MERCER ISLAND PEDIATRICS? **EMAIL ADDRESS FOR PATIENT PORTAL:**					

INSURANCE INFORMATION			
Primary:	Group #:	Policy #:	Co-Payment:
Subscriber:	Subscriber SSN:	Subscriber DOB	Patient Relationship to Subscriber: ☐ Self ☐ Child ☐ Other: __________
Secondary:	Group #:	Policy #:	Co-Payment:
Subscriber:	Subscriber SSN:	Subscriber DOB	Patient Relationship to Subscriber: ☐ Self ☐ Child ☐ Other: __________
EMERGENCY CONTACT			
Name of Friend or Relative (Not living at same address):		Relationship to Patient:	
Phone Numbers: [Home]	[Work]	[Cell]	
THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE. (Please sign and date below)			
______________________________ **Printed Name**	________________________________ **Signature**	___________________ **Relationship to Patient**	___________________ **Date**

Mercer Island Pediatrics, Inc. P.S.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mercer Island Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

Your health information rights:

The health and billing records we create, and store are the property of Mercer Island Pediatrics. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about a service or treatment for which you paid directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours please contact: Jennifer Rouse, Administrator: 206-275-2122

Our responsibilities

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it.

To ask for help or complain:
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Jennifer Rouse, Clinic Administrator: 206-275-2122
If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose health information will fall within one of the categories.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations:

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you with care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
- Medical quality review by your health plan,
- Accounting, legal, risk management, and insurance services; and
- Audit functions, including fraud and abuse detection and compliance programs.

Health Information Exchange (HIE)

- MIP participates in a health information exchange (HIE). An HIE is an electronic system where hospitals, doctors and other healthcare providers share your health information. Participants in the HIE can access your patient health information as necessary for treatment, payment, and healthcare operations. They may also access your information for joint activities with other individuals or organizations like to measure quality and improve services. EXAMPLES: transmitting vaccination information to the Washington State Immunization Registry, exchanging information with Seattle Children's Hospital should your child be referred to another physician or admitted to the hospital. HIE allows us to access laboratory and radiologic results.
- Your health information is automatically included in the HIE. If you choose not to share your health information through the HIE, you must opt out. Ask the receptionist for an opt-out form.

- Pharmacy Management: To provide continuity of care in your medication prescription management we may download your prescription history through our electronic health record.

Statements about certain uses and disclosures:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
  - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be investigating. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Lawsuits and disputes:** We are permitted to disclose protected health information during judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

Web site

- Our web site provides information about us. For your benefit, this Notice is on the Web site at the following address: www.mipediatrics.com

Mercer Island Pediatrics, Inc. P.S.

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

MEDICAL CONSENT: I consent to receive evaluation, care, and treatment from providers working at Mercer Island Pediatrics. I understand such services may include examination, medical and minor surgical treatment, laboratory, immunizations, and other medical services performed or prescribed. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantee or promises have been made as to the result of treatment or examination.

FINANCIAL AGREEMENT: I certify that the information given for payment under government or private insurance is correct. I understand that I am financially responsible to Mercer Island Pediatrics for all co-payments, deductibles, and coinsurance. If I have no insurance, or my insurance does not cover products and service provided to me, I am financially responsible to pay for these products and services, which may include fees for medical supplies, after hours and emergency office visits, missed appointment fees, and after-hours phone call charges. Mercer Island Pediatrics reserves the right to impose reasonable financing and late charges as well as reasonable cost, attorney fees and expenses incurred in the collection of my account if it becomes delinquent.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Mercer Island Pediatrics to request on my behalf and to collect directly, all public and private insurance coverage benefits due for products and services supplied by Mercer Island Pediatrics. In the event insurance benefits are paid directly to me, I will endorse these checks for such payment to Mercer Island Pediatrics.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize Mercer Island Pediatrics to disclose my health information to my insurers, including the center for Medicare and Medicaid Services or its representatives if applicable.

RELEASE OF INOFRMATION:

NOTIFICATION: A family member, personal representative, or other person responsible for my care may be notified of my location, general condition, or demise.

DISASTER RELIEF INFORMATION: Mercer Island Pediatrics may also disclose information to assist in disaster relief efforts.

*** A special Consent for Release of Confidential Information must be signed for those patients' receiving services related to HIV/AIDS*.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Mercer Island Pediatrics' Notice of Privacy Practices. **INITIAL________**

State why patient could not initial ☐ Child ☐ under guardianship ☐ unconscious ☐ Incapacitated

Patient Name:___________________________ ______________________________ _____________

Signature of patient or legal responsible party — Date

Patient DOB:____________________________ ______________________________

Relationship to patient, if not signed by patient

State why patient could not sign ☐ Child ☐ under guardianship ☐ unconscious ☐ Incapacitated

Mercer Island Pediatrics, Inc. P.S.

Financial Policies

1**. Patient Information/Proof of Insurance**: At each visit, please be prepared to present your insurance card as proof of insurance***. If you fail to provide us with your child's correct insurance information, you will be responsible for payment of services rendered*.**

2. **Insurance**: We participate with most insurance plans and will submit a claim to your insurance company on your behalf. ***If you are not insured or not insured by a plan with which we are contracted, payment in full is expected at time of service***. If we are a participating provider with your plan, but you do not have an up-to-date insurance information, payment in full is required at time of service. ***Knowing your insurance benefits and rules is your responsibility***. Please contact your insurance plan with any questions you may have regarding your coverage.

3. **Newborn Coverage**: Most insurance companies will cover your newborn up to 30 days from the date of birth. It is important to enroll your newborn in your plan during this time. If your newborn is not on your plan after 30 days, we will expect payment at time of service.

4. **Co-payments and deductibles**: This arrangement is part of your contract with your insurance company. ***Co-payments must be paid at the time of service***.

5. **Non-covered services**: Our providers follow appropriate medical guidelines for the standard of care based on your medical condition. Please be aware that some of the services you receive may be determined by your insurance plan to be only partially covered or not covered. ***You will be financially responsible for the cost of services that are not paid.***

6. **Coverage changes**: If your insurance changes, please notify us before your next visit. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.

7. **Claims submission**: Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly to process a claim. It is your responsibility to comply with their request*.* ***Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim*.**

8. **Missed and no-show appointments**: If you arrive late for your appointment, you may be asked to reschedule for another day. ***You will be charged a fee of $50 for missed appointments not canceled within 24-hours of your scheduled appointment and for no-shows***. These charges will be your responsibility and must be paid before being scheduled for another appointment. We reserve the right to dismiss patients from our practice who frequently miss appointments without giving 24-hours notice.

9. **Forms and Letters**: You will be charged a fee of $20 for the physician to complete all sports, camp, school forms and letters and a $40 fee for immediate and/or more complicated request.

10. **After-hours**: You will be charges a $25 fee each time you speak with an after-hours RN through our answering service.

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Financial Policies

11. **Medical records**: You will be charged a fee of $1.24 for the first 30 pages and 0.94 cents per page for all other pages for copies of medical records and may be subject to a clerical fee of $28 for searching and handling records.

12. **Divorce/Separation**: In cases of divorce and/or separation, the legal guardian and/or ***the person bringing the child in for services will be held responsible for paying any balance*** originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

13. **Refunds**: If you have overpaid your account, a refund check will be mailed to the patient or guarantor.

14. **Past due balances**: Past due balances of 90 days and over will be sent to a collection agency. If an unpaid balance is sent to a collection agency, payment will need to be made directly to the agency. Once an account is deemed uncollectible by MIP, then it will be necessary to pay for each visit at the time of check in regardless of whether you have insurance.

15. **Stat lab fees**: If the physician determines that your child's lab test needs to be processed immediately by Seattle Children's Hospital or LabCorp, you will be charged a fee on average of $35 - $50 for the specimen transport. If you would like to decline stat lab processing, please inform the physician at the time of your child's collection.

I acknowledge receipt of Mercer Island Pediatrics Financial Policies

Patient's Name: ____ Date of Birth: ___________

Parent/Legal Guardian Signature: __________________________________ Today's Date: ___________

PEDIATRIC PATIENT QUESTIONNAIRE

Patient's Name: ______________________________ Date of Birth: ______________________________

Siblings Name: ______________________________ Date of Birth: ______________________________

Past Medical History

Allergies (Medication, Food, Insects, Etc.): ____

Medications/Supplements: ____

Problems during Mom's pregnancy, the birth or newborn period ________________________________

Hospitalizations/Surgeries: ____

Current or past medical problems: ____

Please check any of the following:

o Vision problems
o Hearing problems
o Speech problems
o Poisoning/ overdose
o Serious accident
o Motor delays
o Learning problems
o Mental health concerns
o Concussion/ serious head injury
o Hay fever or asthma
o Urinary tract infection
o Constipation
o Soiling
o Anemia
o Heart murmur

Briefly explain the above concerns; or add any additional information you feel is important about your child's health:

____

____

Family History

Has anyone in the patient's family had any of the following?

o Child is adopted
o Birth defects/malformations
o Developmental problems
o High cholesterol
o Hip problems at birth
o Anemia or blood disorder
o Asthma or wheezing
o Tuberculosis
o Seizures
o Death before 1 year of age
o Diabetes
o Vision
o Hearing Loss
o Learning problems
o School problems
o Eating disorder
o Mental illness
o Suicide
o Alcoholism
o Substance abuse
o Cancer
o Migraine headaches
o Kidney problems
o Emotional problems
o Depression
o Heart disease or stroke
o Hyperactivity or attention deficit disorder

Today's Date: ____________________ Parent/Guardian Signature: ______________________________