CHILD HEALTH ASSOCIATES

666 Plainsboro Rd. Suite 1300 Plainsboro, NJ 08536
Phone#: (609)750-1521 **Fax#:** (609)750-1523 **Email:** chadoctors@gmail.com

REGISTRATION INFORMATION

DATE:_____/_____/_____ CONTACT EMAIL ADDRESS: _____

CHILD #1: _____ , _____ _____
(LAST NAME) (FIRST NAME) (MI)

DATE OF BIRTH:_____/_____/_____ SEX (CIRCLE): M / F ADDRESS:_____
STREET CITY STATE

ALLERGIES (FOOD/MEDICATION): _____

PRIOR DOCTOR: _____ _____
(NAME) (PHONE #)

CHILD #2: _____ , _____ _____
(LAST NAME) (FIRST NAME) (MI)

DATE OF BIRTH:_____/_____/_____ SEX (CIRCLE): M / F ADDRESS:_____
STREET CITY STATE

ALLERGIES (FOOD/MEDICATION): _____

PRIOR DOCTOR: _____ _____
(NAME) (PHONE #)

CHILD #3: _____ , _____ _____
(LAST NAME) (FIRST NAME) (MI)

DATE OF BIRTH:_____/_____/_____ SEX (CIRCLE): M / F ADDRESS:_____
STREET CITY STATE

ALLERGIES (FOOD/MEDICATION): _____

PRIOR DOCTOR: _____ _____
(NAME) (PHONE #)

MOTHER: _____ , _____ DATE OF BIRTH:_____/_____/ _____
(LAST NAME) (FIRST NAME)

ADDRESS:_____ PHONE #: _____
STREET CITY STATE

EMERGENCY CONTACT:_____ , _____ PHONE #: _____
(LAST NAME) (FIRST NAME)

RELATIONSHIP OF EMERGENCY CONTACT TO PARENT: _____

FATHER: _____ , _____ DATE OF BIRTH:_____/_____/ _____
(LAST NAME) (FIRST NAME)

ADDRESS:_____ PHONE #: _____
STREET CITY STATE

EMERGENCY CONTACT:_____ , _____ PHONE #: _____
(LAST NAME) (FIRST NAME)

RELATIONSHIP OF EMERGENCY CONTACT TO PARENT: _____

PHARMACY: _____ _____
(PHARMACY NAME) (ADDRESS)

PRIMARY INSURANCE COMPANY: _____
(NAME)

ID #: _____ GROUP:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____/_____/ _____

SECONDARY INSURANCE COMPANY: _____
(NAME)

ID #: _____ GROUP: _____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____/_____/ _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned and personally signed the claim.

I, _____ hereby authorize Child Health Associates to pay and hereby directly assign all benefits, if any, otherwise payable to me for services as described on the attached form. I understand that I am financially responsible for charges incurred. I further acknowledge that any insurance benefit, when received by and paid will be credited to my account, in accordance with the above-said assignment.

_____ _____
(Signature) (Date)

CONFIDENTIAL

CHILD HEALTH ASSOCIATES

PATIENT RESPONSBILITY STATEMENT

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We do a hearing and vision screening for all well-child visits starting at 3 years of age; this is a recommendation by the American Academy of Pediatrics. Please be advised, however, that not all insurance companies cover these services. Thus, it is your responsibility to know your coverage. If these services are not covered after the services have been rendered, you are financially responsible for payment.

Your health plan may refuse payment of a claim for some of the following reasons:

1) This is a pre-existing illness that is not covered by your plan
2) You have not met your full calendar year deductible
3) The type of medial service required is not covered by your plan
4) The health plan was not in effect at the time of service
5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as patient to pay the denied amount in full.

Our primary mission is to provide you with the quality, cost-effective medical care. Together, we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient, and our top priority is to provide you with the best possible care.

I_____have read the above responsibility statement and understand my obligations, and I acknowledge that I am fully responsible for the payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Parent Date

CHILD HEALTH ASSOCIATES

OFFICE POLICIES

Deductibles:

If you have not met your deductible, payment is expected at the time of service so you will be billed for the services provided to you.
You are responsible for this payment regardless of any insurance company's determination of usual and customary rates.

Non-Participation:

If you have a health insurance card with a plan that we do not participate in, we will be glad to give you the documentation that may allow you to obtain reimbursement from your health insurance provider. However, payment for today's visit is expected today at the time of service.

Insurance Card:

Please show your insurance card at every doctor's visit. If you do not provide us with your insurance card, we are not able to bill your insurance for the services we provided to you.

Returned Checks:

All returned checks are subject to a $25.00 fee.

HIPAA Compliance

Your signature confirms that you have received and reviewed the HIPAA Compliance notice.

No Show Policy:

We have set aside a specific amount of time especially for you, without 24-hour notice we are not able to fill your scheduled time slot.
Therefore, you will be billed for appointments canceled with less than 24-hour notice. The fee will be in accordance with the level of service.
You will be charged $50.00 for an initial no-show of a visit and $25.00 for any other visit.
Insurance companies do not reimburse for these fees; therefore, you will be responsible for the full charge.

If you have any questions about our financial policy, please speak to our Practice Manager.

Patient Name(s): _____ DOB: _____

Parent Signature: _____ Date: _____

Child Health Associates HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review carefully.
This notice of Privacy Practices describes how we may use and disclose your *protected health information* [PHI] to carry out treatment, payment, healthcare, or operations, and for other purposes that are permitted or required by law. This also describes your access and control of your protected health information.

Protected Health Information is information about you, including demographic information about you that may identify you and relates to your past, present, or future physical appearance, mental health, or condition diagnosed by Healthcare Services.

1. Uses and Disclosures of PHI:

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of our providing healthcare services to you to pay for your healthcare bills and support the operation of the medical practice, and any other use required by law.

2. Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services, including the coordination or management of your healthcare with third parties.
For example, a home healthcare agency that provides care to you, a physician to whom you were referred, and to ensure that the physician has the necessary information to diagnose and treat you.

3. Payment:

Your PHI is used as needed to obtain payment for your healthcare services.
For example, a hospital stay may require that your PHI information be disclosed for approval of a hospital stay or precept if needed.

4. Healthcare Operations:

We may use or disclose, as needed, your PHI to support the business activities of your physician practice. The activities include but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.
For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will write your full name. Within the waiting room, we will also call your name when your physician is ready to see you. We may disclose your PHI when necessary to contact you regarding your appointment.

5. We may use your PHI without your authorization in the following situations

Required by Law, Public Health Issues as required by law, Communicable Diseases, Health oversight, Abuse or Neglect. legal proceeding, law enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal activity, Military Activity, National Security, Workers Compensation, Inmates
Required Uses and Disclosures under the law: we must disclose to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of section 164.50a other permitted and required. Uses and disclosures will be made only with your consent authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights to your Protected Health Information

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of or use in a civil criminal or administrative action or proceedings, and protected health information subject to law that prohibits the access of protected health information.

You have the right to request a restriction of your protected health information.
You may ask us not to use or disclose any part of your protected health information for treatment payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends or family members who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request if the physician believes that it is in your best interest to permit the use and disclosure of your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means, or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively. i.e., electronically.

You have the right to have your physician amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of this agreement with us, and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made if any of your protected health information.
We reserve the right to change the terms of this notice and will inform you. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to our office or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and is effective as of April 14, 2003. We are required by law to maintain the privacy of and provide individuals with this notice of your legal duties and privacy practices concerning protected health information, if you have any objection to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.
Your signature on our log only acknowledges receipt of this notice of our privacy policy.

Compliance Contact
Child Health Associates
666 Plainsboro Road, St. 1300 Plainsboro NJ 08536.
Phone # 609-750-1521

RECORDS RELEASE AUTHORIZATION

CHILD HEALTH ASSOCIATES

666 Plainsboro Road
Suite 1300
Plainsboro, NJ 08536

Phone#: (609) 750-1521
Fax#: (609) 750-1523
Email: chadoctors@gmail.com

Child #1:
Patient Name: _____

Date of Birth: _____

Child #2:
Patient Name:_____

Date of Birth: _____

Child #3:
Patient Name: _____

Date of Birth: _____

Child #4:
Patient Name: _____

Date of Birth: _____

Previous Doctor
Physician/Practice Name: _____

Address: _____
STREET CITY STATE ZIP

Fax Number: _____

I hereby authorize you to release any chart and medical information, including the immunizations, examinations, diagnoses, and treatments rendered from the above name patient(s) to:
Child Health Associates
Dr. Mana Somasundaram

Patient / Parent Signature: _____