Oceans Pediatrics

Pediatric Patient History

Patient Name: _____ Date of Birth: _____ Sex: _____

Completed by: _____ Relationship to Patient: _____

Who referred you to Oceans Pediatrics: _____

Pregnancy & Birth:

Mother's age at pregnancy: _____

Hospital of birth: _____

Birth weight: _____

During pregnancy, did mother use/have (please circle all that apply):

Tobacco
Alcohol
Drugs
Hepatitis B
Group B Strep
Syphilis
HIV

Baby (please circle all that apply):

Premature
Jaundice
Breast Feeding
Birth Complications
C Section
Breathing Problems
Formula

Who resides in the home?

_____

_____

Family Medical History:

Has anyone in your immediate family been treated for (please circle all that apply):

Anemia
Asthma/Lung Disease
High Blood Pressure
Tuberculosis
Thyroid Problems
Seizures
Cystic Fibrosis
Diabetes
Heart Disease/Murmur
High Cholesterol
Kidney Disease
Other: _____

Has/does your child:

Have an allergy to medicine? _____

Have other allergies? _____

Take medication? _____

Had surgery? (age & procedure) _____

Been hospitalized? (age & reason) _____

Had serious injuries? (age and description) _____

Do you have any concerns about your child's development or behavior? _____

Does your child have any communication needs (vision impaired/ hearing impaired/ cognitive issues)?

If so: Reason: _____ Provider: _____ Phone: _____

Does your child receive therapy/counseling/ services (speech, ENT, allergy) from other providers?

If so: Reason: _____ Provider: _____ Phone: _____

Oceans Pediatrics

Authorized Consent to Seek Medical Care

I have the legal right to consent to medical and surgical treatment because I am the parent/legal guardian of the patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Oceans Pediatrics and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to providers in this medical office to provide treatment as long as a physician/ patient relationship exists, or until I withdraw my consent.

_____ _____

Patient Name Patient's date of birth

_____

Parent Signature

IF YOU ARE ALLOWING SOMEONE OTHER THAN THE PARENTS TO BRING IN THE CHILD (grandparents, nanny, friend, step-parent, aunt/uncle, etc. in case parents are at work or out of town)
Pleas Complete and sign below

_____

I (Parent/ Legal Guardian) _____, am hereby giving permission in advance for the following person(s) to bring my child/children to Oceans Pediatrics and to receive medical treatment and advise during my absence.

Name: _____ DOB: ____/ _____/ _____ Relationship: _____

Name: _____ DOB: ____/ _____/ _____ Relationship: _____

Name: _____ DOB: ____/ _____/ _____ Relationship: _____

Please specify date: From ____/ ____/ ____ to ___/ ____/ ____ (ex: The week you will be out of town and child(ren) are with grandparents)

We will continue to rely on the information on the form unless you request changes. It is <u>YOUR RESPONSIBILITY</u> to immediately notify Oceans Pediatrics of a divorce, legal separation, change in custody agreement or any other circumstance which may alter this authorization.

Oceans Pediatrics

New Patient Registration Form

Patient Demographics

Todays date: ___/ ___/ ___ Last Name: _____ First Name: _____

Nickname: _____ Date of Birth: ____/ _____/ _____ Sex: Male/ Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mom's Cell: (____) _____ Dad's Cell: (____) _____ work: _____

Primary email: _____

Race: Asian/ African American/ Caucasian/ Native American/ Hispanic/ other: _____
Ethnicity: _____ Language: _____

Pharmacy Name: _____ Location: _____Phone Number_____

Do you agree to receive periodic messages from the practice (appointment, lab results, Rx, flu shot reminder) Y/N?

FATHER

Last Name: _____ DOB: ___/ ____/ ____
First Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Best Phone # _____ cell/work/home

Email: _____

Occupation: _____

Employer: _____

Mother

Last Name: _____ DOB: ___/ ____/ ___
First Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Best Phone # _____ cell/work/home

Email: _____

Occupation: _____

Employer: _____

Siblings: _____

Biological Parental Status: Married/ Single/ Divorced/ Widowed/ Other: _____

If divorced, who has custody of the child? _____ Who does the child primarily reside with: _____

Any court document documenting custody of the child? YES/ NO If so, please provide copies to the office

Stepfather Name: _____ Stepmother Name: _____

Emergency Contacts

Name: _____ Relationship: _____ Contact: _____

Name: _____ Relationship: _____ Contact: _____

Oceans Pediatrics

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
"Notice of Privacy Practices"

I hereby give consent to Oceans Pediatrics and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operation.

I further authorize Oceans Pediatrics to furnish information from my medical records as requestion by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plana or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe information may identify me.

I understand that I have a right to request Oceans Pediatrics to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations. Oceans Pediatrics is not required to grant my request, but if they do, the restriction will be binding on Oceans Pediatrics.

I acknowledge that I have received the HIPAA Statement and Notice of Privacy Practices for Oceans Pediatrics, which provides more detailed information about how Oceans Pediatrics may use or disclose my protected health information.

Parent/Legal Guardian Name: _____

Patient Name: _____

Signature: _____

Date: _____

Oceans Pediatrics

Office Policy and Financial Agreement

Authorization of Assignment of Insurance Benefits & Release of Medical Records

Please read carefully and sign stating that you understand and agree with our policies

I understand payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my account is not paid in fill by my insurance within 60 days of the date of service, I am responsible for payment in full. I understand that, in case of default, I am responsible for any costs incurred in the collection of patient account, as well as reasonable attorney fees and court costs.

Returned checks are subject to a service charge of $40.00 and you will lose you privilege to write checks in our office.

Missed appointments: Mahoney Pediatrics requires 24-hour advance notice for all cancellations. Failure to notify our office will result in a **$35.00** fee. This fee will be billed directly to the Responsible Party and not to the insurance company. Emergencies will be considered on a case-by-case basis for waiver of this fee. After the third no show, the patient may be discharged from the practice.

Medical Records: There will be a charge of $1.00 per page for the first 25 pages and $0.25 thereafter for copying of medical records.

Medical Forms: Physical and immunization forms, school forms, WIC forms, and medication forms should be requested at your child's yearly will visit. If needed after that visit, we require 3 business days to complete them. **Your child MUST have had a well visit in our office in the last year for any form to be completed.** FMLA paperwork is $20 and takes 5 business days to complete.

Divorced/Separated Parents: A divorce decree is a legal document binding only on the two parties to it. Oceans Pediatrics is not a party to or bound by the divorce decree, custody agreement or other related agreement. The parent or guardian accompanying the pediatric patient at the time of the service is responsible for payment in full at the time of service.

Newborns: ***If you are enrolling your baby to an insurance policy, please be sure to do so within 30 days of birth.*** As a courtesy we will hold claims for 30 days prior to submitting to the insurance allowing you this time to add the baby. Please note: Our office visits are not billable under mother's coverage. Baby must be added as an individual policy holder.

Delinquent Bills: On a case-by-case basis management will work with the responsible party to address delinquent accounts. If unresolved, the account will be assigned to an external collection agency or attorney for collection. I will be responsible for all the collection costs, including attorney's fees and court costs.

Discharging Patients: I understand that I may be discharged as a patient at the discretion of Oceans Pediatrics, I understand that I will be given 30 days to find a new pediatrician and that Oceans Pediatrics will continue to provide care for emergency care and treatment during the 30-day time period.

Parent Name: _____ Date: _____

Parent Signature: _____

Oceans Pediatrics

Consent to Communications: You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide to us. You also consent to us and any other owner or servicer of your account contacting you using any communication channel. This may include text messages, automatic telephone dialing systems, and/or an artificial or prerecorded voice. This consent applies even if you are charged for the call under your phone plan. You are responsible for any charge that may be billed to you by your communications carrier when we contact you.

Your signature on the line below forms a legally binding agreement between Oceans Pediatrics and the undersigned patient who is receiving medical services, or the responsible party for minor patient until the age of 21. The responsible party is the individual who is financially responsible for payment of medical form below as the responsible party in the space provided. **All charges for services rendered are due and payable at the time of service. The responsible party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason.**

Responsible Party Name: _____

Patient Name: _____

Signature: _____ **Date:** _____

Primary Insurance: _____

Full Name of Insured: _____

Subscriber ID: _____

Group #: _____

Subscriber DOB: _____ Effective Date: _____

Relationship to patient: _____ Co-pay $ _____

Oceans Pediatrics

HEALTH INFORMATION EXCHANGE CONSENT: I hereby authorize the electronic exchange of my protected health information (PHI) through the Health Information Exchange (HIE) network. I understand that the purpose of the HIE is to improve the quality, safety, and efficiency of my healthcare by allowing my healthcare providers to securely access and share my PHI with each other. I understand that the information exchanged may include, but is not limited to, the following:

- Medical history and diagnoses,
- Medications and allergies,
- Lab and test results,
- Imaging reports,
- Discharge summaries,
- Treatment plans and progress notes

I understand that my PHI will only be exchanged between healthcare providers who are involved in my care and who have a legitimate need for the information. I understand that my PHI will be protected by state and federal laws governing the privacy and security of health information. I have the right to revoke this consent at any time by notifying the HIE in writing. I understand that if I revoke this consent, it will not affect any actions taken prior to the revocation. I have received a copy of the Notice of Privacy Practices, which explains in detail how my PHI may be used and disclosed, and I understand my rights and responsibilities with respect to my PHI. By signing below, I acknowledge that I have read this consent form, understand its contents, and agree to the electronic exchange of my PHI through the HIE network.

Parent Name: _____

Parent Signature: _____ Date: _____

Oceans Pediatrics

Additional Policies for Divorced or Separate Parents ONLY

In case of a divorce, please do not put our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent, as well as who will attend the medical appointments and provide consent for treatment. If a step parent bringing a child for care is not listed on the consent to treat form, we will be unable to see your child that day.

We expect cordial behavior and cooperation in our office at all times.

Automated appointment reminder call, emails, Rx notifications can only be sent to the phone number and email listed in the demographic section of our EMR. The patient portal can have two separate login accounts.

**** Please note both parents have access to child's information, unless a court order is on file****

Appointments may be cancelled **only** by the person who made the appointment initially. If someone other than the person initially making the appointment cancels, they will be charged a "no show" fee directly

If both parents do not attend the patient's visit the provider will not be able to speak on the phone later to the parent that was not in attendance. If you have questions and feel you *must* speak to the doctor regarding your child's care, you may make a virtual appointment at the end of the day for a fee of $40 paid in advance. This is not an appointment that is covered by insurance. Alternatively, you may make an appointment to see the doctor in our office with or without your child. This may be covered by your insurance.

Any request for letters to be written by the provider for legal purposes will incur a fee of $40.

In the event a Court Order affects the rights of parents and children that will impact an office visit, please provide a copy of the document to the Management. We will make every effort to comply with the Court Order. It is the responsibility of the parents to inform our office of any changes in marital status or legal custody or any other circumstance which may alter this authorization. In the event the Management determines that Oceans Pediatrics is unable to continue to provide care to your child/children we will continue to see the pediatric patient for 30 days on an emergency basis only, to permit you time to find a new provider.

Oceans Pediatrics

Consent for Use of Ambient AI Documentation Support

At **Oceans Pediatrics**, we are committed to giving your child our full, undivided attention. To do this, our providers use **Commure Scribe**, a secure, AI-powered documentation tool.

How it Works:

- **Focus on You:** Instead of typing on a computer during your visit, the provider can look at you and your child while the AI securely listens and drafts the medical note.
- **Security:** The system is fully **HIPAA-compliant**. The audio is encrypted during the visit and is used only to create a clinical summary.
- **Verification:** Your pediatrician reviews, edits, and approves every word of the note before it becomes part of the permanent medical record.

Your Rights:

- **Optional:** Use of this tool is completely voluntary.
- **Right to Opt-Out:** You may ask the provider to turn off the AI scribe at any time during the visit without any impact on the quality of care provided.

Acknowledgment: By signing below, I consent to the use of AI-assisted documentation for my child's visits at Oceans Pediatrics.

Signature: _____ Date: _____

(Parent/Legal Guardian)