**PATIENT REGISTRATION FORM**

Potomac Valley Pediatrics

Avneet K. Bawa M.D.,F.A.A.P. & Associates

11908 Darnestown Road, Suites G&H

North Potomac, MD 20878

**RESPONSIBLE PARTY**

Name:

Relationship to Patient:

Address:

City: State: Zip:

Home Phone: (\_\_\_) Work Phone: (\_\_\_)

Cell Phone: (\_\_\_) Social Security #:

Email:

Best Way to Contact You: Cell Home\_\_\_\_ Work \_\_\_\_ Email

Referred to us by:

**PATIENT INFORMATION**

Please List ALL Children’s Names Sex Date of Birth

1.

2.

3.

4.

5.

 **MOTHER FATHER**

Name: Name:

Address: Address:

Home Phone: (\_\_\_) Home Phone: (\_\_\_)

Cell Phone: (\_\_\_) Cell Phone: (\_\_\_)

Work Phone: (\_\_\_) ext: Work Phone: (\_\_\_) ext:

Employer: Employer:

Work Address: Work Address:

Occupation: Occupation:

Social Security #: Social Security #:
Date of Birth: Date of Birth:

Marital Status: Single\_\_\_\_ Married­­­\_\_\_\_ Divorced\_\_\_\_ Separated\_\_\_\_ Widowed\_\_\_\_

*(If divorced or separated please indicate who has custody)*

Please indicate a preferred pharmacy (including address) to send prescriptions:

**EMERGENCY CONTACT *(not living within patient’s household)***

Name: Relationship to Patient:

Address:

Phone:

**Primary Insurance**

**INSURANCE INFORMATION**

Insured’s Name:

Relationship to Patient:

Date of Birth:

Social Security #:

Employer:

Insurance Company:

ID #:

Group #:

Insurance Company Address:

Insurance Company Phone #:

**PAYMENT POLICIES AND FEES**

* In order to keep costs and fees low, payment is expected at the time of service unless other arrangements are made in advance.
* If an insurance claim is filed for on your behalf, any charges that remain unpaid after 45 days will be billed to the patient’s account and will become due at that time.
* In the event of missed appointments, there is a fee of **$25.00** for sick visits and **$50.00** for well-check exams that are not cancelled at least **24 hours** in advance.
* A **$35.00** fee will be added for checks returned for insufficient funds.
* An **18%** yearly interest fee will be charged on all accounts which are 90 days past due. Additionally, a collection activity fee will be added to any account which has been turned over to the collection agency.
* A charge will be applied to all accounts for calls made to the on-call provider after office hours. The amount will be a minimum of **$15.00**/call until 10pm and a minimum of **$25.00**/call between 10pm and 8am.

**AUTHORIZATION AND RELEASE**

* I authorize the release of any information including the records of any treatment or examination rendered to me or my child during the period of such care to any third party payers and/or other health practitioners.
* I authorize the use/display of any pictures of myself or my dependents that I personally provide to Potomac Valley Pediatrics.
* I authorize and request my insurance company to pay directly to the doctor or doctor’s group insurance benefits otherwise payable to me.
* I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

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Signature of Patient (or parent if minor) Date

**INITIAL HISTORY QUESTIONNAIRE**

Potomac Valley Pediatrics

Avneet K. Bawa M.D.,F.A.A.P. & Associates

11908 Darnestown Road, Suites G&H

North Potomac, MD 20878

Patient Name Form Completed By

 M F

Date of Birth Age Date of Completion

**HOUSEHOLD**

***Please list all of those living in the child’s home:***

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship to Patient | DOB | Health Problems |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are there any siblings not listed? Please list their names, ages, and where they currently live

What is the patient’s living situation if not with both biological parents?

 Lives with adoptive parents Joint custody

 Lives with foster family Single custody

If one or both parents are not living in the home, how often does ***Patient Ethnicity:***  the child see the parent(s) not at home?

Native American/Alaskan Native Pacific Islander

Asian Black

White Hispanic

Other Do not want to report

**BIRTH HISTORY *Don’t know birth history***

Birth weight: \_\_\_\_\_\_ Born at term? Yes No \_\_\_\_\_weeks Delivery Method: Vaginal Cesarean

Were there any prenatal or neonatal complications? If cesarean, why?

 Yes No If yes, please explain:

During the pregnancy, did mother Was a NICU stay required? Yes No

* Use prenatal vitamins Yes No If yes, please explain:
* Drink alcohol Yes No
* Use tobacco products Yes No Did your baby go home with mother from the hospital?
* Use drugs or medications Yes No Yes No If no, please explain:

What When

**GENERAL INFORMATION *DK = Don’t Know***

Do you consider your child to be in good health? Yes No DK Explain: Does your child have any serious illnesses or medical conditions? Yes No DK Explain: Has your child ever had any surgery? Yes No DK Explain: Has your child ever been hospitalized? Yes No DK Explain: Is your child allergic to any medication or drugs? Yes No DK Explain: Do you feel your family has enough to eat? Yes No DK Explain:

**BIOLOGICAL FAMILY HISTORY *DK = Don’t Know***

***Please indicate if any family members have had the following:***

Childhood hearing loss Yes No DK Who Comments

Nasal allergies Yes No DK Who Comments

Asthma Yes No DK Who Comments

Tuberculosis Yes No DK Who Comments

Heart disease (before 55 years old) Yes No DK Who Comments

High cholesterol/takes cholesterol medication Yes No DK Who Comments

**BIOLOGICAL FAMILY HISTORY *DK = Don’t Know (continued from front)***

Bleeding disorder/anemia Yes No DK Who Comments

Dental decay Yes No DK Who Comments

Cancer (before 55 years old) Yes No DK Who Comments

Liver disease Yes No DK Who Comments

Kidney disease Yes No DK Who Comments

Diabetes (before 55 years old) Yes No DK Who Comments

Bed-wetting (after 10 years old) Yes No DK Who Comments

Obesity Yes No DK Who Comments

Epilepsy or convulsions Yes No DK Who Comments

Alcohol or drug abuse Yes No DK Who Comments

Mental illness/depression Yes No DK Who Comments

Developmental disability Yes No DK Who Comments

Immune problems, HIV/AIDS Yes No DK Who Comments

Tobacco use Yes No DK Who Comments

Any additional family history:

**PATIENT PAST MEDICAL HISTORY *DK = Don’t Know***

***Please indicate if your child has ever had any of the following:***

Chickenpox Yes No DK When

Frequent ear infections Yes No DK Explain

Problems with ears or hearing Yes No DK Explain

Nasal allergies Yes No DK Explain

Problems with eyes or vision Yes No DK Explain

Asthma, bronchitis, bronchiolitis, or pneumonia Yes No DK Explain

Any heart problems or heart murmurs Yes No DK Explain

Anemia or bleeding problem Yes No DK Explain

Blood transfusion Yes No DK Explain

HIV/AIDS Yes No DK Explain

Organ transplant Yes No DK Explain

Malignancy/bone marrow transplant Yes No DK Explain

Chemotherapy Yes No DK Explain

Frequent abdominal pain Yes No DK Explain

Constipation requiring doctors visits Yes No DK Explain

Recurrent urinary tract infection issues Yes No DK Explain

Congenital cataracts/retinoblastoma Yes No DK Explain

Metabolic/genetic disorders Yes No DK Explain

Cancer Yes No DK Explain

Kidney disease or urological malformations Yes No DK Explain

Bed-wetting (after 5 years old) Yes No DK Explain

Sleeping problems; snoring Yes No DK Explain

Chronic or recurrent skin issues (acne, eczema) Yes No DK Explain

Frequent headaches Yes No DK Explain

Convulsions or other neurological issues Yes No DK Explain

Obesity Yes No DK Explain

Diabetes Yes No DK Explain

Thyroid or other endocrine issues Yes No DK Explain

High blood pressure Yes No DK Explain

History of serious injuries/fractures concussions Yes No DK Explain

Use of alcohol/drugs/tobacco Yes No DK Explain

ADHD/anxiety/depression/mood disorders Yes No DK Explain

Developmental delay Yes No DK Explain

Dental decay Yes No DK Explain

History of family violence Yes No DK Explain

Sexually transmitted infections Yes No DK Explain

Pregnancy Yes No DK Explain

(For girls) Issues with periods Yes No DK Explain

 Has had first period Yes No DK Age of first period

Any other significant issues

**CNMC IQ NETWORK CONSENT**

Potomac Valley Pediatrics

Avneet K. Bawa M.D., F.A.A.P. & Associates

11908 Darnestown Road, Suites G&H

North Potomac, MD 20878

SINGLE CONSENT TO SHARE MEDICAL INFORMATION WITH CHILDREN’S IQ NETWORK PROVIDERS TREATING ME OR MY CHILD

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, Potomac Valley Pediatrics has elected to participate in the Children’s National Health System’s IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child’s health care provider and one of the country’s leading children’s hospitals.

This single consent will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child’s healthcare information is encrypted and can be accessed only by health care providers who are caring for you or your child and have a need to know.

As Potomac Valley Pediatrics is a part of the Children’s IQ Network, this written single consent will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child’s treatment. You do have the option to opt out of the Children’s IQ Network. If you choose to opt out, you will need to sign a separate consent form each and every time you or your child need to be seen by another member of the Children’s IQ Network other than those at Potomac Valley Pediatrics.

Patient Rights: I have access to a copy of the Children’s IQ Network (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider’s records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share health information with other providers within the CIQN (the right to “opt-out”).

Protected Disclosure of Information: I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child’s treatment as defined in the Notice of Privacy Practices. I agree to Children’s National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

 Patient Name Date of Birth

 Signature of Patient (or parent if minor) Date

CIQN Combo Consent MD 04/2014

**PRACTICE POLICIES**

Potomac Valley Pediatrics

Avneet K. Bawa M.D.,F.A.A.P. & Associates

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North Potomac, MD 20878

**1. CONSENT TO MEDICAL CARE:** By my signature or electronic signature below, I warrant that I am the parent or legal guardian of the registered child(ren) named on the Patient Registration Form. I hereby request and authorize the physician and other health care providers of Potomac Valley Pediatrics and their professional staff to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) of my child. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of Potomac Valley Pediatrics.

**2. RELEASE OF MEDICAL RECORD INFORMATION:** I give authorization to disclose all or any part of the medical record of the patients named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

**3. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby request and authorize that any insurance benefits due and payable for medical services rendered to the patients(s) be paid directly to Potomac Valley Pediatrics.

**4. PRIVACY POLICY ACKNOWLEDGMENT:** I acknowledge that I have access to a copy of the *Notice of Privacy Policies* for Potomac Valley Pediatrics.

**5. FINANCIAL AGREEEMENT AND GUARANTEE:** I accept full financial responsibility for all medical services rendered to my child(ren) and agree to any insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies; in addition, I agree to pay for any medical care that is considered a “non-covered” service under the terms of my medical insurance plan. I further agree that in the event that I fail to make such payments in accordance with the payment policies of Potomac Valley Pediatrics, or in the event of default of my financial obligation to pay for services rendered, the practice may terminate the “doctor-patient” relationship with the registered patient(s). Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs. I understand that in the event that the patient(s) are not covered by a medical insurance plan I will be required to pay in full the estimated cost at the time of visit before any medical care will be rendered. I understand that the payment may represent only a partial payment of the total fees that may be charged for the medical service to be rendered, and that I will receive a statement for the total charges incurred. I understand that this balance must be paid in full within two weeks of the date of service, unless other arrangements have been made in advance.

**6. CORRECT INFORMATION:** The undersigned certifies that he/she has provided correct information in this Patient Registration Form and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient’s parent or legal guardian, duly authorized to execute the above and to accept its terms.

CIQN Combo Consent MD 04/2014

**7. OFFICE VISITS:** are by appointment. Walk-ins are not given priority over parents who call for appointments per our policy. We will try to accommodate all patients, but we request that you be courteous of wait times.

**8. LATE POLICY:** Patients are asked to arrive 10 minutes before their scheduled appointment time in order to complete the check-in process. Patients arriving more than 20 minutes late will be required to reschedule their appointment to the next available opening consistent with the type of appointment requested. Only acutely ill children will be worked into the provider’s schedule the same day.

**9. CANCELLATION POLICY:** As a courtesy to both your provider and other families with sick children, we ask that you cancel any scheduled appointment 24 hours in advance so that others may utilize this time. Failure to attend an appointment without prior cancellation is considered a ***no******show***. ***No******shows*** are charged to the patient at **$25.00** per missed office visit or **$50.00** per missed wellness exam.

**10. CO-PAYS:** must be paid at the time of each visit. This is the policy of your insurance company, which our office is required to comply with. It is your responsibility to have the copayment ready in full on the date of service.

**11. PRESENT A VALID INSURANCE CARD AT EACH VISIT:** If you request that we bill your insurance for your child(ren)’s care, you must present a valid insurance card at each visit. Failure to present a valid card may result in your being required to pay for the service in full at that visit.

**12. PAYMENT POLICY AND FEES:** If an insurance claim is filed for you, any charges that remain unpaid after 45 days will be billed to the patient and will become due at that time. A **$35.00** fee will be assessed for checks returned for insufficient funds. An **18%** yearly interest rate fee will be charged on all accounts which are 45 days past due. Additionally, a collection activity fee will be added to any account which is turned over to a collection agency. A charge may be applied to a patient’s account for calls made to the on-call provider after office hours. There may be a minimum charge of **$15.00** per call until 10:00 pm and a maximum of **$25.00** per call between 10:00 pm and 8:00 am.

**13. CHILDREN UNDER 18 MUST HAVE A PARENT/GUARDIAN PRESENT:** Children under the age of 18 cannot legally consent to their own treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child(ren) alone or with an older sibling, grandparent, or nanny, please be aware that they have no legal authority to provide consent for treatment for your child. You must send a *signed letter of authorization with them*, or give us written pre-authorization naming the person(s) you approve in advance to consent to treatment on your behalf. If you wish to do this, please request a *pre-authorization form* from our front desk staff. The named individual authorized to attend with your child will be required to present a valid photo ID at the time of the appointment as well.

Signature of Patient (or parent if minor) Date

CIQN Combo Consent MD 04/2014

**PROTECTED HEALTH INFORMATION FORM**

Potomac Valley Pediatrics

Avneet K. Bawa M.D.,F.A.A.P. & Associates

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North Potomac, MD 20878

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

The patient or authorized parent/guardian hereby consents to the use or disclosure of their individual protected health information by Potomac Valley Pediatrics in order to appropriately carry out treatment, payment, or routine health care operations.

The patient retains the right to request further restrictions as to how their protected health information is used or disclosed to carry out treatment, payment, or routine healthcare operations.

The patient also retains the right to revoke this consent to disclose protected health information at any time during the duration of service; revocation of consent is required to be submitted in writing by the patient or the authorized parent/guardian. This written revocation of consent will be effective immediately except in the event that Potomac Valley Pediatrics has already taken actions based on previously granted consent.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and DC. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable access to your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an opt-out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

**I have read and understand the information provided above. I have received a copy of this form and understand that a copy of Potomac Valley Pediatrics’ notice of privacy policies is available upon request. I certify that I am the patient or the authorized parent or guardian of the patient and I agree to grant consent to the above stated terms.**

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Signature of Parent/Guardian Signature of Patient (if 18 years or older)

Other individuals authorized to access protected health information:

Name Relationship to Patient

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