FRANCZYK PEDIATRICS, PA. PATIENT REGISTRATION

Date: _____

How did you hear about our practice: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

D.O.B:_____ Sex: M/F Primary Language: _____

Ethnicity: Hispanic/Non-Hispanic/Unknown Race: Asian/Black/ White/ American Indian/Alaskan Native

MAILING ADDRESS:
Street/PO Box: _____ Apartment #:_____

City: _____ State: _____ Zip Code: _____ Home Phone: (_____) _____-_____

Who lives at this household? _____

CONTACT INFORMATION:

Contact 1:

Name: _____ Date of Birth: ____/____/_____ Relationship to patient: _____

Lives with patient: Yes/No If No, please list separate address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you like to be contacted regarding (Circle One)

CELL PHONE AND EMAIL MESSAGES WILL ONLY BE SENT IF REGISTERED FOR THE PORTAL.

Medical Issues: Home Phone / Work Phone / Cell Phone
Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email
Recall Notices: Home Phone/ Work Phone/ Cell Phone/ Home Email
General Practice Notices: These will only be received if family is registered for our online portal

Contact 2:

Name: _____ Date of Birth: _____/____/_____Relationship to patient: _____

Lives with patient: Yes/No If No, please list separate address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you like to be contacted regarding (Circle One)

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ADDITIONAL CONTACT QUESTIONS:
Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No

If parents are divorced or separated please fill out the next two questions:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes/ No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction? _____

EMERGENCY CONTACTS, other than parents: Name and Relationship

1._____ Phone: (____) _____-_____

2._____ Phone: (____) _____-_____

3._____ Phone: (____) _____-_____

4._____ Phone: (____) _____-_____

INSURANCE INFORMATION:

Primary Policy:
Policy Holder's Name: _____ D.O.B_____ Sex: M/F

Insurance Carrier: _____ Member ID: _____

Secondary policy:
Policy Holder's Name: _____ D.O.B_____ Sex: M/F

Insurance Carrier: _____ Member ID: _____

PATIENT AUTHORIZATION (Patients who are minors must have a parent sign):
I authorize payment from Medicare or any other insurance company be made directly to Franczyk Pediatrics, Inc. for all medical services provided to me. I authorize release of medical information as requested by my insurance company. I also agree that I will be ultimately responsible for payment of all medical bills owed to Franczyk Pediatrics, Inc.

Signature: _____Date: _____

FRANCZYK AND STORLAZZI PEDIATRICS
2700 SILVERSIDE RD, SUITE 5
WILMINGTON, DE 19810
Office: 302-478-1975
Fax: 302-478-9120

Patient Consent for Use and Disclosure of Protected Health Information in Accordance with HIPAA Guidelines

Patient Name: _____

In order to comply with the **HIPAA** regulations outlined in our **NOTICE OF PRIVACY PRACTICES**, Franczyk Pediatrics, Inc. will not disclose your medical information without your written permission except as needed for your medical **TREATMENT**, or in order to obtain **PAYMENT** from an Insurance company for medical services rendered, or to facilitate the internal health care **OPERATIONS** of Franczyk Pediatrics, Inc.

By signing below, you will be authorizing Franczyk Pediatrics, Inc. to use your protected health information (PHI) so that a practitioner will be able to record information in your medical record in order to diagnose your condition and determine the best course of treatment for you. In addition, Franczyk Pediatrics, Inc. will be able to provide your medical information to other health care providers involved in your care.

Also, Franczyk Pediatrics, Inc. will use your protected health information to obtain payment from your insurance company. This information will include your diagnosis and a listing of medical services you received.

Franczyk Pediatrics, Inc. will continue to call your home or leave a message on an answering machine or in a voice mailbox, regarding an appointment, test results, other treatment issues, or billing and payment matters. If you are unwilling to sign this **Consent for Use and Disclosure of Protected Health Information**, Franczyk Pediatrics, Inc. may decline to provide treatment to you.

I have read and I understand the information given above. I give my permission to have my protected health information used for my **TREATMENT, PAYMENT**, or other health related **OPERATIONS** of **Franczyk Pediatrics, Inc.**

_____ _____
Patient/Parent/Guardian Signature Date

If you would like a copy of our **NOTICE OF PRIVACY PRACTICES,** they are available on the white bookcase in the waiting room.

I have been offered a copy of Franczyk Pediatric, Inc's. **NOTICE OF PRIVACY PRACTICES.**

_____ _____
Patient/Parent/Guardian Signature Date

Franczyk and Storlazzi Pediatrics

2700 Silverside Rd. Suite 5
Wilmington, DE 19810

Please take a moment to familiarize yourself with our office policies.

Physicals are recommended by the American Academy of Pediatrics in the following schedule, 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months 2 years and then yearly. Please make sure that you know what your insurance covers and if your yearly physicals need to be done after a full year. **Physicals must have a parent or guardian present.**

Please bring your insurance card and photo ID to every appointment. This is required by your insurance company. Please let us know of any address or phone number changes. Due to the new red flag regulations we may need to check a picture ID to prevent Identity theft.

Many insurances now have deductibles or do not cover certain procedures/exams. If you receive a bill please check with your insurance to make sure it is correct. If correct please pay the bill in a timely fashion. If you are having difficulty paying the bill all at once, we understand. Please call my billing company at 302-633-5840 and they will help you set up a payment plan. It is the patient's responsibility to know his/her benefits including deductibles, co-pays and visit limitations. In addition, it is the patient's responsibility to keep track of visits used during his/her benefit year.

Many insurances require us to take a co-pay. Unfortunately this is not optional and we can get in trouble for not taking the copay. Copays that are due and not paid at the time of the time of the visit will be charged a $12.00 billing fee. **Returned check fee is $40.00.** If there is a history of 2 returned checks, our office will only accept cash or credit card payments**.**

Please give us a 24 hour notice when cancelling an appointment. If this is not done a $50.00 charge will be assessed to your account. If this happens three times then you will be asked to leave the practice.

It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls are a courtesy.

Forms that are completed at the time of your physical are done complimentary. If you have forms that need to be filled out aside from the time of your physical a $10.00 fee will be charged. We will sign forms as long as physicals are up to date. Allow 48 hours.

My billing company sends out bills monthly. After three bills your account will go into collections. If this happens you will be charged a 30% collection fee. This is the amount the collection agency charges us.

Copy of records fee per child: $1.25 each for the 1st through 20 pages, $.90 each for the 21st through 60th pages, not to exceed $50 per chart.

This office is a vaccine practice and vaccines are required for all patients.

May we leave test results on primary phone given? Please Circle No Yes Ph. #_____

Referrals need to be requested at least 48 hours ahead of time, unless they are needed to be done emergently.

Fees are subject to change at anytime.

Patient Name_____

Patient/Parent Signature _____

DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representatives(s) can decide about, and you can cancel this at any time. The Department, in the exercise of professional judgment, can decide that it is not in the best interest of the individual to treat the person as the individual's personal representative. See the Department's Privacy Policy and Procedures on *Personal Representatives,* pursuant to 45 C.F.R. 164.502(g).

Patient Name: _____ DOB: _____

DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____(print your name) hereby name the following person(s) to act as my authorized personal representative with respect to decision involving the use and/or sharing of protected health information that pertains to me.

_____ _____
(Print Name of Personal Representative) (Relationship to Individual)

_____ _____
(Print Name of Personal Representative) (Relationship to Individual)

_____ _____
(Print Name of Personal Representative) (Relationship to Individual)

_____ _____
(Print Name of Personal Representative) (Relationship to Individual)

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – Please check one

____ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

____ The person named above is acting as my designated personal representative ONLY for the following functions(s):

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to Medical Records. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Signature: _____ Date: _____

REVOCATION SECTION

I no longer want this person(s) to act as my personal representative(s).

_____ _____

_____ _____

Signature: _____ Date: _____