Uptown Pediatrics Patient Registration

Patient Information:

First Name_____ Last Name_____ DOB_____

Nickname/ Preferred Name_____

Assigned Gender (on Insurance Card) _____ Preferred Pronouns_____

Home Address_____

Phone_____ Email_____

Patient lives with_____

Siblings (names and DOB)_____

Parent Info:

Parent 1_____ DOB_____Gender _____

Phone_____ Email_____

Parent 2_____ DOB_____Gender _____

Phone_____ Email_____

(by providing email, parents give consent to receive email updates from Uptown Pediatrics)

Emergency Contact (other than parents):

Name_____ Phone_____ Relationship_____

Preferred Pharmacy:

Name_____ Address_____

Insurance Information:

Primary Health Plan_____ Policy #_____ Group #_____

Primary Policy Holder Name_____ DOB_____

Relationship to Patient_____ Employer_____

If the patient is covered by an additional health plan, provide secondary insurance information

Secondary Health Plan_____ Policy #_____ Group #_____

Policy Holder Name_____ DOB_____

Relationship to Patient_____ Employer_____

How did you learn about Uptown Pediatrics?_____

Endocrine and Psychiatry Patients Only:

Primary Care Doctor_____ Phone_____

I certify that the information above is complete and correct

_____ _____ _____

Name Signature Date

Uptown Pediatrics Psychiatry Intake Form

Patient name: _____
Patient's DOB: _____

Services seeking, please select at least one:

Medication management only
Medication management + therapy
Therapy only
Neuropsychological testing

In a few sentences, please summarize your main concerns:

_____
_____
_____
_____

Has the patient ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No
If yes, was this within the last 6 months? ☐ Yes ☐ No

Has the patient ever been to the emergency room for a psychiatric reason? ☐ Yes ☐ No

If yes, please provide more information: _____
_____

Has the patient ever engaged in self-harm? ☐ Yes ☐ No

If yes, please provide more information: _____
_____

Has the patient previously been diagnosed with a psychiatric illness? ☐ Yes ☐ No

If yes, please list diagnoses given: _____

Has the patient previously been on any psychiatric medications? ☐ Yes ☐ No

If yes, please list: _____

Is the patient currently in therapy? ☐ Yes ☐ No

If yes, therapist's name and contact information: _____

Any additional information that is important for us to know?

_____
_____
_____
_____

Uptown Pediatrics Psychiatry Office Policies and Consent for Treatment

Patient Name _____
Today's Date _____

In order to best serve you and your family, we would like to share psychiatry specific office policies. We are happy to answer any questions or address any concerns you may have.

Appointments and visit frequency
All patients will need to have routine follow-up visits in order to be prescribed medication. Please keep in mind that patients taking a controlled substance (including many ADHD medications) will require follow up at least monthly unless otherwise discussed with your doctor. _____

Communication outside of office visits
Please send us a message through our patient portal for non-urgent issues. For any issues that require more immediate attention or more thorough discussion, please call our office. If there is a life-threatening emergency, please call 911 or proceed to your nearest emergency room. _____

Confidentiality
We will not discuss any details of your treatment without your permission. You may revoke this permission at any time. The legal exceptions to this confidentiality include, but are not limited to, the following:
1. There is good reason to believe a patient is at risk of serious harm to themselves or others.
2. There is good reason to suspect abuse and/or neglect towards children, the elderly, or disabled persons.
3. A court order may subpoena a medical record.
4. In the case of a medical emergency, a treating psychiatrist may provide necessary information to the treating medical party. _____

Consent for treatment:
I authorize Divya Hoon, MD, to carry out psychiatric examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I understand that many medications utilized in pediatric populations, both for mental and physical health, have been clinically substantiated but are not FDA approved for children. I understand treatment is not guarantee of cure.

I have read and understood the office policies outlined above.

Patient's name: _____

Name of guardian if patient is a minor: _____

Patient's signature (or guardian if patient is a minor): _____

Date: _____

Uptown Pediatrics Psychiatry Financial Policy

Patient Name _____
Today's Date _____

We are committed to providing the best possible care to our patients and their families and feel that this goal is best achieved if everyone is aware of our financial policy. Changes in the health insurance industry have made the cost of healthcare challenging for both patients and healthcare providers. We've developed this policy to clarify your financial obligations and help you understand the requirements imposed by your health insurance carrier. We are happy to answer any additional questions you may have.

Payment Procedures and Payment Options:
Full payment is expected at the time of service, regardless of who brings the child to the office. This includes applicable co-payments as required by your insurance plan. We accept cash, personal checks and all major credit cards. A receipt will be provided to you for all payment transactions. As an added convenience, payment can be made online at *www.UptownPediatrics.com.* Contractual obligations with your insurance plan require us to collect your co-payment in full at the time of service. The accompanying parent or other adult is responsible for payment at the time of service and for providing the proper insurance identification. If there should be a dispute about the financial responsibility, we will hold the accompanying parent responsible for payment. We request that a credit card be kept on file for all payments due, including co-pays. This helps speed your check-in/out process and eliminates the need for you to receive a bill from us**. _____**

Insurance Coverage
As a courtesy, we will bill most insurance carriers directly. If the insurance information is not provided in a timely manner and the office is unable to bill the charges within the time limits set by your insurance carrier, the balance will become your responsibility. Co-pays must be paid in full at the time of the visit. Legally, we cannot reduce or waive co-payments, deductibles or other cost-sharing balances charged by your insurance plan. **As insurance plan benefits vary, it is the policyholder/parent's responsibility to know the specific benefits of their plan.** If your carrier requests other information from you such as evidence of other insurance, they will not reimburse us until you provide it. If you fail to do so, you will be billed for any outstanding charges. Billing insurance does not guarantee payment and the ultimate responsibility of the account will be yours. For self-pay patients, you are required to provide all required documentation to your insurance company for use of out of network benefits and reimbursement _____

Change of Insurance/Change of Account Information
Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. **_____**

Out of Network/ Self-Pay
If we DO NOT participate with your insurance or you DO NOT have proof of insurance at the time of check in, you will be considered a self-pay patient. Full payment will be required at time of service. _____

Non-covered Services
We will always provide your child with what we consider the best and most-up to date medical care. Some insurance plans limit coverage of procedures and services in order to control their costs. As a result, certain services we provide for your child may not be reimbursed by your plan and you will be responsible for these charges. These may include (but are not limited to) charges for after hours, weekend or emergency visits, telemedicine and telehealth visits, allergy testing, and recommended preventive screening. _____

Additional Fees

Laboratory services
We will send your lab work to the appropriate laboratory based on the insurance information you have provided to our office. We are not liable for insurance billing and balances due from outside labs. _____

After hours
There is an additional $75.00 fee charged for visits occurring on weekends, holidays and after routine office hours. We will bill this charge to the participating insurance plan, but you may be responsible if your insurance carrier does not cover this charge. _____

Emergency Basis
For services provided on an emergency basis for patients **without an appointment,** there is an additional $60.00 fee. We will bill this charge to the participating insurance plan. You may be responsible if your insurance carrier does not cover this charge. _____

Telemedicine and Telehealth Visits
There are additional fees for video, telephone, email and portal correspondence with physicians. We will bill this charge to your participating insurance provider, but you may be responsible for a portion of this visit if your insurance carrier does not cover the charge. _____

Medical Records
With the signed request from the patient, parent or legal guardian, we will provide you with a copy of your child's medical record. There is a charge of $0.75 per page for this service. If you request that we mail these records, additional postage fees are attached for mailing. We only mail records via a mail method that requires a signature and proof of delivery upon receipt. _____

Requested Forms and Letters: All forms and letters (aside from school/work excuse letters requested while in the office) will be returned via patient portal unless you provide a self-addressed stamped envelope along with your form. For expedited forms (24 hour turnaround), there will be an additional fee of $25 per form. _____

Missed Appointment Fee
Missed appointments or late cancellations represent a cost to us, you, and the other patients that could have been seen during the time set aside for your child. A $150 "no-show" fee will be charged for appointments not cancelled within 24 hours, not including holidays or weekends, of the scheduled appointment. This fee is not covered by insurance and will be charged to your credit card on file. Please call ahead if you are unable to keep an appointment and we will be happy to reschedule you. _____

Late Arrivals
Appointments will begin and end at the scheduled time. Patients arriving late to a scheduled appointment will be seen during the designated appointment slot, and as such, may be seen for less time than was originally scheduled. The session will be billed for the scheduled time. _____

Returned Check
There is a $50.00 fee for any check returned to us from the bank. _____

Collection Agency
Any charges remaining unpaid for more than 90 days from the date of service are considered delinquent and may be sent to a collection agency. In this situation, the responsible party will have to correspond with the collection agency regarding any financial arrangements and will be responsible for the original amount due in addition to any fees charged for the cost of collection. _____

Payment Plans

Uptown Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy, we may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our Billing Department. Families with a payment plan must be in full compliance with all of the conditions of the agreement at the time of visit. Failure to make the scheduled payment, or not paying the balance in full, may result in your account being turned over to a collection agency. _____

Should you experience financial hardship, please contact our Billing Department for assistance with a payment plan. They are available Monday through Friday between 8:30am and 5:00pm.

I have read the above policy and agree to its terms; by signing this financial policy, I acknowledge that all bills will be sent to me and that I am financially responsible for all bills:

_____	_____	_____
Signature of Responsible Bill Payer	**Print Name**	**Relationship to Patient**

Uptown Pediatrics
Adolescent Confidentiality Agreement

Parent

I, _____ (parent or guardian), allow _____(patient), to enter a confidential patient-physician relationship. I understand that my son/daughter can make independent health care decisions, but that my input and involvement will be encouraged. _____(patient) has permission to schedule appointments and receive confidential reports from Uptown Pediatrics. I further understand that various laboratory tests may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

_____ _____
Parent or Guardian Date

_____ _____
Physician Date

Patient

I, _____(patient), am entering a confidential patient-physician relationship with _____(physician). I will make an effort to communicate with my parent(s) or guardian(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish. I understand that if I pose an imminent risk of danger to myself or others, my parent/guardian will be notified.

_____ _____
Parent or Guardian Date

_____ _____
Physician Date

Uptown Pediatrics
Consent for Treatment of a Minor without Parent Present

I give permission for my child to be medically and psychiatrically evaluated and treated at Uptown Pediatrics in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a blood or urine test) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:
1. complete physician check-up (including blood and urine samples)
2. hearing, vision, scoliosis, and blood pressure screening
3. immunizations
4. first aid and emergency care
5. prescription and treatment for illness
6. referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

My child will be accompanied by:
[ ] himself/ herself
[ ] babysitter(name)_____
[ ] other (name, relationship)_____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Patient or Child's name Date

_____ _____
Patient or Guardian Signature (if child is a minor) Parent or Guardian Name

Phone number where parent or guardian can be reached _____