Ridgewood Pediatrics, LLC

265 Ackerman Avenue, Suite 204
Ridgewood, NJ 07450
Tel: (201)-444-3309 Fax: (201)-444-3349

Patient Registration Form

Patient Name: _____ Patient D.O.B.: _____

How did you hear about our practice? _____

Pharmacy Name and Phone Number: _____

Parent Information

Mother's Name: _____ D.O.B.: _____

Address: _____ City/State/Zip _____

Phone: _____ Mobile: _____ Work: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____ ID #: _____

Group #: _____

Father's Name: _____ D.O.B.: _____

Address: _____ City/State/Zip _____

Phone: _____ Mobile: _____ Work: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____ ID #: _____

Group #: _____

Who is the primary insurance holder? Mother Father (Circle one)

Ridgewood Pediatrics, LLC
Office Policies Form

Patient Name: _____ Patient D.O.B.: _____

Insurance

- We currently participate in most health insurance plans.
- It is your responsibility to keep us updated with your correct and current insurance information.
- Insurance ID cards are to be presented before each visit.
- It is very important that you understand your benefit plan. You should know if your plan covers routine immunizations, well and sick visits.
- If your insurance plan requires choosing a primary care physician (PCP), you have to make sure that our name and telephone number appears on your card.
- All newborns have to be enrolled/added to parent's policies as soon as possible after birth.

Payments

- All payments for services are expected at the time of the visit. This includes co-payments, deductibles, and previous balances.
- We accept cash, personal checks, and credit cards (Visa, Master Card, Discover, and American Express).
- We will bill your insurance company at the time of service as a courtesy to you.
- If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full.
- There is a $20.00 fee for all returned checks.

Referrals

- Advance notice is needed for all specialist referrals (3-5 days).

Camp & School Forms

- There is no charge for a school form completed at the time of your child's well visit.
- There is a $10.00 charge for completion of forms not presented at the time of a well visit. The fee must be paid in advance. Processing of forms may take 3-5 days.

Appointments

- Missed appointments and appointments cancelled at the last minute are a cost to us and to other patients who could have use the time set aside for you. If you are unable to keep your appointment, we would appreciate a 24-hour notice.

Medical Records

- There is a $1.00 charge per page or $100.00 for the entire record, whichever is less.
- We refer to the New Jersey Administrative Code Section N. J. A. C. 13: 35-6.5, "The reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record.

I have read and understand the above policies.

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

Ridgewood Pediatrics, LLC

Family History Form

Mother's Name: _____ D.O.B.: _____

Father's Name: _____ D.O.B.: _____

BIRTH HISTORY

Gestational Age: ____ Vaginal or C-Section: _____ Birth Wt: ____ Discharge Wt: ____

Length: _____ HC: _____ Breastfeeding: Y/N? _____ Birth Hospital:_____

FAMILY HISTORY

Mother's Age: _____ # of Pregnancies: _____ Do you smoke? _____

Health Problems:

_____

_____

Father's Age: _____ Do you smoke? _____

Health Problems:

_____

_____

Siblings:

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Please indicate if there is any family history of: (Circle all that apply)

Allergies	Hearth Disease	High Cholesterol	Drug/Alcohol Use	Stroke
Asthma	Kidney Problems	Seizures	Psychiatric Disorder	SIDS
Anemia	Diabetes	Intestinal Problems	Bleeding	Cancer
High Blood Pressure		Metabolic Disorder	Inherited Illnesses	Others

Please specify any other problems that you think might be helpful to us in the care of your child:

_____

_____

_____

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGEMENT

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem, causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity, more so, we welcome any input regarding any service problem so that we may remedy the situation properly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The "Privacy Rule" provides standards for healthcare providers to follow when disclosing health information about the patient that is needed to carry out treatment, payments, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to those we feel are in need of your healthcare information. We want to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment, or healthcare operations.

If you have any questions, comments, or objections to the privacy policies on this form, please ask to speak with our HIPPA privacy officer. You have the right to renew our entire notice of our privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name:_____

Signature:_____ **Date:** _____

If minor, signature of parent or guardian: _____

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