BEAR POND
FAMILY MEDICINE
PEDIATRICS

FRANCINE D YORK, DNP, APRN, FNP-BC

PEDIATRIC PATIENT REGISTRTION FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____Town: _____ State: _____ Zip Code: _____

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other: _____

Race: ☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/ Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Declined to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Pharmacy: _____ Phone Number: (_____) _____

Any disabilities we should know about?: _____

PARENT / GUARDIAN INFORMATION:

Parent / Guardian: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Email: _____ Can we email you a link to our patient portal? ☐ Yes ☐ No

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: _____

Parent / Guardian: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Email: _____ Can we email you a link to our patient portal? ☐ Yes ☐ No

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: _____

I (we) authorize the following people to bring my child in for treatment, and / or to contact in case of emergency.

Name: _____ Phone Number: (_____) _____ Relationship: _____

Name: _____ Phone Number: (_____) _____ Relationship: _____

Revised: January 1, 2020

55 HAZARD AVENUE ENFIELD, CT 06082
PHONE: 860.744.2244 FAX: 860.744.2220 | WWW.BEARPONDHEALTH.COM

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Patient Name: _____ **Date of Birth.:** _____/_____/_____

HOME & SCHOOL

Who does the patient live with?:_____

If age appropriate, does your child attend: ☐ Daycare ☐ Preschool ☐ Elementary School or Higher ☐ None

Name of School/Preschool/Daycare: _____

If none, who cares for your child/children during the day?: _____

ILLNESSES:

Have there been any hospitalizations?: ☐ Yes ☐ No

Have there been any major medical problems?: ☐ Yes ☐ No

Any childhood illnesses? (ex: chicken pox, measles, etc.): ☐ Yes ☐ No

Fracture or other injury?: ☐ Yes ☐ No

If yes, please describe: _____

GENERAL HEALTH:

Medications: _____

Allergies: _____Special Dietary Needs: _____

REVIEW OF SYSTEMS:

Has she/he had frequent problems with any of the following (please check and/or write in all that apply):

☐ Head Headaches, dizziness, injury, other: _____

☐ Eyes Vision problems, infection, pain, other: _____

☐ Ears Hearing problems, infections, pain, other: _____

☐ Nose Frequent stuffiness, easy bleeding, other: _____

☐ Mouth Tooth decay, poor bite, other: _____

☐ Throat Frequent sore throat, trouble swallowing, other: _____

☐ Neck Stiffness, swelling, swollen glands, other: _____

☐ Chest Deformity, pneumonia, cough, asthma, other: _____

☐ Heart Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other: _____

☐ Abdomen Vomiting, frequent pain, diarrhea, constipation, other: _____

☐ Urinary Pain on voiding, voiding frequently, bed wetting, other: _____

☐ Skin Rash, infection, other: _____

☐ Neurological Development problems, seizures, meningitis, other: _____

☐ Endocrine Weight gain/loss, intolerance to heat/cold, thirst, hair changes (thinning, falling out), other: _____

☐ Arms & Legs Deformity, abnormal walking, joint pain, joint swelling, other: _____

☐ Hematological Anemia, abnormal bleeding, other: _____

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INSURANCE INFORMATION:

Primary Medical Insurance: _____ Policy Number: _____

Secondary Medical Insurance: _____ Policy Number: _____

Party responsible for payment: ☐ Parent ☐ Other: _____

Subscribers information:

Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Cell: (_____) _____ Work: (_____) _____

*****PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor.**
The parent/guardian who is present for the office visits is the Billing Guarantor, please see below***

NOTICE OF FINANCIAL RESPONSIBILITY:

BILLING GUARANTOR

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Bear Pond Family Medicine & Pediatrics to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Bear Pond Family Medicine & Pediatrics. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Bear Pond Family Medicine & Pediatrics may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

COMBINED VISITS

If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these as two separate visits and bill your co-pay and other charges accordingly.

DIVORCE / CHILD CUSTODY

Bear Pond Family Medicine & Pediatrics will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgement, or the like (the "Arrangements"). Since Bear Pond Family Medicine & Pediatrics is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practice.**

BILLING GUARANTOR SIGNATURE / CONTACT INFORMATION:

Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Relationship to Patient: _____

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PERMISSION TO TREAT:

I (We) _____ authorize Bear Pond Family Medicine & Pediatrics and its personnel to deliver medical services to my child, listed below:

Name of Minor: _____ Date of Birth: _____/_____/_____

Signature of Parent/Legal Representative **Date** **Relationship to Patient**

PHOTOGRAPHY RELEASE / CONSENT:

Please check one of the following boxes and sign below.

☐ I **AGREE** and hereby grant full permission for Bear Pond Family Medicine & Pediatrics, Francine York, APRN, and staff to use my child / children's name(s) and picture for the wall of fame, "Office Baby Bears Just Out of Hibernation." NO photos will be used in a matter that would exploit or cause malicious representation. Your child / children's photos will not be posted on any social media websites, etc.

☐ I **DO NOT AGREE** to have my child / children's name(s) and picture used for public viewing.

Name of Minor: _____ Date of Birth: _____/_____/_____

Signature of Parent/Legal Representative **Date** **Relationship to Patient**

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ACKNOWLEDGMENT OF POLICIES

CONSENT TO TREATMENT/ASSISNMENT OF BENEFITS:

I hereby authorize Bear Pond Family Medicine & Pediatrics and associated providers, through its appropriate personnel, to perform or have performed upon me, or the client, appropriate assessment and treatment procedures.

I consent to receive calls and/or text messages from Bear Pond Family Medicine & Pediatrics for my protected healthcare and other services at the phone number(s) provided on the Patient Registration Form. I understand that I may be charged for such calls and/or text messages by my wireless carrier and that such calls and/or text messages may be generated by an automated dialing system.

I hereby assume financial responsibility for and agree to make payment in full to Bear Pond Family Medicine & Pediatrics and associated providers for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Co-payments and fees for services not covered by insurance are required at the time services are rendered. I understand and agree to inform Bear Pond Family Medicine & Pediatrics of changes in my insurance at the time of service so that claims can be filed within the insurance carrier's deadline and I will be responsible for the full fee for services rendered but not covered by my insurance carrier.

I authorize Bear Pond Family Medicine & Pediatrics and associated providers to release my information for all claims and payment purposes, as may be required by my insurance company or any third-party payer, and release Bear Pond Family Medicine & Pediatrics and associated providers from any liability related to such release of information.

I authorize Bear Pond Family Medicine & Pediatrics to disclose any information needed to confirm the validity of my prescription, as well as any information needed to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, and to third party payors. ***This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**

I assign all benefits and rights to payment for services provided by Bear Pond Family Medicine & Pediatrics and associated providers, and authorize payment to be made directly to Bear Pond Family Medicine & Pediatrics and associated providers by any third-party payer that provides benefits or payment for such services.

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their clients at their first visit. It also requires that we seek a written acknowledgement from our clients that we did, in fact, deliver that notice.

***NOTICE TO PATIENTS:* When a new baby enters the world at Johnson Memorial, your provider may need to leave the office to care for the little one. This can happen with very little notice to reschedule the day's appointments. We will do everything in our power to accommodate your needs. Thank you for your patience and understanding**

Accordingly, Bear Pond Family Medicine & Pediatrics asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" and "Office Policies" by signing this form.

Signature of Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

Revised: January 1, 2020

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HIPAA AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Name (First, MI, Last): _____ Date of Birth _____/_____/_____

I, or my authorized representative, authorize disclosure of my Protected Health Information as follows:

BEAR POND FAMILY MEDICINE & PEDIATRICS TO OBTAIN MY MEDICAL RECORDS FROM:
Name of Provider / Office: _____
Address: _____
Phone Number: (_____) _____ Fax Number: (_____) _____

DATES OF TREATMENT COVERED BY THIS RELEASE:

Date(s) of Treatment: _____

☐ **ALL PRIOR DATES OF SERVICE / TREATMENT, THROUGH DISCHARGE FROM PRESENT DATE OF SERVICE / TREATMENT.**

INFORMATION TO BE RELEASED:

☐ All Records
(**Includes** Mental Health, Alcohol / Drug / Substance, Genetic, HIV / Aids, & Medication History)

Initial _____ Alcohol or Drug Use **Initial** _____ HIV Status or Treatment **Initial** _____ Mental Health Information

☐ Progress Notes ☐ History / Physical ☐ Medication Reports ☐ Radiology Reports ☐ Consult Reports

☐ Lab Reports ☐ Discharge Summaries

This information is to be used for the following purpose(s):

☐ Continuing treatment, care and continuity of care ☐ Disability ☐ Transfer of care ☐ Patient Request

☐ Care coordination or case management ☐ Billing, collection or payment of claims ☐ Other: _____

EXPIRATION:

☐ I **do not** want this authorization to expire ☐ This authorization will expire on: _____/_____/_____

PLEASE SEND REQUESTED INFORMATION TO:
BEAR POND FAMILY MEDICINE & PEDIATRICS
55 Hazard Avenue, Enfield, CT 06082
FAX: 860.774.2220

I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Bear Pond Family Medicine & Pediatrics and associated providers to send and/or receive protected health information and that it accurately reflects my wishes.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child

☐ Guardian or conservator of conserved patient

Revised January 1, 2020

Redisclosure notice to client: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of client health care records: You are prohibited from making any further disclosure of client health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

- *Right to receive copy of this authorization* — You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* — You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization.
- *Right to withdraw this authorization* — You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact our office staff. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* — You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting our office staff.
- *HIV test results* — Your HIV test results may be released without your authorization to persons/organizations that have access under Connecticut law and a list of those persons/organizations is available upon request.

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