

WELCOME TO MILL BROOK PEDIATRICS, PC

Please Print Clearly

PATIENT INFORMATION

Last Name: _____ First Name: _____ M _____

Date of Birth: _____ Sex: M / F Nickname/goes by: _____

Street Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Email _____

Mailing Address (if different) _____

Patient's Primary Care Physician: (as listed with insurance company: circle one) Dr. Lauren Geddes / Dr. William Wirth

Name(s) of siblings in this practice: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Copay amount: _____

Member ID/Cert #: _____ Suffix # _____

Policyholders/Subscribers Name: _____ Relationship to Patient: _____

Policyholders Address if Different: _____

• Does Patient Have Secondary Insurance? Yes / No

• If Yes: Company and ID# _____

Person Responsible for Bill: (must be parent/guardian: if 18 or older, or mature/emancipated minor, must be self)

Name: _____ Phone Number: _____

Address: (if different from above) _____ Relationship to Patient: _____

CMS requires providers to report both race and ethnicity

Circle one - Race: White, Black or African-American, Asian, Japanese, Latino, Multiracial, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, Other, decline to answer

Circle One - Ethnicity: Hispanic or Latino, not Hispanic or Latino, Decline to answer

Circle One - Primary Language: English French Portuguese Hindi Mandarin Spanish Russian Other

VFC STATUS Check only one box below:

THIS CHILD IS ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC) because he/she:

- Is enrolled in Medicaid (includes Mass Health and HMO's etc. if enrolled in Medicaid)
- Does not have health insurance (check this box if enrolled Children's Medical Security Plan)
- Is American Indian (Native American) or Alaska Native

THIS CHILD IS NOT ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC) because he/she:

- Has health insurance and is not American Indian (Native American) or Alaska Native

SIGNATURE _____ **DATE** _____

FAMILY HISTORY

Family Name: _____ Who lives in your home? _____

List Children:	Name	Date of Birth	Sex	General Health	Cell # if >13 yrs. old

Parent/Guardian Information Marital Status: married / single / divorced / separated / widowed

Parent/Guardians name: _____	Parent/Guardians name: _____
DOB: _____ Occupation: _____	DOB: _____ Occupation: _____
Cell Phone: _____	Cell Phone: _____
General health: _____	General health: _____
Relationship to child(ren): _____	Relationship to child(ren): _____
Primary caregiver? Yes No	Primary caregiver? Yes No

Has anyone in the family had: (parents, grand-parents, aunts/uncles, cousins)

Allergies (list)	yes	no	If yes, how related	comments
Asthma				
TB / Lung disease				
HIV/Aids				
Suicide Attempts				
Heart Disease				
High Blood Pressure/Stroke				
High cholesterol				
Blood Disorders / Sickle Cell				
Diabetes				
Seizures				
Depression/Mental Illness				
Cancer				
Birth Defects				
Hearing Loss				
Speech Problems				
Kidney Disease				
Alcohol/Drug Abuse				
Hepatitis/Liver Disease				
Thyroid Disease				
Learning Problems/ Attention Deficit Disorder				
Family Violence				
Childhood Death / Sudden Death				

MILL BROOK PEDIATRICS, P.C.

CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS.

Patient Name: _____

Address: _____

Telephone: _____ Patient Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have received or have been offered, a copy of the Practices Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby authorize Mill Brook Pediatrics (MBP) to disclose my medical information so that MBP may treat me, seek payment from third parties for such treatment and generally carry on MBP health care operations (e.g., quality assurance). I also authorize the practice to disclose my medical information to insurers and providers outside of the practice when necessary so that these providers may treat me, seek payment for that treatment and for the purpose of their health care operations.

MY HIGHLY CONFIDENTIAL INFORMATION

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside MBP for the purpose of obtaining treatment for me, payment for the treatment provided to me and so that these entities can carry out their health care operations:

- Information about genetic testing
- Information related to confidential communications with a psychologist, social worker, allied mental health professional or human services professional
- Information about venereal disease(s)
- Information about family planning services
- If I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- Information about research involving controlled substances

Signature of Patient _____ Date _____

If the patient is an **unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:*

*Signature of Representative _____

Relationship _____ Date _____

Patient Name: _____

D.O.B: _____

Mill Brook Pediatrics (MBP) is committed to providing you with quality care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your MBP financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day that services are rendered.
- Provide your insurance company and MBP with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance and pre-certification (sign on this sheet below)

UNACCOMPANIED MINORS:

Minor must have an authorization for treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and /or deductibles are expected at the time of service.

REGARDING DIVORCE:

MBP does not get involved in disputes between divorced or separated parents. MBP does not get involved in disputes regarding financial responsibility for their child's medical expenses, copayments or scheduling appointments. By signing as guarantor below, you agree to be financially responsible for the care we provide for your child, regardless of whether a divorce decree or other arrangement place that obligation on your former spouse.

REGARDING INSURANCE:

Indemnity / Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

(PLEASE CHECK BOX) Patient: **does** **does not** currently have Masshealth / Medicaid - HMO Insurance

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)

Each time you make an appointment with a MBP physician, it is your responsibility to make sure that Lauren Geddes, MD; William Wirth, MD or Mill Brook Pediatrics is currently under contract with your managed care plan and listed as your Primary Care Physician (PCP) or provider. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your card at each visit.

REFERRALS: If you are referred to a specialist, contact your insurance company to see if a pre-approved referral or authorization is required. Your PCP will send you to a specialist affiliated with MBP. Your PCP may occasionally make a referral to a physician outside his/her usual network of specialists, but only if the expertise needed to handle the condition is not available from a specialist affiliated with MBP. Call your PCP's office in order to obtain an insurance referral if one is required. It is your responsibility for giving your doctor's office a minimum of 1 week before being seen by a specialist. Retro referrals may not be allowed on all managed care plan. Therefore if a referral is not obtained, you may be responsible for payment in full by the Specialist.

PAST DUE ACCOUNTS: Accounts that have a balance that is 120 days past due will be unable to schedule any health maintenance visits for any patients associated with this account. In order to schedule your next health maintenance visit full payment or payment arrangements must be made. If difficulty should arise in paying your bill, please call our office.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to MBP or my Physician. Any changes in this authorization must be received in writing within 30 day of the effective date.
- I understand that this practice has a no show appointment fee of \$25. I am responsible for paying the fee if I do not cancel with 24hrs notice.
- In the event that my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment. I agree to the release of any and all medical information and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Signature _____

Date _____

Well Child Visit Co Pay and Deductible Policy

Due to confusion regarding the collection of out-of-pocket payments for well visits, Millbrook Pediatrics would like to attempt to clarify when a copay or coinsurance will be required.

Preventive health services for children are covered under most insurance plans without a copay or coinsurance.

These preventive services are defined by the Affordable Care Act as (in alphabetical order):

- Alcohol and drug use assessment
- Autism screening
- Behavioral assessment
- Blood pressure screening
- Cervical dysplasia screening
- Depression screening
- Developmental screening
- Dyslipidemia screening
- Fluoride supplements
- Hearing screening
- Height, weight, and body mass index screening
- Hematocrit or hemoglobin screening
- HIV screening
- Immunizations
- Iron supplements
- Lead screening
- Medical history review (allergies to medications, prescriptions, family history, surgical history, hospitalizations, etc.)
- Obesity screening and counselling
- Oral health assessment
- Sexually transmitted infection counselling and screening
- Vision screening

Your insurance carrier may require a copay or coinsurance payment if medical problems outside the scope of preventive health services, as defined by the Affordable Care Act, are addressed at the time of a well visit. This may include new problems or concerns identified at the time of the visit, or evaluation and management of previously identified problems. Common issues that may require copay or coinsurance payment include but are not limited to:

- Acne
- Acute illnesses
- ADD or ADHD
- Asthma
- Developmental delays
- Feeding issues
- Fatigue
- Headaches
- Mental health concerns
- Menstrual abnormalities
- Musculoskeletal complaints
- Physical exam abnormalities
- Rashes or skin lesions
- School problems
- Scoliosis

Millbrook Pediatrics will not collect copays at the time of a well visit. ***If your insurer determines that due to the services provided a payment is required, you will receive a bill describing the payment due.***

Patient Name: _____ Date of birth: _____

Signature: _____ Date: _____

Mill Brook Pediatrics Vaccine Policy Statement

Mill Brook Pediatrics is dedicated to providing comprehensive, compassionate, and quality care to our patients and families in the communities we serve. We are committed to practice medicine in compliance with the evidence based guidelines established by groups of experts, such as the American Academy of Pediatrics, Centers for Disease Control and Prevention, and the Advisory Committee on Immunization Practices. To that end, we feel that the best way to protect the health of all our patients is to require that they are all fully immunized according to the schedules published by the above organizations.

We at Mill Brook Pediatrics firmly believe that vaccinating children and young adults may be the single most important health intervention we perform as healthcare providers, and that parents perform for their children. The recommended vaccines and the schedule for administering them are the result of decades of scientific study and data gathered on millions of children by thousands of our most accomplished physicians and scientists. To put it simply, vaccines save lives. A recent study by the CDC reported that childhood immunizations administered over the past two decades will prevent 322 million illnesses, 21 million hospitalizations, and 732,000 deaths.

We at Mill Brook Pediatrics firmly believe in the safety of our vaccines. We firmly believe, based on the wealth of available literature, evidence, and medical studies, that vaccines do not cause autism or other developmental disabilities. Vaccines are safer today than they have ever been and there are no detrimental effects of giving multiple vaccines or combination vaccines at the same visit. Vaccines do not weaken a child's immune system, they strengthen it and allow it to combat viruses and bacteria it is exposed to at a later time.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that this policy is necessary. Because of vaccines, most people have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or chicken pox, or known a friend or family member whose child has died or become permanently disabled from one of these diseases. Such success has made some of us complacent with oftentimes tragic results. Over the past few decades we have seen multiple outbreaks of vaccine-preventable diseases such as measles, H. Influenza, and pertussis, with multiple deaths from these diseases and their complications. Many of those who contract disease during these outbreaks are unvaccinated, some by choice, but more importantly some are infants too young to receive vaccines.

As your trusted health care providers, we feel that we have an important responsibility to protect our patients, their families and their communities from vaccine-preventable diseases, especially the most vulnerable among us, namely infants too young to receive vaccines. We can no longer accept the risk that unimmunized or under-immunized children or adolescents pose to other children and their families in our practice and our communities. We will not tolerate the chance that an infant may be exposed to a vaccine-preventable disease in our waiting room by an unvaccinated patient. Our actions are consistent with what many other pediatric practices across the country are doing to prevent the spread of deadly preventable diseases.

We at Mill Brook Pediatrics therefore ask that each of our patients be up to date at each visit with the recommended vaccines for diphtheria, tetanus, pertussis, H. influenza, S. pneumonia, rotavirus, measles, mumps, rubella, varicella, polio, and meningococcus, unless medical contraindications exist. Although we also recommend that patients be vaccinated against hepatitis B, hepatitis A, and HPV; and that they receive yearly influenza vaccines, these vaccines will not be considered mandatory. If a patient is not currently up to date, then a catch-up vaccination schedule will be developed by the physician and parents of the patient. If a family decides not to follow the catch-up vaccine schedule, then the names of other pediatric providers in the area will be given to the family so they may find alternative care.

We hope that you see that this decision is in the best interest of your children and the other children in our practice. Please contact our office if you have any questions about this policy. Further information regarding immunizations can be obtained from the American Academy of Pediatrics (aap.org), Centers for Disease Control and Prevention (cdc.gov) and the Vaccine Education Center at the Children's Hospital of Philadelphia (vec.chop.edu).

Patient Name: _____ Date of birth: _____

Signature: _____ Date: _____

How did you hear about us?

- Another patient in our practice
- Website
- Social Media
- OB/GYN
- Other: _____

Visit our website:

MillbrookPediatrics.com

