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MERIDIAN PEDIATRICS
PATIENT REGISTRATION FORM
(Please print)

Today's date: ______________________ **Physician:** ______________________________

PATIENT INFORMATION

Patient Name:_____________________________ **DOB:**_________________________

Address:_____________________________________ **City:**____________**State:**_____
Zip Code:______________ **Phone:**_____________**Male or Female:**___________

INSURANCE/ GUARANTOR INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill: _______________________ **DOB:**_________________
Social Security Number:__________________________

Address: (If different from above)______________________**City:**__________**State:**_____

Zip Code:______________**Phone:** __________________ **Email:**____________________
(We will use your email address only for appointment confirmation)
Employer: __________________________**Employer Phone Number:** _________________

INSURANCE CARRIER:
(Without this information we are unable to bill your insurance.)

Primary Insurance Company: _____________________________________

Subscriber:___________________DOB:_____ Social Security Number:________
Insurance Address:__________________________City:______________State:_____
Phone:____________________________Policy #:_____________________________
Group #:_____________________________ Relationship to patient: ____________

Copay or Deductible amount: ________

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INITIAL HISTORY QUESTIONNAIRE

NAME:

Date of Birth: ______________________ Age: ________

Form completed by: ____ Date: ________________

Household Information:

Name	Relation to child	Birth Date	Health Problems

Are there siblings not listed? If so give names and where they live. If one or both parents are not living in the home, how often does he/she see that parent? ____

____

Birth History

Birth weight ____________ Vaginal or Caesarean Section? (please circle) If Caesarean, why? ______________

____

Was your baby born term or early? If early, why? ______________________

Any illness or problems in the pregnancy? ☐ Yes ☐ No How many weeks gestation? ______________

During pregnancy did mother smoke, drink alcohol, or use illicit drugs? ☐ Yes ☐ No

Was mother on any medications during pregnancy? ☐ Yes ☐ No

Did your baby have any problems right after birth? ☐ Yes ☐ No If so, what were they? ______________

____

Was initial feeding ☐Breast or ☐Formula?

Did your baby go home with mother from the hospital? ☐ Yes ☐ No

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain: ______________

Does your child have any illness or medical condition? ☐ Yes ☐ No Explain: ______________

Has your child had any serious injuries or accidents? ☐ Yes ☐ No Explain: ______________

Has your child had any surgeries? ☐ Yes ☐ No Explain: ______________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain: ______________

Is your child allergic to any medications: ☐ Yes ☐ No Explain: ______________

Is your child allergic to any foods? ☐ Yes ☐ No Explain: ______________

Is your child on any chronic medications? ☐ Yes ☐ No Explain: ______________

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain: ______________

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain: ______________

If your child is in school:

- How is his/her bahavior in school? ______________
- Has he/she repeated or failed a grade in school? ☐ Yes ☐ No Explain: ______________
- How is his/her academic performance? ______________
- Is he/she in a special/resource class? ☐ Yes ☐ No Explain: ______________

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FAMILY HISTORY

Have any family members had any of the following?	YES	NO	WHO?
Deafness			
Nasal allergies			
Asthma			
Tuberculosis			
Heart Disease (before 50 years old)			
High Blood pressure (before 50 years old)			
High cholesterol			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Diabetes (before 50 years old			
Bed-wetting (after age of 10)			
Epilepsy/ Convulsions			
Alcohol abuse			
Drug abuse			
Mental Illness			
Mental retardation			
Immune problems, HIV Aids			
Additional family history:			
PATIENT PAST HISTORY: Has your child ever had:			
Chickenpox			
Frequent ear infections			
Nasal Allergies			
Problems with eyes/ vision			
Asthma, bronchiolitis			
Pneumonia			
Any heart problem or heart murmur			
Anemia or bleeding problem			
Blood transfusion			
Frequent Abdominal Pain			
Constipation requiring doctor's visit			
Bladder/ Kidney infection			
Bed-wetting after age of 5			
Has she started her menstrual periods			
Chronic or recurrent skin problems			
Frequent headaches			
Seizures or neurological problems			
Diabetes/thyroid problem			
Use of alcohol or drugs			
Any other significant problems			

CONSENT FOR ELECTRONIC COMMUNICATIONS

Phone Messaging, E-mail, or Other Electronic Communications. To provide the best care possible, Meridian Pediatrics seeks to communicate with its patients in a convenient and effective manner, including phone messages and email. Please note that such communications sent through the internet or over phone systems may not be encrypted or secure, and could result in unauthorized persons accessing your information. If you would like Meridian Pediatrics to communicate with you electronically despite these concerns, please indicate your preferred method of communication and sign below.

☐ **E-mail.** Use this e-mail address: ________________________________

☐ **Secured Phone Number.** Use this number to leave a message regarding protected health information such as lab and x-ray results and referral information__________________________. This number will remain the primary phone number on your child's account.

☐ **Please check this box if you DO NOT want a message left.**

____

____

Patient Name (printed): ____

Patient's Date of Birth: ____________________

Patient/Personal Representative's Signature: ______________________________

6404765_1.DOCX

CONSENT FOR TREATMENT OF MINOR CHILDREN

(Accompanied by an adult other than parent or legal guardian)

I,____, authorize Meridian Pediatrics

(Parent or Legal Guardian)

to treat ____

(Child)

for routine and emergency medical treatment, including vaccinations when deemed necessary by qualified medical personnel when accompanied by:

____

____

____

____

This authorization is valid for:

- ☐ Today's visit only
- ☐ From________________ (date) to __________________ (date)
- ☐ Until revoked in writing by me

This consent will be valid for one year from the date signed unless otherwise specified in writing.

Printed Name of parent/legal guardian:____________________________

Signature of parent/legal guardian:__________________________
Date:__________________

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MERIDIAN PEDIATRICS FINANCIAL AND OFFICE POLICIES

Meridian Pediatrics is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the doctors of the practice and the child's parent or guardian. Your clear understanding of the financial policy agreement is important to our professional relationship.

Insurance

- As a courtesy to our patients, Meridian Pediatrics will file claims to most insurance carriers. It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier as well as if we are contracted with your carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the insurance company has not processed and paid the claim within a timely manner or has denied the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for treatment.
- We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from **THE DATE SERVICES ARE RENDERED**. Therefore, it is necessary for you to know what benefits your insurance plan provides.
- It is the responsibility of the patient to provide accurate and timely insurance information. Therefore, an insurance card must be presented at the time of service.
- It is your responsibility to understand your benefit plan with regard to covered services. For example:
  a. Not all plans cover annual well child visits, sports physicals, hearing or vision screenings, and developmental screenings. If these are not covered, you will be responsible for payment.
  b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay and you will be responsible for payment.
- If your insurance requires you to designate a primary care physician, it is your responsibility to notify them.
- We will bill secondary insurances as a courtesy, however, if payment is not received in a timely manner then you are ultimately responsible for any outstanding balances.
- Auto Accidents/Workers' Compensation/Liability Injury: Full payment is due at the time of service. Due to the lengthy settlement process, our office does not get involved in third party liability claims. Upon your request, itemized billing can be requested from our billing department to assist you in filing your claims.

Change of Personal Information

It is your responsibility to notify our office of changes in personal information such as insurance, address, phone number.

Copays

Copayment for services, in accordance with your insurance benefits, is due at the time of service. The cost of billing co payments often exceeds the actual co payment amount, therefore, we reserve the right to charge a $10 processing fee if you are unable to pay your co-payment at the time of service.

Remaining Balances After Your Insurance Company has Paid

Meridian Pediatrics will submit a claim to your primary health insurance company for services provided. Any balance remaining after insurance reimbursement is your responsibility. This balance may include your deductible, coinsurance and any and all charges not covered by your insurance company.

Self Pay Patients

Payment is due in full when services are rendered and will be given a 20% discount. If payment cannot be made in full at the time of service then a payment arrangement must be made prior to leaving the office. The 20% discount is forfeited if payment is not received in full on the date of service.

Divorce

In cases of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out payment of your child's medical care between custodial and non-custodial parent.

PAST DUE BALANCES

- Meridian Pediatrics makes every attempt to collect past due balances by sending monthly statements. We understand that full payment may not be possible in certain circumstances. All balances are due within 90 days from date of service. After 90 days, all unpaid balances will be turned over to a Collections Agency where additional fees may apply. As a courtesy, Meridian Pediatrics offers payment plans if arranged within 60 days from date of service. If payment arrangements are not set up within 60 days then payment is due in full by 90 days after date of service.
- If your account is turned over to a Collections Agency, you will be required to pay in full at future dates of service until account is in good standing.
- Meridian Pediatrics accepts cash, check, and all major credit cards. We also accept Flex account and health saving account payments. We are unable to accept CareCredit as a form of payment. A $25 fee will be assessed to your account for all returned checks.

Missed Appointment Policy

- Meridian Pediatrics requires a 24 hour cancellation notice prior to scheduled visits. If you are going to be more than 10 minutes late, please be prepared to reschedule your appointment. If your child no shows more than 3 visits without 24 hour notification you will be subject to dismissal from our practice.

Prescription Refills, Medical Records Requests, Referral Requests and Physical Forms to be filled out:

- Please allow our staff 72 hours to complete these requests.

Acknowledgement:

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient name: ______________________________________

Responsible Party Name: ______________________________

Relationship to Child: _________________________________

Responsible Party Signature: ___________________________ Date: ________________

Meridian Pediatrics

Office Use Only: □ Faxed □ Mailed □ In person/ID checked

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AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION

Patient: ______________________________ Date of Birth: ______________

Address: ______________________________

____

Phone: ______________

Release Information From:	**Release Information To:**
□ Meridian Pediatrics	□ Meridian Pediatrics
□ Other: (Specify Name, Address, Phone)	□ Other: (Specify Name, Address, Phone)
______________________	______________________
______________________	______________________
______________________	______________________

1. **Relevant Time Period.** The entity/person listed above may use or disclose information relating to healthcare provided during the following time period:
   - ☐ Anytime.
   - ☐ Healthcare provided between (*date*) ______________ and (*date*) ______________.
2. **Types of Information.** Meridian Pediatrics may use or disclose the following type(s) of information:
   - ☐ Any information concerning the Patient's healthcare or payment during the relevant time period.
   - ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
     - ☐ Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc.*)
     - ☐ Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc.*)
     - ☐ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: ______________________________
3. **Purpose.** Meridian Pediatrics may use or disclose the information for the following purpose(s):
   - ☐ The disclosure is made at the Patient's request.
   - ☐ For a potential or pending legal proceeding.
   - ☐ For marketing. Meridian Pediatrics *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.
   - ☐ Other: ______________________________

I understand that I have the right to revoke this authorization at anytime except to the extent that Meridian Pediatrics has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Meridian Pediatrics Medical Records Department

I understand that Meridian Pediatrics may not condition the Patient's healthcare on this authorization unless (1) the purpose for Meridian Pediatric's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Meridian Pediatrics pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: ______________________________.
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

______________________________ ______________________
Signature Date

____
Authority or relationship to the Patient

** Give a copy of the authorization to the Patient or personal representative.*

Meridian Pediatrics
Competence
Caring
Compassion

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.

Meridian Pediatrics
Phone (208) 338-5437

- To contact you to raise funds for our affiliated hospital. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Idaho Health Data Exchange. Meridian Pediatrics has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE and you do not want to have your health information shared with other providers involved in your care then you can opt out. To opt out, you will need to complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form and mail or fax it to IHDE. You will receive a confirmation letter upon completion of your request. This will only restrict your information from being released through the exchange only (you will need to contact direct any facility you wish to also restrict your information with). The opt out form is located at the front desk. If you do not complete this form, we may share your protected health information with other participating healthcare providers involved in your care through the IHDE. This is a secure statewide internet based health information exchange, with the goal of improving the quality and coordination of health care in Idaho.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Tiffany Neale
Phone:	(208) 338-5437
Address:	3653 N. Locust Grove Road

8. Effective Date. This Notice is effective May 12, 2015.

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MERIDIAN PEDIATRICS
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ **Patient ID #:** ____________________

I hereby acknowledge that I have received a copy of Meridian Pediatric's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

____________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____
____

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