Atlantic Pediatrics

Web: AtlanticPediatricsRI.com
Phone: (401) **943-7337 Fax:** 401.942.1509

Patient Registration-1

Parents, please fill out these forms to update important information for our electronic medical records. Please write clearly, and use only a BLACK INK PEN as this form will be scanned into our computer system.

Child's Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____ Ext _____

Child's BirthDate: ___MM___/___DD___/___YYYY_____ Sex: M F Child's Social Security # (if available): _____-_____-_____

Primary Doctor: (Concannon & Vitale) or _____

Pharmacy Name: _____ Address: _____ City/State: _____

Mother's Last Name: _____ First Name: _____ Initial: _____

Mother's BirthDate: ___MM___/___DD___/___YYYY_____ Mother's Social Security #: _____-_____-_____

Mother's Home Address: (Check box if same as child's) ☐ _____

Mother's City: _____ State: _____ Zip: _____-_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____ Ext _____

Father's Last Name: _____ First Name: _____ Initial: _____

Father's BirthDate: ___MM___/___DD___/___YYYY_____ Father's Social Security #: _____-_____-_____

Father's Home Address: (Check box if same as child's): ☐ _____

Father's City: _____ State: _____ Zip: _____-_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____ Ext _____

Medical Insurance Company: _____

Policy Holder's Last Name: _____ First Name: _____ Initial: _____

BirthDate: ___MM___/___DD___/___YYYY_____ Policy #: _____-_____-_____ Sex: M F

Relationship to Insured (Circle one): Child Step-Child Foster-Child Grandchild Niece/Nephew Other: _____

Second Insurance Company (if any): _____ Policy # _____

Second Policy Holder's Name: _____ BirthDate: ___MM___/___DD___/___YYYY_____

I hereby consent for my child to be treated by Atlantic Pediatrics (Drs. Concannon & Vitale), and I present that I have the authority to do so. I authorize the release of any information relating to claims for benefits submitted on behalf of my children, and I authorize Atlantic-Pediatrics to submit claims for benefits for medical services rendered. I consent to allow their access to all other sources of medical records on my child. I give permission for medical information to be left on my personal voice mail. I have received or been offered a copy of the Notice of Privacy Practices for Atlantic Pediatrics. If my child will be receiving any immunizations, I am offered standard vaccine information statements about the reasons and side effects of each vaccine. I understand there is a $20 fee for missed appointments not cancelled 3 hours ahead, and a $20 fee for processing bounced checks.

_____ Date: ____/_____/_____

Parent Signature-
Additional Information (if any):

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Patient Registration-2

Parents, please fill out these forms to update important information for our electronic medical records. Please write clearly, and use only a BLACK INK PEN as this form will be scanned into our computer system.

Child's Name: _____

Current Medicines: (*Daily or as needed)* ☐ None _____

Allergies to Medicines or Foods: ☐ None _____

Long-term illnesses, such as asthma, diabetes, etc.: ☐ None _____

Medical specialists your child currently uses: ☐ None _____

Other specialists your child has seen in the past 5 years (*example*: *skin doctors*, *heart doctors*, etc) ☐ None _____

Child's hospitalizations overnight: ☐ None _____

Child's Surgeries or Operations: ☐ None _____

New Patients Only: How did you hear about us?: _____

Anything else? _____

Thank You!

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Patient Registration-3

Parents, please fill out these forms to update important information for our electronic medical records. Please write clearly, and use only a BLACK INK PEN as this form will be scanned into our computer system.

Child Name: 1._____ Date of Birth:____/_____/_____

Child Name: 2._____ Date of Birth:____/_____/_____

Child Name: 3._____ Date of Birth:____/_____/_____

Child Name: 4._____ Date of Birth:____/_____/_____

Your Best Phone Number: _____-_____-_____ **Text (Cell) Number:** _____-_____-_____

Your preferred e-mail address: _____ □ None

Do you allow Atlantic Pediatrics to look up your child's medication and health history from external sources? This will allow us in some cases to select the most appropriate and least costly medication for you child by cross-checking with data from your health insurance company. *Circle One:* Yes No

Do you allow us to leave a message on your home answering machine and cell voicemail? *Circle One:* Yes No

Do you allow us to leave a message on your work voicemail? *Circle One:* Yes No

Do you allow us to contact you via videoconference either through your cell-phone or computer? *Circle One:* Yes No **Note: You may be responsible for any applicable CoPays or Deductible payments, depending on your health insurance plan.**

Please Excuse Us……

The Federal government now requires doctors to collect all sorts of personal information on their patients. This is part of regulations for health care reform and equity, and may be used in reporting data for improvements in public health. If you prefer not to answer the questions, please select "Refuse to Answer".

Your child's residence type: *Circle One*: Private home, house, condo or apartment Group Home Homeless Refuse to Answer

Your child's race: *Circle One:* White Asian Black/African-American Hispanic Native American Refuse to Answer

Your child's ethnicity: *Circle One:* Non-Hispanic Hispanic Refuse to Answer

Primary language spoken at home: English Spanish Cambodian Portuguese French Creole Other:_____

X_____ _____/_____/_____
Signature of Parent/Legal Guardian of all children listed above Date

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Our Office Financial Policy

As the health insurance market changes, many of our patients' families will be facing **large deductible** costs before their new health insurance provides coverage for medical payments. Others may encounter **higher co-pays** for office visits. **Please realize that we cannot be absorbing these costs for you**. Therefore, we have adopted this **Financial Policy** for our office that we require all parents and guardians to **read and sign at the bottom**. If you have any questions, do not hesitate to ask a member of our staff. We accept cash, checks, Visa, MasterCard, and Discover cards.

1. There are many different types of health insurance, plans, and coverage levels. Most families have health insurance of some type for their children, but it is still the **parent's or guardian's responsibility to make sure that all charges for our services are paid.**
2. If applicable according to your health insurance plan, **you are responsible for all co-payments, deductibles, and coinsurances** for all medical services received. These fees are determined by the insurance company you selected, not by us.
3. **All co-payments are expected to be paid at the time of service.** This is an insurance company requirement.
4. We consider the **parent that schedules the child's appointment and/or accompanies the child on the visit to be personally responsible for all past and present charges.**
5. **We are required to see your child's health insurance card at each visit.** If we are your child's primary care physician (PCP) and your insurance requires it, make sure the **name of Dr. Vitale, Dr. Concannon, or Atlantic Pediatrics appears on your card**. If your insurance company has not yet been informed that we are your PCP, you may be financially responsible for your current visit.
6. It is your responsibility to keep us updated with your **correct insurance information**. If the insurance information you provide us with is incorrect, you will be responsible for payment of the visit.
7. It is your responsibility to know which of our medical services are covered by your insurance company. For example, **not all plans cover well visits, sports/camp physicals, virtual or video visits (telemedicine). Recommended shots, vision, hearing, and developmental screenings may or may not be covered by your insurance.** If these are not covered, you will be responsible for payment for those services. We suggest before you make an annual physical appointment, that you check with your insurance company to see whether the visit will be covered as a healthy (well-child) visit.
8. **Care rendered related to sick child issues and chronic care follow ups are not considered well-child care and are not covered by well-child care No Co-Pay rules. This applies even if the child was originally scheduled for a well-child visit but has health concerns brought up during the physical exam. We may perform tests for strep, flu, COVID etc., that might also result in a copay or deductible charge for you.**
9. Once the health insurance company has settled the claim with us for each visit, we will bill you for any amounts due but not paid by your insurance under the contract terms. **Your payment to us is due within 10 business days of your receipt of our bill for our services.**
10. It is your responsibility to know if a written referral authorization from us is required to see specialists, and whether the specialist is participating with your health insurance. Remember, we must approve all such referrals authorizations **before** they are issued.
11. **It is your responsibility to understand your health insurance plan** about the need for you to receive medical services at participating specialists, labs, x-ray centers, and hospitals.
12. If you do not have current health insurance, if we do not participate in your insurance plan, or if you cannot prove current health insurance, you are expected to **pay for services in FULL at the time of the visit.** We accept cash, checks, Visa, MasterCard, and Discover credit and debit cards.
13. Unless previous arrangements have been made with our office for a payment plan, any unpaid amounts due to us for **longer than 90 days will be forwarded for collection action**. You will be responsible for any reasonable attorney fees we incur to collect the debt.
14. **There is a charge of $20 for missed appointments. Please know that insurance companies (including Medicaid/RIteCare) will NOT pay this bill for you.**
15. **A $20 fee in addition to all bank fees will be charged for any bounced checks (insufficient funds).**
16. For well-child and physical appointments, **any prior unpaid amounts due to us must be paid before we issue the Physical Exam and clearance form.**
17. We will give you a **physical form and vaccine record** at the time of your child's annual well-child physical provided your balance due us is up to date. It is your responsibility to keep and make copies of the form as needed throughout the upcoming year. However, should you lose this form and need to replace it there will be a **$5 charge for a new copy**.
18. Any special school, camp, or sports physical forms that are requested are subject to a **$5-per-form fee.** This includes Family and Medical Leave Act forms and many special football clearance forms. Payment is due when the forms are dropped off. We require a 3-day turnaround time. Other fees may apply in special circumstances.

I have read and understand this Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name: _____ **Parent Signature:** _____ Date: _____/_____/_____

Atlantic Pediatrics
Drs. Concannon & Vitale LLC
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055
Phone: (401) 943-7337 **Fax:** 401.942.1509 **Web:** AtlanticPediatricsRI.com

Patient Records Transfer-IN

Mail, fax, or bring this 1 page form to your child's previous doctor. Please note that prior medical and immunization records MUST be received by our office at least 3 days before any appointment for your child with us, so that the records can be properly reviewed and entered. You may submit this one page directly to your previous physician. Any applicable fees are your responsibility.

Request for Transfer of Medical Records from:

Please transfer my child's/children's medical records to Atlantic Pediatrics via fax to **401.942.1509** (preferred) or at the above address if by mail.

Previous provider & Address

Child Name: 1._____ Date of Birth: ____/_____/_____

Child Name: 2._____ Date of Birth: ____/_____/_____

Child Name: 3._____ Date of Birth: ____/_____/_____

Child Name: 4._____ Date of Birth: ____/_____/_____

_____ _____ _____ _____ Address
City State Zip

I hereby authorize the disclosure and/or transfer of medical records

◯ Pertinent past records, immunizations, consults etc.

◯ All medical records covering the period from birth to present

for the purpose of providing continuing medical care for my children or myself as listed above. This information to be disclosed will include all information, inclusive of alcohol, drug abuse, HIV testing, psychiatric notes, venereal disease and/or other sensitive information.

Medical information is protected under law and, except as provided by law, cannot be disclosed without written consent. Information released with this authorization must not be given, sold, transferred, or in any way relayed to any other person or entity not specified above. When medical information is transferred, the sender cannot necessarily prevent further disclosure by the recipient under HIPAA privacy rules. This authorization may be withdrawn at any time by submitting a written revocation to the sender.

_____ _____
Printed Name of Parent/Guardian/Patient Relationship to Patient(s)

_____ _____/_____/_____
Parent/Guardian/Patient Signature Date

Comments: