Regal Pediatrics

Dr. Mahmoud Elghoroury

ADULT NEW PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION CLEARLY

Name:______________________________ Date of Birth: ______________

Gender: M / F SSN #: ____________________ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

Address:______________________________City:____________________Zip:________

Phone Number: ______________ Cell: ______________Email:____________________

Would you like to receive automated apt. reminders & access medical records? ☐ YES ☐ NO

How did you hear about us? ______________________________

EMPLOYER INFORMATION

Are you currently employed? [] YES [] NO

Name of Employer: ______________________ Phone: ______________ Fax: ____________

Address: ____________________ City: ____________________ State: ________ Zip: ________

EMERGENCY CONTACTS

(LIST ADDITIONAL PERSONS WHO MAY BRING CHILDREN FOR APPOINTMENTS OR WHO WE ARE AUTHORIZED TO COMMUNICATE WITH FOR MEDICAL INFORMATION)

Name: ______________________Relationship:______________ Phone: ______________

Name: ______________________Relationship:______________Phone: ______________

Name: ______________________Relationship:______________Phone: ______________

INSURANCE INFORMATION – PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD

Primary Insurance Plan:______________________________ Plan Type: ☐ Medicaid ☐ Private/Commercial

Member ID: ______________ Group ID: ______________

Subscriber Name: ____________________ Date of Birth: ____________ SSN: ____________

Secondary Insurance Plan:______________________________ Plan Type: ☐ Medicaid ☐ Private/Commercial

Member ID: ______________ Group ID: ______________

Subscriber Name: ____________________ Date of Birth: ____________ SSN: ____________

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT

- ✓ I understand that I am financially responsible for all professional charges that my children may incur.
- ✓ All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.
- ✓ I hereby authorize payment of medical benefits direct to Regal Pediatrics. I further authorize the release of any medical information necessary for processing the insurance claim.
- ✓ I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.

______________________________________ ______________

PATIENT SIGNATURE DATE

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PATIENT HISTORY INFORMATION

Please list ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. (Include specific doses and when taken. If you don't know, please call your pharmacist to confirm):

____

____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: ________________	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes/No Date:	Normal Abnormal
Mammogram	Yes/No Date:	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above: ____

____

Surgical History: *Please list all prior surgeries and approximate dates performed.*

________________________________ ________________________________

________________________________ ________________________________

SOCIAL / CULTURAL HISTORY:

Education Level: ☐Elementary ☐High School ☐ Vocational ☐ College ☐Graduate / Professional

Are there any **vision** problems that affect your communication? ☐Yes ☐No

Are there any **hearing** problems that affect your communication? ☐Yes ☐No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐No

Current Living Situation (Check all that apply):

- ☐ Single Family
- ☐ Household
- ☐ Multi-generational Household
- ☐ Homeless Shelter
- ☐ Skilled Nursing Facility
- ☐ Other: ______________

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Smoking/ Tobacco Use: ☐ Current ☐ Past ☐Never Type:___________ Amount/day:__________Number of Years: _________

Alcohol Use: ☐Current ☐Past ☐Never Drinks/week: __________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type:

Are you sexually active? ☐Yes ☐No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age ________________ Deceased: Age _________________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ______________________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other:

MOTHER: Living: Age ________________ Deceased: Age _______________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________________________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other:

Siblings/other family members:

____

____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

____

____

Patient Signature: ____ **Date:**___________________

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Regal Pediatrics

PATIENT PAYMENT & FINANCIAL POLICY

Regal Pediatrics is committed to providing you with quality and affordable health care. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Please read this payment policy in full, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. Your insurance is a contract between you and your carrier. We work with most insurance companies; however, it is your responsibility to check with your carrier and confirm that we are "in-network" for your plan. The benefit packages vary from plan to plan. It is your responsibility to know what benefits and restrictions your plan has. As a courtesy to you, we will bill your insurance company for your child's visits. You will be responsible for any charges not paid by your insurance company. Please contact your insurance company with any questions you may have regarding your coverage.

2. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. For ***newborns***, please ensure you contact the insurance plan to enroll them for coverage **within 30 days** of their date of service. Failure to do so will result in a bill for the full payment of services.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicaid or other insurers. You must pay for these services in full at the time of the visit. *Our prices are representative of the usual and customary charges for our area.*

4. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. *Failure on our part to collect co-payments and deductibles from patients can be considered fraud*. Please help us in upholding the law by paying your co-payment at each visit. If you wish to save your payment information for automatic processing, your copay and balances will be applied as payments are due.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will **not** be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find an alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

I hereby acknowledge Regal Pediatrics payment policy and agree to abide by the financial agreement.

______________________________ ______________________

Signature of patient/responsible party **Date**

PATIENT APPOINTMENT & CANCELLATION POLICY

Welcome to Regal Pediatrics! We are honored that you have chosen us as your Primary Care Provider. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner. We have created this policy to keep you informed of our current patient appointment office policies.

Office Hours: We are open Monday - Thursday from 9:30 am- 5:00 pm and two Saturdays a month from 9:30 am - 2:00 pm. We are **closed** for lunch during the week from 2:00 pm to 3:00 pm and phone lines are turned off.

Appointments: When you schedule an appointment with Regal Pediatrics we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Cancellation/No Show: We understand that there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment, so we ask that you call in advance if you cannot keep your scheduled appointment. This allows us to provide that time slot to another patient.

- Any established patient who fails to show up or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a **No Show** and sent a warning letter.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a **second** time will be sent another warning letter reinstating Regal Pediatrics appointment policies.
- If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Regal Pediatrics and provided with a 30-day notice to seek another Primary Care Physician.
- Any **new patient** who fails to show for their initial visit will not be rescheduled.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy may be waived.

Running late: We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 30 minutes late.

Urgent Need or Sudden Illness: We have a limited number of same day or "walk-in" appointments available every day. Please call early in the day, as these spots fill up quickly. If there are no available same-day appointments with Dr. Elghoroury, you may schedule the next earliest appointment or in the event of an urgent medical need, we will direct you to the nearest Urgent Care.

After Hours and Emergencies: For any serious or urgent medical emergencies *call 911 right away*. If you are not sure and call our office, please be sure to tell the receptionist that it is an emergency. If you need to reach Dr. Elghoroury after hours, you may call our after-hours line at **(248) 214-6961.**

You may contact Regal Pediatrics 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

I have read and understand the appointment and cancellation policy and agree to abide by its guidelines.

_______________________________ _______________

Signature of patient/responsible party **Date**

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Regal Pediatrics
Prescriptions and Medication Refills Office Policy

Prescriptions and Refills:

Please bring all your prescription and over-the-counter medications with you during your initial visit. Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
    a. When you are down to a 30-day supply of medication, we ask that you call and schedule your follow-up office visit to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
2. For the safety and well-being of our patients,
    a. Requests for new medications (including antibiotics) and medication refills require an appointment and evaluation by Dr. Elghoroury.
    b. No new medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.

Controlled Substances:

- Patients prescribed controlled substances must be seen on a regular basis. Dr. Elghoroury will determine interval times. Please be aware that if the patient does not show up for regular visits, their medication **will not** be prescribed.
- For any new patient being prescribed controlled substances for the first time, a follow up visit must be made after 2 weeks for medication review.
- Dr. Elghoroury must be informed of any other medications being prescribed by another medical provider.
- The parent and/or legal guardian of the child is responsible for keeping track of administering the correct dosage, keeping all medications in a safe place, and ensuring that there is no access to any drugs of abuse or alcohol in the household.
- We ask that you call our office for any medication refills at least 5 business days before the medication is out.
- Dr. Elghoroury has the right to **terminate** prescribing any controlled substances to a patient and may request a transfer of care to another medical provider, if the need arises.
- All patients are required by law to sign a **"Start Talking" Consent Form** for any controlled substance containing an opioid.

Thank you,

Regal Pediatrics

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Regal Pediatrics

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Regal Pediatrics reserves the right to change the privacy policy as allowed by law.
- Regal Pediatrics has the right to restrict the use of the information but does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Regal Pediatrics may condition receipt of treatment upon execution of this consent.

May we disclose health information the **Emergency Contacts** you provided? [] YES [] NO

If you would like to authorize additional family members/friends/relatives, please list below:

Name: ______________________________ Relation: ______________ Phone: ________________

Name: ______________________________ Relation: ______________ Phone: ________________

Name: ______________________________ Relation: ______________ Phone: ________________

I hereby agree to Regal Pediatrics privacy policy and HIPAA consent requirements.

Print Name: ______________________________________

Signature: ______________________________________ **Date**: ______________

REGAL PEDIATRICS

MEMO OF UNDERSTANDING PATIENT-PROVIDER PARTNERSHIP AGREEMENT

Thank you for choosing Regal Pediatrics as your choice for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing, and personal medical care.
For this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN RESPONSIBILITIES

- Listen to you as to your health care matters, and encourage a culture of open, full and frank communication.
- Provide counsel and information regarding the different treatment plans for chronic conditions or prevention programs.
- When possible, provide convenient options including electronic access for non-urgent communications for scheduling office visits and follow up visits, and for obtaining test results and referrals.
- Provide flexible and expanded office hours, schedule appointments within a reasonable time, and see Patient as closely as reasonably possible to scheduled appointment time.
- Provide telephone availability to patient for urgent communications 24 hours per day, 7 days per week.
- As technology develops, provide convenient options for non-urgent communications between Patient and Physician including post-hospital support, follow up visits and consultations.
- Use a team approach to health care by providing access to other clinicians and health care institutions when and where appropriate.
- Coordinate and integrate care provided by my practice team and other clinicians and health care institutions effectively to avoid duplication, delay and error.
- Communicate test and treatment results promptly and correctly.
- Provide information, recommendations and advice regarding preventative care, maintaining wellness, self-management direction and counseling.
- Send reminders of the need for follow up care and preventative care.
- Maintain clinical information in a format that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records and patient registries.
- Coach the medical home base staff in the responsibilities described above.

PATIENT RESPONSIBILITIES

- Communicate openly, fully, frankly and proactively with Physician and Physician's staff.
- Be an active participant in the development with Physician of action plans and treatment plans for Patient's acute or chronic condition and follow agreed-upon treatment plans.
- Provide Physician with feedback regarding Patient's treatment plan.
- Appear on time for appointments, procedures and other medical tests at Physician's office, and timely submit materials, samples and information as requested by Physician.
- Schedule and attend follow up appointments at intervals suggested by Physician.
- Involve yourself in Physician's and other healthcare professionals' recommendations with respect to maintenance or improvement of Patient's health and wellness.
- Participate in action planning and goal setting with respect to maintenance or improvement of Patient's health and wellness.
- Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.
- Patient can opt out at any time with no repercussion.

Please take the time to carefully read this Memo of Understanding and ask the front desk if you have any questions or concerns!