

PEDIATRIC NEW PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION CLEARLY

Patient's 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:** _____ **State:** _____ **Zip:** _____

Whom does the child live with? Mother Father Both Other: _____

Are there any legal custody issues we should be aware of? _____

How did you hear about us? _____

PARENT/GUARDIAN INFORMATION

Relationship to Patient: Father Mother Other: _____

Name: _____ **Date of Birth:** _____ **SSN:** _____

Address (if different than child's): _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone #: _____ Home Cell **Email:** _____

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

Relationship to Patient: Father Mother Other: _____

Name: _____ **Date of Birth:** _____ **SSN:** _____

Address (if different than child's): _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone #: _____ Home Cell **Email:** _____

EMERGENCY CONTACTS

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.
- ✓ Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Regal Pediatrics to treat my child in their office as required by the events of that emergency.
- ✓ 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.

PARENT/GUARDIAN SIGNATURE

PRINTED NAME

DATE

PATIENT HISTORY INFORMATION

Birth History

1. Birth weight: _____ (lbs. / kg.) Birth length: _____ (in.)
2. Mother's age at baby's birth: _____
3. Type of delivery: Vaginal C-section
 - a. If C-Section, reason _____
4. Gestational age: Full-term Preterm: # of weeks _____ Post-term: # of weeks _____
5. Initial feeding: Breast Formula
6. Current feeding: Breast Formula
7. Supplements taken: _____
8. Did mother use cigarettes, alcohol, recreational drugs or medications? Yes No
 - a. If yes, explain _____

9. Were there any problems during pregnancy? (i.e. diabetes, infections, high blood pressure, breech presentation) Yes No
 - a. If yes, explain _____

10. Were there any problems during labor or nursery stay? (i.e. jaundice, feeding difficulties, breathing problems, birth defects) Yes No
 - a. If yes, explain _____

Medical History

11. Does the child have any known allergies? (i.e. drugs, foods, plants) Yes No Unsure
 - a. If yes, please list: _____

12. List any hospitalizations, surgeries and/or serious illnesses and the corresponding dates.

13. List any medical troubles? (i.e. speech, hearing, skin, ADHD, seizures) Yes No Unsure
 - a. If yes, please list: _____

14. Do you immunize your child? Yes No Unsure
15. Are their immunizations up to date? Yes No Unsure
16. Is your child exposed to smoke? Yes No
17. Do they go attend school/daycare regularly? Yes No
18. Any other medical/social/behavioral issues not listed above? _____

FAMILY HISTORY

19. Has anyone in your family (parents, grandparents, sisters/brothers, aunts/uncles) had any of the following?

High/ Low blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Hearing loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Kidney problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Alcohol/Drug abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Psychological Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Exposure to TB, STI or HIV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Mental illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Cystic fibrosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Cerebral palsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Speech problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Birth defects	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Learning problems/ attention deficit disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?
Family violence	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who?

20. Is there any other family history not listed above that you would like Dr. Elghoroury to be aware of?

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. We participate in most insurance plans, including Medicaid. If you are **not** insured by a payer we do business with, payment in full is expected at the time of each visit. If you are insured by a payer we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. 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.

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. 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 may 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 within 30 days will result in a bill for the full payment of services.

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

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

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

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!