Long Pond Pediatrics & Osteopathy

Dr. Sabine M. Schmitt, DO, FAAP, C.S.P.O.M.M.
Dr. Shoshana Katz, MD, FAAP
Dr. Kimberly Ingalls, MD, FAAP, M.P.H

Today's Date_____________

NAME OF PATIENT (CHILD)_________________________________ DOB_________________

SSN of child_______________________________ SEX M ☐ F ☐

Home Address____

City____________________________________State________________________Zip________

Home Phone___________________________Cell #____________________________________

Father's Name__________________________Mother's Name___________________________

Date of Birth___________________________Date of Birth____________________________

Work Phone____________________________Work Phone_____________________________

Cell Phone_____________________________Cell Phone______________________________

Email_________________________________ Email__________________________________

Patient lives with ☐Both Parents ☐Mother ☐Father ☐ Other ________________________

Our EHR system allows for text messages for appointment reminders and global messages to all patiens. Do you wish to receive text messages? ☐Yes ☐ No

Legal Guardian/Custody____

> Please note that Long Pond Pediatrics expects co-parents or guardians to communicate with each other with regard to their child's healthcare. LPO is not responsible for multiple points of communication. It is the responsibility of the parents or guardian to communicate in a reasonable and responsible manner with each other. If such communication is not possible, then parents and guardians are expected to arrange for a mutually acceptable third party to be the go between. Visit notes and summaries, including any instructions or referral list will be given to the adult who accompanies the child to the visit.

Preferred Pharmacy____

Emergency Contact Name (Other than Parent)____________________Relationship_____________

Home Phone_______________________________Cell Phone______________________________

Please Note a parent or legal guardian MUST come with any new patient for the first visit.

MEDICAL INSURANCE and BILLING INFORMATION

Guarantor (name of person to whom a statement is sent)________________________________

Address (if different than above)____

■ Primary Insurance

Insurance Company ____

Insurance ID # ____________________ **Group #** ____________________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle)

Relationship to Patient ________________________ **Birthdate** __________________

Address ____ **Home Phone**________________

Employer ____ **Work Phone**________________

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company ____

Insurance ID # ____________________ **Group #** ____________________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle)

Relationship to Patient ______________________ **Birthdate** __________________

Address ____ **Home Phone**________________

Employer ____ **Work Phone**________________

■ Assignment and Release

I hereby authorize payment directly to LONG POND PEDIATRICS AND OSTEOPATHY, PC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: Date:

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

____ ______________________

Parent/Guardian Name (print): Relationship to Patient:

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after if changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $50 for each no-show occurrence. Should this occur more than three times, you may be dismissed from the practice. (These policies do not apply to Medicare beneficiaries in regard to no-show charges only.) By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, pre-certifications or other required documentation prior to your appointment. If our team office determines that your plan requires an authorization, and you do not provide such referral, authorization or certification, you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, and should our team need to invoice you for that payment, you will be responsible to pay an invoice fee in the amount of $10 for each instance we send you an invoice for an unpaid copayment (except for Medicare beneficiaries), including multiple invoice instances for the same occurrence. By signing below, you accept these policies. **Copayment is expected from the adult accompanying the child to the visit REGARDLESS of legal agreements between parents.**

Returned checks: There will be an additional returned check fee of $25 for any check retuned by your bank.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee of $25, except for Medicare beneficiaries) and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services, you will be reimbursed within 30 days. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Long Pond Pediatrics and Osteopathy for any services furnished to me or my dependents.

Signature of Patient: ______________________________ Date: ____________
If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my child's appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other:

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my child's PHI may be shared with my spouse or co-parent.

♦ I agree that my child's PHI may be shared with the following other people:

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

♦ I authorize Long Pond Pediatrics and Osteopathy to fax health forms to the following educational or child care facilities:

(__ __ __) __ __ __ - __ __ __ __ Facility:__________________________ or As requested: ☐

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to LONG POND PEDIATRICS AND OSTEOPATHY, PC.

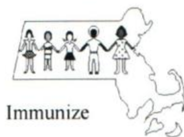
**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):

Signature: ______________________________________ Date:

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): __________________ Relationship to Patient:



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM (VFC)

Patient Eligibility Screening Form

For use in all Provider Sites, except Federally Qualified Community Health Centers

Initial screening

Initial screening date ______________________ Child's date of birth ______________________

Child's full name ____

Parent, guardian or legal representative's full name ________________________________

Health care provider's full name ____

This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office.

The form may be completed by the parent, guardian, or legal representative, or by the health care provider.

Verification of responses is not required.

Check only one box below:

This child is eligible for immunizations through the federal VFC program because he/she*:

- ☐ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled in Medicaid)
- ☐ does not have health insurance
- ☐ is American Indian (Native American) or Alaska Native

This child is not VFC-eligible because he/she:

- ☐ has health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

*This form identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the first three boxes in the section above is checked, the child is VFC eligible.

Screening at each subsequent visit (documentation required)

	VFC Eligible			Not VFC Eligible
Date	Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)	Does not have health insurance	Is American Indian (Native American) or Alaska Native	Has health insurance