WARREN PEDIATRIC ASSOCIATES, LLC

34 Mountain Blvd Ste 130 Warren, NJ 07059

Phone: 908-490-0900 Fax: (908) 490 0910

Patient Name(s): ______________________ **Date of Birth (s):** ___________________________

____________________________________ ______________________________________

____________________________________ ______________________________________

Address: ____________________________ **Gender: ( ) male ( ) female**

____________________________ **Home Phone Number** _______________________

Mother's name: ______________________ **Cell Phone Number:** ________________________

Mother's Address : ____________________ **Employer Name:** ___________________________

______________________ **Work Number:** ____________________________

Father's name: ______________________ **Cell Phone Number:** ________________________

Father's address: ____________________ **Employer Name:** ___________________________

______________________ **Work Number:** ____________________________

Primary Insurance Company: _________________ **Ins Co. Phone # :** __________________________

Policy Holder Name: ______________________________ **ID Number:** ____________________________

(no abbreviations – spell out name of policy holder) Group Number: ________________________________

Social Security Number: __________________________ **Date of Birth:** ____________________________

***Email address (for notifications, appointment reminders, etc):** _____________________________________

***Preferred Pharmacy:** _____________________ **#:** _________________ **Town:** _____________________

Referred By: ____________________________

Parent/ Guardian Printed Name: _______________________________

Parent/Guardian Signature: ___________________________________ **Date:** _________________

Warren Pediatric Associates

34 Mountain Blvd. Building A Suite 130 Warren, NJ 07059
Phone: (908) 490-0090 Fax: (908) 490-0910

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We require a minimum of 24 hour notice of an appointment cancellation. **Failure of notification will result in a $45 fee per child for any late cancellation or no show appointments.**

2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit. Well-child exams are completed year-to-date (3 years and older). If you need your child's physical sooner, parents' are responsible to contact their insurance company and obtain the name & a reference number from the representative they speak with. If claim is denied, the parents will be financially responsible for the visit.

5) Copays and deductibles apply to **All Telemedicine Visits.**

Insurance Plans – *Please Understand Your Policy*

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**

2) If we are your primary care physician, make sure that our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

3) It is your responsibility to understand your benefit plan with regarding covered services and participating laboratories. For example

a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.

b. There may be a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company may not cover the visit and you will be responsible for payment.

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.

2) It is your responsibility to know if a selected specialist participates in your plan.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-pays, deductibles, and co-insurances.

2) Co-payments are due at the time of service. A **$10 service fee** will be charged in addition to your co-payment if not paid by the end of the next business day.

3) Self-pay patients are expected to pay for services in FULL at the time of the visit. If we do not participate with your insurance plan, payment is expected from you at the time of your visit.

4) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **30** business days of your receipt of your bill. Failure to do so will result in an additional late payment fee.

5) If previous arrangements have not been made with our financial office, any balance outstanding longer than **90** days will be forwarded to a collection agency.

6) For scheduled appointments, prior balances must be paid prior to the visit.

7) If you participate with a high-deductible health plan, we require a copy of the health savings account credit card, or a copy of a personal credit card to remain on file. We accept cash, checks, Visa, Mastercard, Discover, & American Express credit cards.

8) A $30 fee will be charged for any checks returned for insufficient funds.

Forms

The is a $10 cash or $15 Credit Card charge for each school form, Sports Physical, and Camp form. Payment is due at the time the forms are dropped off. Once forms are completed, they can be picked up or emailed to you. Please allow 3-5 days for completion of the forms.

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to the physician, free of charge, as a courtesy to you. We do require 48 hours notice.

2) A copy of your complete record is available for a $1.00 per-page fee.

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(s) ____

Responsible Party Member's Name ______________________ **Relationship** ____________

Responsible Party Member's Signature ______________________ **Date** ____________

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Vasavi Parikh, MD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledged that I was provided a copy of the Notice of Privacy Practices for Warren Pediatric Associates.

Print Patient Name: ___________________________________

Signature of Patient: ___________________________________

Date: ____

*If the person signing is not the patient, please print your name and relationship to the patient:

Name: _________________________________

Relationship: ____________________________

I {patient or representative} request a copy of the Notice of Privacy Practice:

Yes: _________________ No: ________________

____

____

For Office Use:

If Patient / Representative requested a copy of the Notice of Privacy Practice, the date it was provided:

________________________.

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement:

____

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