Tender Care Pediatrics PC
2322 New Rd
Northfield, NJ 08225

For Office Use Only:
- ❑ HIPAA Patient Consent
- ❑ Privacy Policy
- ❑ Others _____

PATIENT REGISTRATION RECORD

Date of Registration: _____

PATIENT'S NAME: _____ SEX: M / F DATE OF BIRTH:_____
(LAST NAME) (FIRST NAME)

ADDRESS : _____

_____

HOME PHONE: ( ) ____ - _____ SECOND PHONE: ( ) ____ - _____

SOCIAL SECURITY #: ____-___-_____

MOTHER'S INFORMATION:

NAME: _____ DATE OF BIRTH:_____
(LAST NAME) (FIRST NAME)

ADDRESS:_____

SOCIAL SECURITY#: ___-____-_____HOME PHONE: ( ) ___-____ MOBIL PHONE: ( ) ___-____

EMPLOYER'S NAME & ADDRESS : _____

_____

WORKPHONE:( ) ____-_____ EXT: _____ OCCUPATION: _____

MARITAL STATUS: S M W D EMPLOYMENT STATUS: FULL TIME/PART TIME

FATHER'S INFORMATION:

NAME: _____ DATE OF BIRTH:_____
(LAST NAME) (FIRST NAME)

ADDRESS:_____

SOCIAL SECURITY#: ___-____-_____HOME PHONE: ( ) ___-____ MOBIL PHONE: ( ) ___-____

EMPLOYER'S NAME & ADDRESS : _____

_____

WORKPHONE:( ) ____-_____ EXT: _____ OCCUPATION: _____

MARITAL STATUS: S M W D EMPLOYMENT STATUS: FULL TIME/PART TIME

WHO DO WE CONTACT IN CASE OF AN ENERGENCY? _____

ADDRESS: _____

RELATIONSHIP TO THE PATIENT:_____CONTACT PHONE: ( ) ____-_____

DATE OF LAST PHYSICAL EXAM: _____

WHO REFERRED YOU TO OUR OFFICE? _____

Insurance Information

Primary Policy

Name of Insurance: _____ Phone: ( ) ____-_____

Name Of Insured: _____ Relationship: _____

Date Of Birth: _____ SSN: ____-___-_____ ID#:_____

Name of Employer: _____ Group#: _____

Employer's Address: _____

_____

Secondary Policy

Name of Insurance: _____ Phone: ( ) ____-_____

Name Of Insured: _____ Relationship: _____

Date Of Birth: _____ SSN: ____-___-_____ ID#:_____

Name of Employer: _____ Group#: _____

Employer's Address: _____

_____

Our Insurance and Financial Policy

We will accept your insurance assignment in lieu of payment from you for care and treatment in our office. This office also does most insurance billing as a service to our patients at no charge. The following policy prevails:

1. You will be responsible for paying the deductible and any co-insurance of the prevailing change. Our billing of services rendered is not a guarantee of payment.
2. If your insurance is such that it will not assign benefits directly to the doctor, you will be responsible for paying at the time services are rendered. We will however, submit insurance bills to your carrier and reimbursement will be made directly to the patient.

Our Method of Payment

1. For those patients who do not have insurance coverage for our services, you may pay at the time of service by cash or check. All fees for services rendered are expected to be paid at the time of service. Balance older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month. Returned checks will be subject to a $20.00 service charge.
2. Budget plans are available if you truly cannot pay for services. Please discuss your particular situation with the office manager and she will decide the best payment program for you.
3. Charges may also be made for broken appointments and appointments cancelled without a 2 hour advance notice. If you have any questions concerning our financial policy, please do not hesitate to speak with us.

Consent for Treatment

I, the undersigned, hereby authorize Tender Care Pediatrics Physicians and their authorized designates to perform lab test, administer immunizations and treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to my children, spouse or self or charged directly to me and that I am personally responsible for payment.**

Parent or Guardian's Signature _____ Date: _____

Request for Payment of Benefits to Provider of Care

I authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: **Tender Care Pediatrics P.C., 1909 New Rd, Suite 2, Northfield, NJ 08225** the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered to my child/ward. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Parent or Guardian's Signature _____ Date: _____

Consent for Treatment for Minor

I, the undersigned, hereby authorize Dr. Padma Mandalapu and whomever she may designate as her assistant(s) to perform lab test, administer immunizations and treatment as she deems necessary to my (indicate relationship of child) _____, (Child's name) _____.

Parent or Guardian's Signature _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Tender Care Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Tender Care Pediatrics's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tender Care Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tender Care Pediatrics Privacy Officer at *1909 New Road, Ste 2, Northfield, NJ 08225*

With my consent, Tender Care Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Tender Care Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Tender Care Pediatrics may e-mail to my appointment reminder cards and patient statements. I have the right to request that Tender Care Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Tender Care Pediatrics's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Tender Care Pediatrics may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian