COLTS NECK PEDIATRICS
410 RT 34, STE 212
COLTS NECK, NEW JERSEY 07722
TEL (732) 683-0099 FAX (732) 683-9503

DATE:

TO: _____
ADDRESS: _____
_____
_____
PHONE: _____

Please release any pertinent medical records and immunizations on the child(ren) listed below to Colts Neck Pediatrics, Inc. Thank you.

Child's Name	Date of Birth
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

_____ _____
Parent's (Guardian) Name Signature

COLTS NECK PEDIATRICS
REGISTRATION FORM

Patient Information

Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Family e-mail address: _____
Name of Previous Physician: _____
Father's Name: _____ SS#: _____ DOB__/__/__
Address: _____ Home Phone: _____
_____ Cell Phone: _____
Occupation: _____ Employer: _____
Business Address: _____ Work Phone: _____
_____
Mother's Name: _____ SS#: _____ DOB__/__/__
Address: _____ Home Phone: _____
_____ Cell Phone: _____
Occupation: _____ Employer: _____
Business Address: _____ Work Phone: _____
_____

Family Information

(Please list all children)

Name	DOB	Allergies

In case of an emergency and we need to contact you but are unable to reach you at the phone numbers you have previously listed, please provide us with an alternate contact, i.e. grandparents, friend, neighbor, etc.

Name: _____ Phone: _____
Signature: _____ Date: _____

Insurance Information

Name of Insurance Plan: _____
Policy Holder: _____ DOB __/__/__
ID Number: _____ Group Number: _____
Employer: _____ Effective Date: __/__/__

COLTS NECK PEDIATRICS

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Colts Neck Pediatrics (CNP)** as your preferred healthcare provider. We are happy and honored by your choice and are committed to providing you with the highest quality healthcare. We request that you read and sign this form to signify your acknowledgement and understanding of our patient financial policies.

Patient / Parent / Guardian Financial Responsibilities

- The patient, parent, or patient's guardian is ultimately responsible for the payment of his/her treatment and care.
- We are pleased to assist you by billing for your contracted insurers. However, the patient/parent/guardian is required to provide us with the most recent and correct information about their insurance and the patient/parent/guardian will be solely responsible for any charges incurred if the information provided to CNP is erroneous or not updated.
- The patient/parent/guardian is responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by his/her insurance plan. Payment is due at the time of service and for your convenience, we accept cash, check, and all major credit cards. Any payments received by CNP may be applied to any unpaid bills(s) for which patient/parent/guardian is liable. Any and all balances assigned as patient/parent/guardian responsibility may be subject to collection efforts after 90 days, including credit reporting.
- Patient/Parent/Guardian is to be aware that our laboratory services are provided by us or in some instances by Quest Diagnostics, Meridian or LabCorp. Please check with your insurance company as there may be additional charges if your insurance coverage does not include such laboratory work(s). Please bear in mind that these outside laboratories are not in any way affiliated with CNP. If patient/parent/guardian has any question about billing from these laboratories, it should be resolved by contacting the specific laboratory directly.
- Unscheduled Visits – If you want more than one child to be seen by the doctor, you must tell us before you arrive. Surprises cause long waits and unhappy patients. Please be considerate.
- Missed Appointments – We are doing our best to accommodate your needs. You can help us by keeping your appointment and arriving on time.
    - If you arrive 15 minutes late for an appointment, we may ask you to reschedule
    - If you miss 3 appointments within a 6-month period, we regret that we may not be able to keep you on as a patient
    - A check-up or well visit must be cancelled 24 hours prior to appointment
- Patient/Parent/Guardian may incur, and are responsible for the payment of additional charges. These charges may include, but are not limited to the following:
    - Charge for returned checks
    - Charge for missed appointments without the 24-hour advance notice
    - Charge for copying and distribution of patient medical records outside our usual courtesy records for the growth chart and immunization record
    - Any and all costs associated with collection of outstanding patient balances
- Divorce - In case of divorce, the divorce papers are an agreement between you and your ex-spouse. The person who brings the child to the office is responsible for the bill at the time of service. **NO EXCEPTIONS!**
- Baby-Sitters – If it is necessary for someone other than a parent to bring your child to the office, you must send a note explaining who has permission to do so.

By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance requirements, coverages, deductibles and payments.

Patient / Parent / Guardian Authorizations

- By my signature below, I hereby authorize CNP and its physicians, staff, and hospitals associated with CNP to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third-party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to CNP and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account not paid by my insurance company within 90 days are the patient's/parent's/guardian's responsibility. I also understand that account balances not paid within 90 days from the date of service will be sent to collections.
- By my signature below, I authorize CNP personnel to communicate by mail, answering machine message, voicemail, and/or e-mail according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

Signature of Patient / Parent / Legal Guardian Date

Waiver of Authorization: I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and/or submit claims to insurance at my discretion.

Signature of Patient / Parent / Legal Guardian Date

COLTS NECK PEDIATRICS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **COLTS NECK PEDIATRICS (CNP)** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Colts Neck Pediatrics Notice of Privacy Practices provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CNP 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 CNP's Privacy Officer at 410 Route 34, Suite 212, Colts Neck, NJ 07722.

With my consent, CNP may mail to my home or other designated location and leave a message on voice 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, CNP 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 "Private and Confidential".

With my consent, CNP may e-mail to me appointment reminder cards and patient statements. I have the right to request that CNP 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 CNP's use and disclosure of my PHI to carry out TPO. A copy of CNP's Notice of Privacy Practices will be provided upon my request.

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, CNP may decline to provide treatment to me.

Signature of Patient/Guardian	**Printed Name of Parent/Guardian**	**Date Signed**

Name of Children:

COLTS NECK PEDIATRICS
410 Route 34, Suite 212
Colts Neck, NJ 07722
www.coltsneckpediatrics.com

FORMAL AUTHORIZATION TO MAKE MEDICAL DECISION

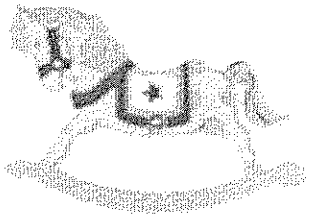
In my absence, I hereby authorize the following:

Name	Relationship

to make medical decision/s for my child/children (please state their full names):

This authorization remains in effect until a new formal written authorization is submitted to Colts Neck Pediatrics.

Name of Parent/Guardian	Signature	Date Signed



Policy Announcement

Missed Appointment

We are doing our best to accommodate all your needs. You can help us by keeping your appointment and arriving on time. Following is our policy for missed appointments:

- If you believe you cannot make it to your well visit appointment on time, you need to call the office at least 24 hours in advance. Otherwise, we will have to charge you a fee of $**50.00 for a missed well visit.**
- Since sick visits are scheduled on the day itself, you need to call us at least 1 hour before your appointment. Otherwise, we will have to charge you a fee of **$30.00 for a missed sick visit.**
- Please be reminded that we allotted that time slot for you and, by so doing may have deprived other patients from being seen at that time.
- If you arrive 15 minutes late for an appointment, we may ask you to reschedule.
- If you miss 3 appointments within a 6-month period, we regret that we may not be able to keep you on as a patient.

Thank you.

COLTS NECK PEDIATRICS