Ridgefield Pediatric Associates
Boston Children's Health Physicians
Until every child is well

WELCOME TO RIDGEFIELD PEDIATRIC ASSOCIATES

Patient's Name_____ Date of Birth _____ Sex: Male / Female

Address_____ Home #_____

City_____ State_____ Zip Code_____

Email Address_____

Patient Cell # (If over 16 years old) _____ Preferred Contact Method_____

Preferred Provider:

- ☐ Dr. Britto
- ☐ Dr. Angiello
- ☐ Dr. Brotanek
- ☐ Dr. Kilchevsky
- ☐ Jessica Flutie, CPNP

GUARANTOR INFORMATION

Insurance Subscriber _____Date of Birth_____ Sex: Male / Female

Parent's Name _____Cell#_____ Sex: Male / Female

Parent's Name _____ Cell#_____ Sex: Male / Female

FAMILY MEMBERS

Sibling's Name: _____ Date of Birth _____

Sibling's Name: _____ Date of Birth _____

Sibling's Name: _____ Date of Birth _____

How did you hear about Ridgefield Pediatrics?

- ☐ Referred by Patient: _____
- ☐ Referred by OB/GYN: _____
- ☐ Ridgefield Pediatrics Website
- ☐ Other_____

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Pediatric Health History Form

Date:_____

Patient Name:_____ **DOB:**_____ **Sex: M**___ **F**___

Patient Medical History: **Birth Weight**_____ **Full Term**_____

Has your child ever had the following?

Allergies	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	HIV/AIDS	Yes	No
Asthma	Yes	No	Kidney/Bladder Disease	Yes	No
Birth Defects	Yes	No	Measles	Yes	No
Blood Transfusions	Yes	No	Mental Illness	Yes	No
Bone/Joint Problems	Yes	No	Mumps	Yes	No
Bronchitis	Yes	No	Pneumonia	Yes	No
Cancer	Yes	No	Psychological Issues	Yes	No
Chicken Pox	Yes	No	Seizures/Convulsions	Yes	No
Ear Infections	Yes	No	Tonclilitis/ Pharyngitis	Yes	No
Epilepsy/Seizures	Yes	No	Wooping Cough	Yes	No
Genetic Defects	Yes	No			

Hospitalizations/Surgeries/Serious Illnesses:_____

Please list current medical problems your child is experiencing now:_____

Current Medications:

_____

Any known drug allergies:_____ **Any other allergies:**_____

Family History

Regarding grandparents please note ***maternal*** or ***paternal.***

Issue	Yes	No	Family Member	Issue	Yes	No	Family Member
Allergies	Yes	No		High Cholesterol	Yes	No	
Anemia	Yes	No		HIV/AIDS	Yes	No	
Asthma/ Bronchitis	Yes	No		Kidney Disease	Yes	No	
Birth Defects	Yes	No		Lung Disease	Yes	No	
Bone/Joint Problems	Yes	No		Mental Illness	Yes	No	
Cancer	Yes	No		Muscle Disorder	Yes	No	
Depression	Yes	No		Rheumatoid Arthritis	Yes	No	
Diabetes	Yes	No		Seizures/Epilepsy	Yes	No	
Drug/Alcohol Abuse	Yes	No		Skin Disease	Yes	No	
Eye/Ear Disorders	Yes	No		Thyroid Disease	Yes	No	
Genetic Defects	Yes	No		Tuberculosis	Yes	No	
Heart Disease	Yes	No		Venereal Disease	Yes	No	
High Blood Pressure	Yes	No					

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I hereby acknowledge that a copy of ***Boston Children's Health Physicians, LLP's*** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *BCHP's* privacy practices or my rights with regard to my personal health information, I may contact *BCHP's* Privacy Officer for further information as set forth in the Notice.

Patient Name:

Guarantor's Name:

Patient Signature:

Guarantor's Signature:

Date:

Relationship to Patient:

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Identification #: _____

I hereby certify that on ____/____/____ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of BCHP's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name) _____

Signature of Staff Person

Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

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PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments

We are required to collect your co-payment at the time of visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. BCHP accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

No Show/Late Cancel Policy

A $50 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel 24 hours prior to the appointment. Please consult with your physician's office for specific information about the late cancel period.

Insurance

We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

Participating Plans

BCHP participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans

If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

Referrals

If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay

Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

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PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

Name of Patient | Date of Birth

Name of Patient | Date of Birth

Name of Patient | Date of Birth

Name of Patient | Date of Birth

Signature of Parent or Authorized Person
Person

Print name of Parent or Authorized

Date

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RACE & ETHNICITY PATIENT FORM

The U.S. government now requires that we ask patients for their race and ethnicity. You have the option to provide this information or to decline by checking the box. All responses will be kept confidential.

Patient Name _____ Date of Birth _____

1. Which category best describes the patient's ethnicity?
   - ☐ Hispanic or Latino or Spanish origin
   - ☐ American Indian/Alaskan native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Black or African-American
   - ☐ White/Caucasian
   - ☐ Other

2. What is the patient's preferred language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other _____

[ ] I do not wish to provide this information

Thank you for your time