REGISTRATION FORM

Child's Name(s):

Today's Date: ___/____/____

	Last Name	First Name	Sex	Birth Date	*Internal Use*
1.	_____		M F	_____/_____/_____	PCC # _____
2	_____		M F	_____/_____/_____	PCC # _____
3.	_____		M F	_____/_____/_____	PCC # _____
4.	_____		M F	_____/_____/_____	PCC # _____

Parents Information:

Mother's Name: _____ D.O.B: _____/_____/_____

Address _____
Street City State Zip Code

Cell phone #: _____ Home #: _____

Email address: _____

Father's name: _____D.O.B. _____/_____/_____

_____
Street City State Zip Code

Cell phone #: _____ Home # _____

Email address: _____

Who has custody of the child/children? Mother ___ Father ___ Both ___ Other ___

Emergency Contacts:

Names & Relationships of others who have permission to bring & are authorized to make medical decisions for your child:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Health Insurance

1. Name of Insurance Carrier _____ Copy Enclosed _____

2. Policy Holder's Name: _____D.O.B. _____/_____/_____

How did you hear about us? _____

Providing this information is optional and voluntary. All patients receive the same medical care regardless of the answer or answering, "I prefer not to answer".

Your Child's Race:

□ American Indian/Alaskan Native
□ Asian
□ Black/African American
□ Caucasian
□ Hispanic
□ Hawaiian Native/Pacific Islander

Ethnicity:

□ Unknown
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline to specify

Your preferred language: _____

Signature of parent/guardian: _____ Date: _____/_____/_____

Print name of parent/guardian: _____ Date: _____/_____/_____

AUTHORIZATION OF TREATMENT AND ASSIGMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified, and TLC Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to TLC Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize TLC Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

I have requested medical services from TLC Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original

_____ _____

(Child's First & Last Name) Date of Birth

_____ _____

(Child's First & Last Name) Date of Birth

_____ _____

(Child's First & Last Name) Date of Birth

_____ _____

Signature of parent/guardian Date

TLC PEDIATRICS, LLC

10 Mott Avenue, Suite 2A • Norwalk, Connecticut 06850 • (203) 855-7551 • www.tlcpediatrics.org

NOTICE OF PRIVACY PRACTICES

SUMMARIZED

Our practice is required by law to follow the practices described in this summary. This is a summary of our Privacy Practices, but does not replace the full version, which you have also received and is always available in our office waiting room. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice applies to personal health information that we have about you, and which are kept in or by our medical practice. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Officer for this medical practice.

Who has access to your personal information?

We may use your personal health information to:

- Plan your treatment and services
- Submit bills to your insurance, Medicaid, Medicare, or third-party payer
- Obtain approval in advance from your insurance company to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician
- Perform healthcare operations such as sharing your information with business associates who need to use or disclose your information to provide a service for our medical practice (such as our billing company)
- Exchange information with other State agencies as required by law
- Treat you/your child in an emergency
- Treat you when there is something that prevents us from communicating with you
- Send you appointment reminders
- For certain types of research
- When there is a serious public health or safety threat to you or others
- To agencies involved in a disaster situation
- As required by State, Federal, or local law. This includes investigations, audits, inspections, and licensure
- To law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime
- To coroners, medical examiners, and funeral homes when necessary for them to do their jobs
- When order to do so by a court
- To Federal officials involved in security activities authorized by law
- To the correctional facility if you are in an inmate

PATIENT RIGHTS

As a patient in our practice, you have the right:

- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing
- To inspect and get a copy of your record (with some exceptions)
- To appeal if we decide not to let you see all or some parts of your record • To ask for the record to be changed if you believe you see a mistake or something that is not complete. You must make this request in writing. We may deny your request if:
- We did not create the entry that is wrong; or
  - the information is not part of the file we keep; or
  - the information is not part for the file that we would let you see; or we believe the record is accurate and complete
- To limit how we use or disclose information about you. For example – not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request
- To know to whom, we have sent information about you for up to the last six years. The first request in a 12-month period is free. We may charge you for additional requests.
- To have a paper copy of the Notice of Privacy Practices
- To file a complaint if you believe any of your rights have been violated. All complaints must be in writing. You will not be penalized if you file a complaint
- To tell us (authorize) other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing)
- If you wish to exercise any of these rights, or to file a complaint, you should contact the Privacy Officer of this medical practice

Initial: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that TLC Pediatrics., LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information.

- I understand that if I have questions or complaints, I may direct my questions to the Office Manager.
- I also understand that I am entitled to receive updates upon request if TLC Pediatrics., LLC amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient/patient's representative Relationship to patient

EMERGENCY ROOM VISIT

At TLC Pediatrics we understand that emergencies happen and sometimes a visit to the Emergency Room at your hospital is essential. At TLC we also know that many times a visit to the ER may not be necessary if you have access to your doctor. TLC Pediatrics is a Patient Centered Medical Home. One of the things this means to our patients is that as a medical home, ***TLC offers 24/7 access to one of our providers***. So, if you (or your child) are not feeling well, and you are concerned and would like to consult with a doctor, please call us first! If it is after hours your call will be routed to the provider **on call** at that time and we will consult with you over the phone.

Many times, concerns about your child's health can be discussed and resolved without an unnecessary trip to the ER. There are times when you call our providers first and the advice will still be to go to the ER, but many times it may be avoided which will save you time and money and reduce risk to exposure to other diseases.

So, ***remember call TLC first!*** We are available for a consultation 24/7 before you head out to the Emergency Room. This will ultimately result in better care for you or your children.

Initials_____

TLC PEDIATRICS, LLC
10 Mott Avenue, Suite 2A • Norwalk, Connecticut 06850 • (203) 855-7551 • www.tlcpediatrics.org

OFFICE POLICIES

Today's Date: _____

Dear Parent or Guardian,

TLC Pediatrics is a Medical Home

At TLC Pediatrics, we are committed to providing comprehensive quality care for your child in a family-friendly environment. To that end, we expect that you contact our office FIRST before seeking specialty care or heading to another provider for urgent care. We want to be involved in either providing care in our office where appropriate or referring you to the most appropriate specialist and helping to coordinate your care. Whenever you do see a specialist, we ask that you request a report be sent directly to our office so we may stay informed and have the most up-to-date information in your medical record. In order to accomplish this, we need to work together.

Please review & sign the following policies that have been developed to provide the highest possible care for your child:

Vaccinating:
I **agree** to have my child fully vaccinated while under the care of TLC Pediatrics. Immunizations have had an enormous impact on improving the health of children in the United States. Vaccination is one of the best way's parents can protect infants, children, and teens from 16 potentially harmful diseases. (Should you have any questions, you may ask to speak to our Office Manager)

Antibiotics
We work hard not to overuse antibiotics. We educate families on appropriate use of antibiotics but follow evidence-based guidelines and don't automatically treat ear pain or a green snotty nose with antibiotics. We do not routinely prescribe antibiotics over the phone as we do not believe that is good medicine We will prescribe an antibiotic when we believe it is an appropriate treatment.

After-Hours Service and Phone Calls:
Our office offers after-hours services in case of an **emergency**. Call **203-855-7551** or **855-303-1969** and the **on-call** doctor will be paged. The doctor will then call you to determine the next step. Our phone system requires you to leave detailed specific information. Please speak slowly and clearly. Repeat the contact phone number twice so we are able to accurately return your call.

Payment at the Time of Service:
Our office requires payment for the office visit or co-pay be paid **at the time of visit**. There will be a $5 fee for all co-pays not paid at the time of service
*Please keep in mind that payments will be collected **from the individual accompanying the patient to their visit**. TLC Pediatrics is **not** responsible for contacting parents/guardian to collect payment at the time of visit. *

Appointment confirmations, No Shows and Late Arrivals:

It is considered **a No Show** when:
1) The patient does not arrive to their appointment.
2) The patient arrives so late that appointment is unable to be performed.
3) An appointment is canceled with less than 24 hours' notice.

If you have scheduling conflicts, we will gladly work with you in rescheduling the appointment at a time more convenient for you. A call to cancel a physical exam/consultation 24 hours in advance will allow us to use the appointment time for other patients who need to be seen). In addition, we require a **1-hour notice** of cancellation or rescheduling for all other appointments (sick visits, nurse visits, vaccine administration, weight check etc.) In consideration of our other patients, a client who is late may be asked to reschedule their appointment. Additionally, a missed appointment will result in a $50.00 cancellation fee (This fee will **NOT** be billed to your insurance)

Our office confirms appointments 1-2 days prior to your appointment. This is provided as a **courtesy** to our families, it is your responsibility to remember your appointment. If an appointment if missed 3 times you will be asked to transfer care to another practice.

Technology

Our practice prides itself on efficiency through use of technology. You will be encouraged to consult our website, register for and use our patient portal, and effectively use automated reminders for appointments and for routine care/immunizations that are due.

Insurance

Make sure we participate with your insurance plan. **It is your responsibility to know the limits and coverage of your particular health insurance policy, to show your cards to us at each visit, and be prepared to pay any copays at the time of service.** Our billing staff will do their best to assist you with insurance questions; however, If you have questions about your coverage, it is best check with your specific insurance company. Our office does not want you to be surprised by a bill, but must always bill your health plan based on federal guidelines and the actual services provided.

Billing and Fees

Insurance copays are expected to be paid at the time of service. If you are unable to comply, you must speak with the billing department prior to the visit to set up a payment plan.

Daycare, Camp, school, sports forms and immunization records:

Forms that need to be filled out by the doctor can be left at our office for completion and then picked up in **two weeks**. Also you can request them to: Docs@tlcpeds.org . Parents—please read the requirements for physicals on camp and sports forms. If you need a form filled out, and it indicates the need for a physical exam within the last year, we cannot sign the form unless your child has had a complete physical exam within that time period.

Note: if you need a form filled out before the one-week time frame, there will be a $15 fee to have any forms completed with a minimum of 3 business days.

Well care physicals and sick appointments:

Well care physicals consist of a complete physical exam. A well care psychical exam is required every 12 months for most day cares and facilities, camps, junior high and high school sports. The AAP recommends yearly well care physicals from 3yrs -21 yrs. Visits are more frequent under the age of 3yrs (see attached well care physical schedule)

Sick appointments are given a time slot much less than physicals. This time is set up for the doctor to examine the patient and diagnose the illness. If your child has multiple symptoms, problems, or concerns, please let the receptionist know when you make the appointment so the visit can be extended. We want to make sure the doctor has enough time to address all of your concerns without feeling rushed.

Our schedule is **not** set for walk-in appointments. Please call ahead (at 9am) to establish an appointment time. Please keep in mind that the doctor cannot schedule appointments from home, if you wish to schedule a same day appointment, please call the office at 9am.

Medication refill:

For routine medication refills, please contact your pharmacy first. They will contact us directly for refill requests. When leaving a message for medication refills, the nurses need the name of the child (with spelling), the prescription medicine and the name of the pharmacy we should call. Prescription refills will be called in the same day requested and available for pick up after 5pm. If an ADD/ADHD medication refill is needed, a 24-hour advance notice is needed. Medications recheck visits for ADD/ADHD/Asthma are performed every 3 months. Yearly well care visits are recommended, and this fulfills a medication recheck visit.

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*I have read and understood the office policies and procedures of TLC Pediatrics, LLC. *

Parent/Guardian Name (Print): _____

Signature of Parent/Guardian: _____ Date: _____

Patient & Family Medical History Form

Patients Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Parent/Guardian Name:

_____

Allergies/Reactions to medications, food, or vaccines:

_____

_____

Mediations the patient is currently taking (please include both prescriptions and over the counter):

_____

Hospitalizations? (When, Where, Why):_____

_____

Delivery and Birth History

Mother's age at child's birth: _____

How was the patient delivered?

□ Vaginal □ Caesarean □ Adoption □ Other _____

Any problems during pregnancy? □ Excessive weight gain □ Excessive swelling □ UTI □ Toxemia □ Venereal Disease

Other (please explain): _____

Medications during pregnancy? _____

□ During pregnancy did mom: □ Smoke □ Drink □ Other: _____

At birth, how many gestational weeks was your child? (e.g., term = 40 weeks): _____

Birth weight: _____ Birth length: _____

Problems with baby at birth? □ Breathing □ Jaundice

Other: _____

Problems soon after birth? _____

□ Feeding: □ Breast milk □ Formula □ Both Feeding Problems:
□ Colic □ Recurrent vomiting □ Recurrent diarrhea □ Multiple formula change

Child's History

Is the patient affected by any of the following (please check all that apply)?

□ ADD/ADHD	□ Depression	□ Rashes	□ Allergies	□ Diabetes
□ Reflux	□ Anemia	□ Diarrhea	□ Seizures	□ Asthma
□ Ear infection	□ Sickle Cell	□ Autism	□ Eczema	□ Urinary Problems
□ Broken bones	□ Food allergies	□ Vaccine Reactions	□ Chickenpox	□ Hearing Loss
□ Wheezing	□ Concussions	□ Heart Murmur	□ Other Issue	□ Constipation
□ Lead exposure				

Other: _____

Social History

Who does the patient live with? _____

Are parents:	□ Married	□ Unmarried	□ Separated □ Divorced
Was the patient's house built before 1978?			□ Yes □ No
Do you have access to a pool?			□ Yes □ No
Are there any guns in the home?			□ Yes □ No
Are there any pets in the home?			□ Yes □ No
Any foreign travel within the past 5 years?			□ Yes □ No

If yes, where? _____

Any smokers in the home?	□ Yes □ No
If so, where do they smoke?	□ Inside □ Outside

Family History

Please state which of the following relatives have the conditions below (if none leave blank) (F) Father, (M) Mother, (B) Brother, (S) Sister, (MG) Maternal Grandparent, (PG) Paternal Grandparent, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood disorders:	Allergies:	Alcoholism:	Arthritis:	Aids/HIV:
Asthma:	Allergy Shots:	Cancer:	Cystic Fibrosis:	Cholesterol Problems:
Birth Defects:	Diabetes:	Eczema:	Ear Tubes:	Epilepsy/Seizures:
Drug Problems:	Early Deafness:	Heart Attack/Stroke:	Heart Disease:	High Blood Pressure:
Hereditary Problems:	Intellectually Challenged:	Migraines:	Tuberculosis:	Sudden infant death:

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