PLEASE LIST ALL CHILDREN

Child's Name: _____ **DOB:**_____ **Sex:** ❑ **M** ❑ **F**

Child's Name: _____ **DOB:**_____ **Sex:** ❑ **M** ❑ **F**

Child's Name: _____ **DOB:**_____ **Sex:** ❑ **M** ❑ **F**

Child's Name: _____ **DOB:**_____ **Sex:** ❑ **M** ❑ **F**

Address:_____

(Street) (City, State) (Zip Code)

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Patient Declined

Race: ❑American Indian or Alaska Native ❑Black or African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑White

Language: ❑English ❑Spanish ❑Other _____ **Referred By:**_____

Pharmacy Name, Address & Phone #: _____

PARENT/GUARDIAN INFORMATION

Parent 1: (first name) _____ (last name) _____

Relationship to patient: _____

DOB: _____ SSN: _____ E-mail Address_____

Address: ❑ Check box if same as above If different: _____

Phone: _____ Cell: _____

Employer Name & Address: _____

Parent 2: (first name) _____ (last name) _____

Relationship to patient: _____

DOB: _____ SSN: _____ E-mail Address_____

Address: ❑ Check box if same as above If different: _____

Phone: _____ Cell: _____

Employer Name & Address: _____

EMERGENCY CONTACT

(Someone living outside the primary household)

First & Last Name: _____

Relationship to patient(s): _____

Phone Number: _____

☐ Please check box to give permission to bring child to appointment(s)

2 Brighton Road
Suite 404
Clifton, NJ 07012

286 Park Street
Montclair, NJ 07042

Phone: 973-250-2970
Fax: 973-250-2971
Email: info@nuheights.com

INSURANCE INFORMATION

PRIMARY:

Insurance Company Name: _____ Guarantor's Name: _____

Member ID#: _____ Group/Plan #: _____

Do you have secondary insurance? Yes or no (circle one)

SECONDARY:

Insurance Company Name: _____ Guarantor's Name: _____

Member ID#: _____ Group/Plan #: _____

Office Financial 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. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2.If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3.According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances.
4. It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service. **A $10.00 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due ***within* 10 business days** of your receipt of your bill.
9. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $25.00 re-bill fee. Any balance over 90 days will be forwarded to a collection agency.
10. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately.
11. We require 24-hour notice for canceling any appointments. There is a **$25.00** charge for weekday appointments and **$30.00** charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given.
12. A **$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
13. We charge **$6.50** per child to copy or transfer medical records.
14. If your child has school, camp, or sport forms to be completed, there is a **$10.00** charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms.

I have carefully read and understand the above Office Policy.

Signature: _____ Date:_____

Print Name: _____

Please acknowledge the following statements by initialing on the line provided next to each statement.

Consent

_____ I give full permission to have my aforementioned child(s) to be treated under the care of NuHeights Pediatrics Physicians. By initialing, I agree and consent for my child(s) to be immunized, treated and cared for by the physicians and medical staff at NuHeights Pediatrics. I understand that this care included but is not limited to:

Initial

- Physical examinations of your child(s) (also known as head to toe examinations)
- Age appropriate and/or symptom specific examinations (which may include the genital area)
- Medications in office
- Prescription medications
- Immunizations as recommended by the American Academy of Pediatrics (AAP) and the Center for Disease Control (CDC).

_____ I understand that NuHeights Pediatrics reserves the right to discharge patients and their families from the practice for the following reasons:

Initial

- Abusive behavior (verbal, physical and online slander)
- Failure to vaccinate according to the recommended schedule
- Consecutive no shows for appointments without canceling prior to the appointment

_____ I understand the NuHeights Pediatrics requires all patients to be vaccinated according to the recommended schedule. I understand that by choosing not to vaccinate or delay any recommended vaccines, NuHeights has the right to discharge my child(s) from the practice.

Initial

_____ I understand that it is my duty as parent and/or legal guardian to follow through with the medical treatment plan laid out by the physicians at NuHeights Pediatrics. I understand that by not following through with treatment plans, immunizations, an routine care, I may be putting my child at risk for medical complications.

Initial

_____ I understand that by initialing this statement, I give NuHeights Pediatrics permission to contact me and leave a detailed message at the aforementioned phone number(s) regarding my child's personal health information.

Initial

_____ I give NuHeights Pediatrics permission to contact me by mail at the following home address including but not limited to appointment reminder cards, billing statements, lab or test results etc. regarding my child's personal health information.

Initial

_____ *Assignment of Benefits/Authorization/Notice of Collection Action:* I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the NuHeights Pediatrics Payment Policy and Notice of Privacy Practices for more information)

Initial

_____ *Use of Photograph:* The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Initial

_____ *Vaccine Registry:* Please be advised that our office submits confidential data of children and adult vaccinations to your States Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

Initial

I have carefully read and understand all the above statements.

Signature: _____ Date:_____

Print Name:_____

PRIVACY NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY NUHEIGHTS PHYSICIANS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE READ CAREFULLY

Effective Date: April 14, 2013

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulation, **NUHEIGHTS PEDIATRICS** and all similar health care providers are required by federal law to maintain the privacy of your protected health information ("PHI") and will abide by the terms in this Privacy Notice.

Please be advised that **NUHEIGHTS PEDIATRICS** may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you with medical care/treatment when you visit our office or we treat you in a hospital or nursing facility. Under federal law, we may disclose your PHI to you or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist, we will forward your medical information to such specialist. We can disclose your PHI for payment purposes. For example, we will disclose your PHI to your insurance provider, employer, Medicare, Medicaid or other party responsible for providing you with health insurance coverage for **NUHEIGHTS PEDIATRICS** to be reimbursed for our services rendered to you. We will also use or disclose your PHI for health care operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which is part of our health care operations. We may also disclose your PHI when required by the Secretary of Health & Human Services.

Unless disclosure is required under federal, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with specific requirements of the HIPAA rules without **NUHEIGHTS PEDIATRICS** needing to obtain your authorization if any of the following instances occur:

1. required by law
2. required for public health purposes
3. required disclosures about victims of abuse, neglect or domestic violence,
4. required by health oversight agency for oversight activities authorized by law
5. required in the course of any judicial or administrative proceeding,
6. If disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
7. required for a law enforcement purpose to a law enforcement official
8. required by a coroner or medical examiner,
9. required by and organ procurement organization, for research, or

Additionally, if you are member of the armed forces, **NUHEIGHTS PEDIATRICS** are permitted to disclose your PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission.

We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives.

In the event our practice wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if **NUHEIGHTS PEDIATRICS** desired to release your PHI for reasons other than treatment, payment or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you will have the ability to revoke such authorization at any time by sending **NUHEIGHTS PEDIATRICS** a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures only.

Please be further advised that you can access, copy, inspect and amend your medical information that we maintain. Additionally, if you desire, **NUHEIGHTS PEDIATRICS** can provide you with an accounting of all disclosures that we have made of your PHI to third parties, except disclosures for treatment, payment or health care operations and pursuant to authorization.

If you have a dispute with our practice regarding our use of your PHI or disclosure by **NUHEIGHTS PEDIATRICS** and believe that your primary rights have been violated, please contact the Secretary of Health and Human Services to file a complaint.

Please understand that **NUHEIGHTS PEDIATRICS** will not retaliate against you in any way for filing a complaint.

Lastly, please be advised that you have the right to request restrictions on certain use and disclosures of your PHI to carry out treatment, payment or health care operations or disclosures by **NUHEIGHTS PEDIATRICS** of your PHI to a family member, relative or close friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you also can request that we send it to an alternative location (different address) and by alternative means.

Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact our office. **NUHEIGHTS PEDIATRICS** reserves the right to amend this Notice as revised.

Please sign below acknowledging receipt of the **NUHEIGHTS PEDIATRICS.**

Patient or Representative Signature: _____ Date: _____

WELCOME TO YOUR PATIENT PORTAL!

Our patient portal offers many convenient features to help you manage your health more easily.

Please contact our office to request an email invitation for the patient portal.

WITH THE PORTAL, YOU CAN:

- Request appointments and see them once they are scheduled.
    - *You can request appointments online*
    - Once you have submitted a request for an appointment, *a member of our staff will contact you to confirm it*
- Request prescription refills
- See your test results
- See your billing statements and balance
- Make secure credit card payments
- Communicate with your doctor's office with secure messages
- Get health facts and information to help you live well and stay well
- Update your demographic information

Please note: *Registration is only available for laptop or desktop computer users. It is not available on mobile devices at this time.*