HACKETTSTOWN PEDIATRICS, LLC

Ksymena Kedzierska, MD & Jacek Sakowski, MD
4C Doctor's Park
Hackettstown, NJ 07840

ALL INFORMATION MUST BE COMPLETED
Patient Information:

Name:_____Date:_____

Address:_____Phone:_____

_____Age:_____Sex:_____

Parents E-Mail:_____Date of Birth:_____

Father/Guardian Information:

Name:_____Date of Birth:_____

Address if different from patient:_____

Social Security #_____Phone:_____

Employer:_____Full or Part time:_____

Employer Address:_____
Street or PO Box **City** **State** **Zip Code**

Cell Phone #_____Work Phone:_____

Mother/Guardian Information:

Name:_____Date of Birth:_____

Address if different from patient:_____

Social Security #_____Phone:_____

_
Employer:_____Full or Part time:_____

Employer Address:_____
Street or PO Box **City** **State** **Zip Code**

Cell Phone:_____Work Phone:_____

Emergency contact if we cannot contact you:

Name:_____Phone:_____

Patient Name:_____

Primary Insurance Information:

Name of Insurance Subscriber:_____

Name of Insurance:_____Copay Amount:_____

ID Number:_____Group #_____

Secondary Insurance Information:

Name of Insurance Subscriber:_____

Name of Insurance:_____Copay Amount:_____

ID Number:_____Group #_____

[ ] I hereby authorize Hackettstown Pediatrics, LLC to evaluate, treat, and coordinate healthcare and related services for the patient named on this form.

[ ] I hereby authorize Hackettstown Pediatrics, LLC to release to my insurers, its agents and/or assigns, any Information necessary to determine the payment of benefits for services rendered.

[ ] I authorize payment of benefits to be made to Hackettstown Pediatrics, LLC for services rendered.

Signature of Patient:_____
(parent/guardian if patient is a minor child)

Allergies:_____

Please list any medications taken on a regular basis, including multivitamins and/or herbal supplements.

_____

_____

Pharmacy:_____Pharmacy Phone:_____

Do you have a prescription plan? Yes No

Race:_____Ethnicity:_____Preferred Language:_____

_____ I prefer to not answer questions regarding race, ethnicity, or language.

Payment is expected when services are rendered unless prior arrangements have been made. Thank you.

HACKETTSTOWN PEDIATRICS, LLC Office Payment Policy

It is the policy of this office to request payment at the time of service. If you will be submitting insurance claims, we request your coinsurance or copay at the time of service. **Copays that are not paid at the time of service and have to be billed will assessed a ten percent processing and postage charge.** We will gladly submit your claim for you. Please remember that you are ultimately responsible for the balance of your account and to be informed of your plans benefits. If we do not receive payment from your insurance company, or there is a portion due from you, we will bill you twice. If, after the second billing, you do not pay your bill or contact the office, your account will be charged a ten percent billing fee. If your account remains unpaid after three billing cycles you will be referred to our collection agency for payment. Payment methods accepted by our office are cash, money order, Visa, MasterCard and Discover credit/ debit cards.

This office does not get involved in domestic situations; therefore the parent who brings the child in for treatment is responsible for paying the copay. We cannot bill the other parent for the copay in the case of divorce or separation.

All patients, including those with Managed Care HMO plans are responsible for knowing the limitations and allowances of their plan. We make every effort to be aware of what your plan allows, however, it is impossible for us to know what your benefits are as each employer negotiates separate plans for their business. It is your responsibility to know if you need referrals, precertification's, etc. Due to the increased volume of our practice, we require 48 hours' notice for referral requests. Please do not go to a specialist without a referral and expect our staff to fax a referral immediately because we may not be able to accommodate you immediately and you will be forced to reschedule your appointment. Specialist will not see you without a referral. All referrals must be approved my either Dr. Kedzierska or Dr. Sakowski.

Missed appointment charge. Please call the office and leave a message if you cannot keep your scheduled appointment so that we may give that time slot to another patient who may need to be seen by the doctor. We are aware that we all have busy schedules and from time to time you may forget an appointment. We will call to reschedule your missed appointment. However, if you repeatedly miss your appointments without calling to cancel you will be charged a missed appointment fee of $30.00.

I have read, understand and agree to the terms above.

Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Hackettstown Pediatrics, LLC
4C Doctor's Park
Hackettstown, NJ 07840

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

If I would like a full copy of Hackettstown Pediatric's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information, I may request one from the front desk. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____Date:_____

OFFICE USE ONLY

I attempted to obtain the patient or guardian's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____

Signature:_____

Reason:_____

VACCINE AND ALTERNATE VACCINE POLICY FOR HACKETTSTOWN PEDIATRICS, LLC

Dear Parents,

In accordance with the guidelines of the American Academy of Pediatrics and the Center for Disease Control, it is recommended that all children are vaccinated according to the AAP and CDC vaccination schedule. It is our policy to not accept children into our practice that are not being immunized. We also are no longer offering parents the option to delay or choose an "alternative vaccine schedule" at Hackettstown Pediatrics.

The dangers of alternative vaccine scheduling proposals are numerous and it is important to understand them:

- Delaying any vaccine is an obvious risk. The longer you wait to protect your baby against sickness, the higher his or her chance of contracting or developing an illness becomes. Unvaccinated children also pose a risk to young babies that are still too young to be fully vaccinated or children that are immunocompromised. Timing is critical in disease prevention and that is why all vaccines have a schedule.
- Vaccine schedules are well studied both for their safety and their effectiveness. Breaks in that routine or proposed schedule, and you are taking a chance with your child's health, in addition to the health of other children your child comes in contact with. You are setting a schedule that has not been studied in large numbers of children, and there may be some unforeseen problem with the invented schedule that puts your baby at risk.

Thank you for understanding our position on vaccination and alternate vaccine scheduling. Our goal is to provide you and your children with the safest and most accepted vaccine schedule proposed by the American Academy of Pediatrics and the Center for Disease Control.

Please sign to acknowledge your understanding and acceptance of our office vaccine policy.

_____ _____

Signature of Parent /Guardian Date Print Parent/Guardian Name

Prohibition of Recording Devices

Hackettstown Pediatrics LLC reserves the right to prohibit any and all use of recording devices during an office visit. We prohibit the use of all recording devices in the waiting area, office, hallways and exam rooms for photograph, video recording, audio recording or other imaging. It is against our direct policy to photograph, record video, record audio or any imaging without expressed written consent from all parties involved. Direct violation of this policy will result in legal action, as well as discharge from Hackettstown Pediatrics LLC.

Patient Name(s): _____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

Hackettstown Pediatrics LLC
4 C Doctors Park
Hackettstown, NJ 07840

Patient Name _____

Date of Birth _____

I, _____ herby acknowledge and understand that
(parent /guardian / self - print first and last name)

even with the best training, skill and experience, a medically trained professional is not always capable of solving my/my child's/my dependent's medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me/my child/my dependent, that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my/ my child's/my dependent's doctor.

I understand that if a doctor in this office refers me/my child/my dependent to see another doctor or receive another test including, but not limited to, a blood test, an X-ray, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my/my child's/my dependent's treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my/my child's/ my dependent's current health or increase future health risks.

I understand that it is solely my responsibility to follow up on any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my/my child's/my dependent's doctors should be expected.

Signature_____ Date_____