

HAMDEN PEDIATRICS 2024 REGISTRATION FORM (18+)

Patient Information:

Name: _____ Birth Date: _____
Permanent Address: _____ Home Phone: _____
Email Address: _____ Cell Phone: _____
Race: _____ Ethnicity: _____ Preferred Language: _____

Hispanic/Latino Not Hispanic/Latino Prefer not to answer

What is the best phone number to confirm appointments? _____

Can we leave a secure voicemail or send text messages to the above confirmation number? _____

Parent(s)/Guardian(s) Information:

Parent/Guardian 1:

Name: _____ Birth Date: _____
Permanent Address: _____ Cell Phone: _____

Parent/Guardian 2:

Name: _____ Birth Date: _____
Permanent Address: _____ Cell Phone: _____

Insurance Information: We will also need to keep a copy of the card on file for billing purposes

Primary Insurance: _____ ID #: _____
Subscriber's name: _____ Group # _____
Subscriber's DOB: _____ Co-Pay Amount listed on card: _____

Secondary Insurance: _____ ID #: _____
Subscriber's name: _____ Group # _____
Subscriber's DOB: _____ Co-Pay Amount listed on card: _____

Where should medical bills be sent? (Circle one) Parent/Guardian 1 or Parent/Guardian 2

Consent for Release of Medical Information/Permission to speak with your parents/guardians

- ☐ I, _____, give authorization to the following individual(s) to have access to/discuss my medical care with no limitations (For ex: test results, med refills, specialist referrals, history and labs related to gender and sexual orientation, drug use, sexual history):

Name	Relationship	Date
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_____	_____	_____
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- ☐ I do not give Hamden Pediatrics, P.C. permission to discuss anything with my parents/guardians.

Release of Information

I authorize my physician, health care provider, and their representatives to release information relating to an illness, injury, diagnosis, care, or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payor or their agents, contractors, subcontractors, or affiliates, schools and camps, provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including immunization information. I understand that the reason for furnishing such information may include the following: for use in medical, financial, or physician auditing, or other such auditing, as may be legally required, for utilization and/or quality of care review and assessment for determining available health benefits and coverage.

Patient Signature

Date

I AUTHORIZE HAMDEN PEDIATRICS P.C. TO RELEASE INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

Patient Signature

Date

No-Show Policy

No Show Policy: When a patient does not show up for a scheduled appointment, another patient loses the ability to be seen. It is your responsibility to give the practice sufficient notice (at least 24 hours prior to the scheduled appointment) if you cannot keep your appointment. The office provides reminder calls out of courtesy. If you are more than ten minutes late to an appointment, we will kindly ask you to reschedule. A missed appointment is defined as any scheduled appointment in which the patient either does not arrive to the appointment, cancels with less than 24 hours notice, or arrives more than 10 minutes late and is unable to be seen. You may be subject to a **fee of \$50.00** for each missed appointment. After three missed appointments in a twelve month period, you may be dismissed from the practice.

Prescription Policy: Our office requires an in person evaluation by one of the physicians for any new prescriptions. This is to ensure that any new medication is safe, appropriate, and necessary for you.. For this reason, our office cannot prescribe any antibiotics for acute illnesses over the phone. Prescriptions for controlled substances (such as medications for ADHD) are prescribed on a monthly basis. Please give us 72 hours notice for controlled substance refills. Certain medications (such as stimulants, asthma controller medications, psychiatric medication, etc.) require more frequent visits at 3 to 6 month intervals in order to keep your medication current.

STD Testing: As part of your routine care, we will send a urine sample to Quest to test for chlamydia and gonorrhea. We can send the sample to Yale at your request. This screening is recommended by the American Academy of Pediatrics. Chlamydia and gonorrhea are common in adolescents and may be present without any symptoms in adolescent females. These infections can cause many complications in females, including infertility. The lab will bill your insurance provider for this testing.

Portal Policy: We require all adolescent patients to be set up with our patient portal. Communication should be kept to non urgent concerns and medical questions. While we can offer advice or guidance, in many instances an appointment will be required to discuss your concerns and/or diagnose your child. Allow us at least 24-48 hours to respond to all messages. The patient portal is not routinely checked when the office is closed.

X

Patient Signature

Date