redbudpediatrics LLC

PATIENT REGISTRATION

CHILD 1: Last name: _____ First name: _____ Middle Initial: _____

DOB: ____/____/____ Sex: _____ Primary language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

CHILD 2: Last name: _____ First name: _____ Middle Initial: _____

DOB: ____/____/____ Sex: _____ Primary language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

CHILD 3: Last name: _____ First name: _____ Middle Initial: _____

DOB: ____/____/____ Sex: _____ Primary language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

CHILD 4: Last name: _____ First name: _____ Middle Initial: _____

DOB: ____/____/____ Sex: _____ Primary language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

MAILING ADDRESS

Street or PO Box: _____

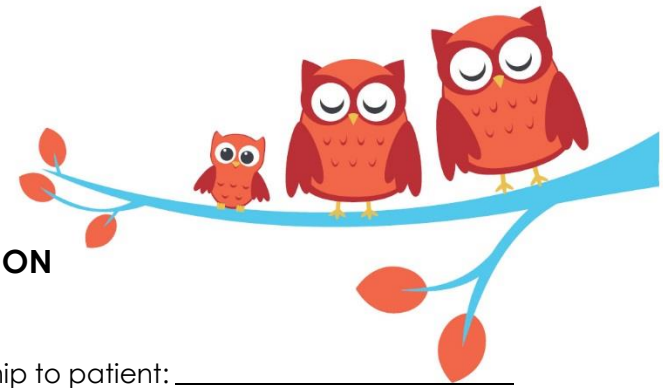
City, State & Zip code: _____

Home Phone: (____)_____-_____

Who lives at this household? _____

_____

_____



CONTACT INFORMATION

PRIMARY CONTACT:

Name: _____ Relationship to patient: _____

Lives with patient? Yes/No Date of birth: ____/____/____ Social Security #: _____

Work Phone: (_____) _____-_____ Cell phone: (_____)_____-_____

Home email: _____ Work email: _____

Employer: _____ Occupation: _____

CONTACT 2:

Name: _____ Relationship to patient: _____

Lives with patient? Yes/No Date of birth: ____/____/____ Social security #: _____

Work Phone: (_____) _____-_____ Cell phone: (_____)_____-_____

Home email: _____ Work email: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACTS, OTHER THAN PARENTS:

1. Name: _____ Relationship:_____ Phone: (_____)_____-_____

2. Name: _____ Relationship:_____ Phone: (_____)_____-_____

CONSENT TO LEAVE MESSAGES

In compliance with HIPPA laws and in an effort to better protect your family's privacy, Redbud Pediatrics needs consent to leave messages regarding your child/children's test results, appointments, referrals, or billing/insurance information. By signing at the end of this document you give Redbud Pediatrics permission to leave detailed messages at any the phone numbers that you have listed on the Patient Registration.

If there are any numbers that you would not like for us to leave a message on please let our staff know and they will have you fill out a restricted consent to leave messages form for the primary and secondary contacts.

POLICY FOR COMMUNICATING WITH NON-INTACT FAMILIES

Patient name: _____ **Date of birth:** ____/____/____

We understand that many of our patients come from families with divorced, single, or separated parents, or with other family make-ups that involve multiple caregivers. This helps us communicate with your family appropriately.

1. Are parents legally married? Yes/No **IF YES, STOP AND SIGN BELOW.**

2. If No, who has legal custody of this child?

___ Parent 1 (name): _____

___ Parent 2 (name): _____

___ Joint (check both above and provide names):

___ Other: _____

3. Are there any legal actions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?

____Yes ____ No

4. If Yes, please explain briefly:

_____

_____

5. If Yes, please provide us with a copy of the legal paperwork which supports this restriction:

___ Provided today ___ Will fax or mail

_____

By signing at the end of this document I understand that Redbud Pediatrics, does not have the authority to restrict access of lawful guardians or parents to their child's medical records unless the proper legal paperwork has been provided to us. I further understand that it is not Redbud Pediatrics responsibility to play go-between for families that fail to communicate with one another about their child's medical care. Please be aware families with past due balances may be rescheduled until they can fulfill their financial obligation.

_____

Signature or Parent/ guardian Date

_____

Printed name of Parent/ Guardian

redbudpediatrics LLC

ALTERNATE CAREGIVER CONSENT FORM

I authorize the following individual(s) to bring my children to their appointments: (Other than parents)

Name:_____ **Relationship to child:**_____

Name:_____ **Relationship to child:**_____

Name:_____ **Relationship to child:**_____

Name:_____ **Relationship to child:**_____

I attest that the above named individuals are all 18 years of age or older as of this date.
I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, immunizations, procedures, and hospitalization. Redbud Pediatrics may relay any medical information, including protected health information, about my child that is necessary for the above named individual(s) to provide informed consent to the treatment.
I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for services requested by the above named individual(s) when permitted by my insurance carrier(s).
I agree to hold Redbud Pediatrics, LLC, and its staff harmless for any disagreement between the above named individuals and myself regarding treatment decisions.
I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Children covered by this consent (list full names and dates of birth):

1)_____

2)_____

3)_____

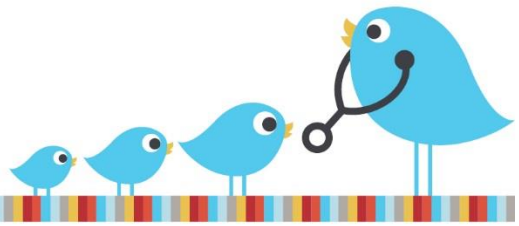
4)_____

_____

Parent/guardian's name Date

_____

Parent/guardian's Signature



Dear Parents,
Redbud Pediatrics Patient Portal is a tool for you to access many aspects of your child's medical records.**You will be able to view and print your child's immunization records, completed daycare, school, and sports physical forms, and lab results.** The portal also allows you to review and/or pay your billing statements online, as well as several other useful features.

To begin using the Patient Portal go to **portal.redbudpediatrics.com** or visit our website at **redbudpediatrics.com** for a link to the Patient Portal and register on the portal website.

TO REGISTER ON THE WEBSITE:
1) On the Home page, click "create account".

2) On the "Create Account" page, fill in your information **(parent's name and email address).** Click on the "save" button to create your account.

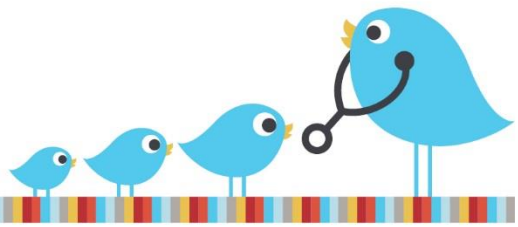
3) After you have created your account, a temporary password will be emailed to you. It may take up to 20 minutes to receive your temporary password.

4) On the home page, sign in using your email address and the password that was emailed to you. When you first login, you will be prompted to change your password and set a reminder question.

When registering for the portal make sure to use the e-mail address you gave to us on your patient registration in order to view your child's medical records. If you are unsure, call to have our staff register your e-mail address in our system.
If you have any questions please call our clinic at (316) 201-1202 and we will be happy to help you.

Sincerely,

The Redbud Staff



Financial and Office Policies

Immunizations: Redbud Pediatrics vaccinates *all children* on the schedule recommended by the Center for Disease Control and Prevention and the American Academy of Pediatrics. This means that we do not split up vaccines or do a slow schedule of vaccinations. By signing below acknowledge that I have read this document and plan to immunize my children accordingly.

Insurance Plan: I agree to be responsible for all copays, deductibles and non-covered services as determined by my insurance plan. I understand that copays are due at the time of check-in, regardless of the care provider who accompanies the child for the appointment. *If I do not have the copay or have not come prepared to pay past due balances, I understand that my child's appointment may be rescheduled for a later time so that I can meet my financial obligation. (Except in the case of a medical emergency)*. If my child's insurance plan requires a PCP (Primary Care Physician), I will make sure that my child's physician at Redbud Pediatrics, LLC is designated on my child's insurance.

Balances on Account: I understand that balances are due when I receive a statement from Redbud Pediatrics, LLC, or at my family's next appointment, whichever is sooner. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for services rendered by the practice within 60 days, Redbud Pediatrics, LLC may require me to pay the practice directly. The practice agrees to return payment that I have made on my account in the event that my insurance eventually pays the claim in question. If I am not responding, not able, or unwilling to cooperate or make a reasonable payment plan, the practice may ask for the assistance of an outside collection agency. If my family's account is turned over to a collection agency, my children will be dismissed from the practice.

Credit Card on File Policy: All patients are required to have a credit card/ debit/ HSA/ flex spending card number on file with our office. The card number will be securely encrypted off site with a third party secure data center. Holding your card on file allows a method for quick and convenient payment, including copayments when a non-parental care provider brings your child to an appointment. ***When a balance is due you will receive a statement via postmarked mail or e- mail. If this balance is not paid within 30 days your card will be charged.*** For larger balances please contact Redbud Pediatrics, LLC within 30 days of receiving your statement so that we can discuss payment options with you.

Insurance/ Payment Verification: Please bring the patient's current insurance information & credit card/ debit/ HSA/ flex spending card with you to every visit. If your insurance changes, please notify us before the appointment so we can make the appropriate changes to help you receive your insurance benefits. We attempt to verify your insurance two (2) business days prior to, and again on the morning of, your scheduled appointment. If we are unable to confirm active insurance coverage by the scheduled appointment time, you will have two options: 1.) Pay for the visit out of pocket. 2.) Reschedule for another day when you have had an opportunity to contact your insurance. For same day appointments, we will check eligibility when the appointment is made.

Late Arrivals & Missed Appointments: We ask you to arrive on time to your appointment. If you are more than 10 minutes late you may need to be rescheduled. We call to confirm appointments 2 business days in advance and request a 24-hour cancellation notice. Please call our office as soon as possible if you are not able to keep an appointment. We understand that there are family emergencies and difficulties which arise, and we therefore do not charge for missed appointments. However, if a family has a pattern of repeated missed appointments or last minute cancellations, they may be asked to leave the practice.

Authorization to release information and Assignment of Benefits: I hereby authorize the Redbud Pediatrics, LLC to release any information acquired in the course of my child's treatment necessary to process insurance claims. ***Authorization to pay benefits to Physician:*** I hereby authorize direct medical/surgical payments to the physician/practice for services rendered.

Notice of Privacy Practices (HIPAA): I understand the Notice of Privacy Practices documents that are made available to me regarding HIPAA. I understand that I have the right to ask for a complete copy of these documents for evaluation at any time.

(Please list ALL family members seen at Redbud Pediatrics, LLC)

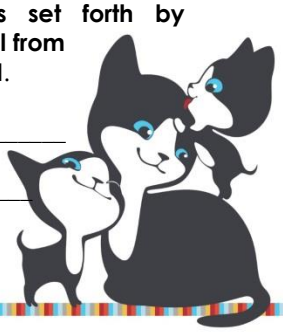
_____ _____ _____

_____ _____ _____

By signing below I acknowledge understanding and agree to adhere to the policies set forth by Redbud Pediatrics, LLC for ALL of my family. I understand that failure to do so may result in dismissal from Redbud Pediatrics. Signature of parent/ legal guardian is required if patient is less than 18 years old.

Signature: _____ **Date:** _____

Print Name: _____



redbudpediatrics LLC

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Patient Name:_____ Date of Birth: _____

Patient Address:_____ Phone: (_____)_____ -_____

I hereby authorize the request of medical records from: Physician/Clinic/Hospital:

Physician's Name & Facility:_____

Address:_____

Phone: (_____)_____ - _____ Fax: (_____)_____ - _____

Reason for request:_____

To be released to: Physician/Clinic/Hospital:
Physician's Name & Facility:_____

Address:_____

Phone: (_____)_____ - _____ Fax: (_____)_____ - _____

I, the undersigned, have read the above and authorize the disclosure of such protected health information as described herein. I understand that treatment is not conditioned upon execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to Redbud Pediatrics. (Note: Revocation is not effective for disclosures that have already been made.) I also understand that Redbud will send one free copy of medical records to the physician to which I am transferring care and that any other requests for medical records will result in a $25.00 charge.

Signature of parent/guardian_____ Date_____

Printed name of parent/guardian _____

Please release the following information:

____**Immunization records** ____**Growth charts** ____Progress notes

____**Medical summary (if any)** ____**Consultation reports** ____Cardiac studies

____Other:_____ ____Imaging/Radiology reports

(INTEROFFICE ONLY:)
Request was sent via:_____ Date_____
Request was sent by:_____ Redbud East _____Redbud West