Polar Pediatrics
Monique M. Child M.D.
Phone (907) 522-KIDS (5437)
Fax (907) 522-5435
www.polarpediatrics.com

NEW PATIENT INFORMATION SHEET

Patient Information			**Account#**
Last Name:	First Name:		MI:
Birth Date:	Sex: M F	Social Security#	
Child resides with (check one):	Both Parents	Mother Father	Other:
Home Phone:			
Mailing Address:			
City:	State:		Zip:
Physical Address:			
City:	State:		Zip:
Email:			
Other Children in Household:			
1.) Name: Birth Date:	Sex: M F	2.) Name: Birth Date:	Sex: M F
3.) Name: Birth Date:	Sex: M F	4.) Name: Birth Date:	Sex: M F

Responsible Party	Relation to Child:	
Last Name:	First Name:	MI:
Birth Date:	Social Security#:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:
Email:		

Other Legal Guardian	Relation to Child:	
Last Name:	First Name:	MI:
Birth Date:	Social Security#:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:
Email:		

Emergency Contact		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:

Pharmacy Information
(Please indicate which pharmacy you prefer to have your prescriptions filled.)

Please Fill Out Page Two

NEW PATIENT INFORMATION SHEET
PAGE TWO

Primary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security#:	
Policy#:	Group#:	CoPay Amount:
Employer:	Occupation:	Deductable Amount:

Secondary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security#:	
Policy#:	Group#:	CoPay Amount:
Employer:	Occupation:	Deductable Amount:

Medicaid or Denali Kid Care #

Assignment and Release I, the undersigned, certify that I have provided complete and accurate information on behalf of my family. I assign directly to Polar Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize Polar Pediatrics to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.	
Responsible Party Signature:	**Date:**

HIPPA Privacy Acknowledgement I have received and been given the opportunity to review the Notice of Privacy Practices for Polar Pediatrics.	
Responsible Party Signature:	**Date:**

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NEW PATIENT HISTORY

Concerns you would like addressed today:

Past Medical History:

Past Hospital Stays:

Past Surgeries:

Allergies to Medications:

Other Allergies:

Family Medical History:

Who lives at home:

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OFFICE FINANCIAL POLICIES

1. OFFICE VISITS: Applicable fees are payable at the time of service unless current information is on file. Polar Pediatrics accepts cash, checks, MasterCard and Visa as forms of payment.

   _____ (Initials)

2. MEDICAID: Medicaid patients need to provide a current coupon or sticker at the time of check-in. If a sticker cannot be provided, **the appointment will either be rescheduled or the guardian accompanying patient will be considered personally responsible for the bill.** Newborn infants will be given four weeks to be approved by Medicaid.

   _____ (Initials)

3. DENALI KID CARE: Patients with Denali Kid Care need to present a current ID card at time of check in. If a card cannot be provided, the appointment will either be rescheduled or the guardian accompanying Patient will be considered personally responsible for the bill. Newborn infants will be given four weeks to be approved by Denali Kid Care.

   _____ (Initials)

4. LATE APPOINTMENTS: Patients arriving more than fifteen minutes late will be rescheduled.

   _____ (Initials)

5. MISSED APPOINTMENTS: When a patient "no-shows", other patients who are ill are denied that time slot. As courtesy we ask that you please give 24 hours notice to reschedule or cancel your appointment. Patients who repeatedly miss appointments may be dismissed from our practice.

   _____ (Initials)

6. COLLECTIONS: Should collections become necessary I agree to pay all collection agency fees.

   _____ (Initials)

7. INSURANCE: As a courtesy to our patients, we bill primary insurance (we do not bill secondary insurance carriers) for office visits. In order for us to provide this service, we need documentation of insurance. This includes a copy of the insurance card, yearly deductible amount, and maximum yearly allowable for preventative care; any co-pay requirement. and coverage effective dates. Our receptionist will provide you with a form on which to provide the necessary information.

   If we bill insurance, the patient remains responsible for 1) the deductible amount, 2)any co-pay, 3) any unpaid balance after 90 days, and 4) that portion of our charges not covered by insurance (unless collection of the uncovered portion is prevented by contract, such as a preferred provider agreement). .

   For new patients, we will continue to request payment at the time of service until we have all requested information on file.

   _____ (Initials)

8. RETURNED CHECKS: Our NSF (Non Sufficient Funds) fee for returned checks is $25.00. If your check is returned for non-sufficient funds, then we will no longer accept personal checks as payment on your balance due. You can pay by credit card, cash or a cashier's check.

   _____ (Initials)

Signature _____Date _____

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RELEASE OF INFORMATION

I **hereby authorize Polar Pediatrics to REQUEST information FROM:**

_____

_____

(facility name and address)

Regarding the following patient:

Patient Name: _____ DOB: _____

Other Names Used: _____

Records to be released:
Date(s) of service: _____

Check all that apply:

Consultation Report	Laboratory Reports	Office Visits
Discharge Summary	Operative Report	Other: _____
Emergency Room Visit/Report	Pathology Reports	
History and Physical	X-Ray Report	

Purpose: Continuing Care

This authorization expires on the following date, event or condition: _____ .
If I do not specify any expiration date event or condition, this authorization expires in one year.

Statement of Authorization:

- I understand that, except for research related Polar Pediatrics will not condition my treatment on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Monique M. Child, M.D.
- A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to a third party.
- I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ Date:_____
Signature of Patient/Legally Authorized Representative

_____to a MINOR (reason patient unable to sign)
Relationship

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Eligibility Screening Record for Administered Vaccine(s)

Eligibility screening and documentation prior to vaccine administration must be conducted every time a person receives a vaccine. The health care provider is responsible for completing the eligibility screening record. While verification is not required, it is necessary to retain this or a similar record for each person receiving vaccine. This form (or pre-approved similar information) must be maintained in the patient's medical record for at least 3 years.

Patient's Date of Birth: _____ / _____ / _____
(MM) (DD) (YY)

Patient's Name: _____
Last Name First Name Middle Initial

Parent/Guardian/ Individual of Record: _____
Last Name First Name Middle Initial

The state-supplied vaccine eligibility categories are as follows:

Children (0 through 18 years)
- VFC Medicaid Eligible
- VFC Uninsured
- VFC American Indian/Alaska Native
- VFC Underinsured (FQHC/RHC)
- State Vaccine (AVAP)
- Ineligible (Private Vaccine)

Adults (19 years and older)
- State Vaccine (AVAP)
- Ineligible (Private Vaccine)

For eligibility criteria: Children / Adult / Flu

*Eligibility status must be reviewed and documented **EVERY** time a vaccine is administered.*

Date (MM/DD/YY)	Eligibility Status (place an "x" under the appropriate category)					
	Children Only				***Children and Adults***	
	VFC Medicaid Eligible	VFC Uninsured	VFC American Indian/Alaska Native	VFC Underinsured (FQHC/RHC)	State Vaccine (AVAP)	Ineligible (Private Vaccine)