"for healthy little beginnings"

We welcome you to our practice!

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www.kentpediatrics.com

• WELCOME •

Thank You!

We would like to extend to you a warm welcome to Kent Pediatrics. We are very excited that you have chosen us, and we are confident that you will be very pleased with the service and care we provide to your family. Please take a moment to read this letter in order to get to know us better.

Making Appointments:

We are in the office Monday-Friday between the hours of 8:15am-5:15pm. We begin seeing patients at 8:30am and the office staff breaks for lunch from 12pm-1pm.

Appointments are available for same day sick visits. All other appointments need to be scheduled in advance.

Being late for appointments negatively affects our workflow and ability to adhere to our daily schedule. Kindly call if you are running late. If you are more than 15 minutes late for an appointment, you will be considered a no-show and may only be seen that same day if the doctors' schedule permits. You may be discharged from our practice if you have more than two no-shows in a twelve-month span.

Office Visits:

For every visit to our clinic, you will be prompted to sign-in, present your current insurance card, and verify your demographic information. Your photo ID will be needed if it's your first visit to our clinic and once a year thereafter. Shortly thereafter, a Medical Assistant (MA) will direct you to a triage room where she will gather detailed information about the reason for your visit and take your child's vital signs. The MA will then escort you to the exam room where your child will be seen by the doctor and receive any required shots, tests, or procedures. It is very important that you "Check Out" with the front staff to ensure that any test, referrals, prescriptions, etc. are taken care of before you leave the clinic. Also, it is our policy to have a well visit scheduled for all of our patients, even if it is a year away.

Health Forms/Medications:

We are happy to complete any forms for school, camp, etc. (Please bring form with you to appointment) However, we do ask that you give us up to 48 hours to complete them.

For prescriptions, **please call the pharmacy before pick up to ensure the prescription is ready.** For prescription refills, please allow up to 48 hours for prescription to be sent to the pharmacy from Kent Pediatrics and **please call the pharmacy before pick up to ensure the prescription is ready.**

For controlled substances, a written prescription must be picked up from the office and delivered to the pharmacy. Please allow up to 48 hours before picking up written prescriptions from Kent Pediatrics.

Insurance:

Kent Pediatrics participates with all major health insurances that conduct business in Delaware. However, it is your responsibility to contact your insurance company and verify coverage at our clinic. If you have any questions regarding your insurance, please feel free to ask the front desk. **We do ask that you bring your current Insurance card and Identification card to every visit.**

Medical Advice:

During business hours, we are happy to answer general questions over the phone. For more complex questions, please make an appointment so that our doctors may evaluate your child and provide you with the most accurate information and best care.
Urgent matters will be addressed as soon as possible before the end of the day. (This could be after 5:00 pm depending on doctor's schedule) For non-urgent matters, we will return your call within 24 business hours. If your child is experiencing a life threating situation, please take them to the nearest emergency facility.

Night and Weekend Coverage:

Doctors of Kent Pediatrics share after-hours coverage with 2 other doctors' offices: Smyrna Pediatrics and Adolescent Medicine. Just call our main office number and the answering service will have the on-call doctor paged. Please allow time for the doctor to return the page. If your child needs to be seen after office hours, the doctor will refer you to a walk-in clinic or the emergency department.
On weekends that our doctors are on call, we may see patients on an "as needed" basis. The doctor will determine by phone call if the patient needs to be seen.

Hospital Care:

Effective July 2015, a hospitalist group will take care of your child and manage the admission and hospital stay. After discharge we will see the patient back in the office for follow up care. Rest assured that our doctors will be advised of your child's care during their hospital stay.

It's The Law:

The law requires that a parent or legal guardian accompany all patients to every appointment. However, on a case-by-case basis, we can accept a written note with your signature allowing a friend or family member to authorize care for your child. Please ensure that the person you authorize to accompany your child to the clinic brings a valid photo ID. Please note that our doctors have the best interest of your child in mind and therefore may need to disclose current and/or relevant medical information to whomever is authorized to care for your child during an office appointment. Patients between the ages of 16-18 years may be seen unaccompanied by an adult with the parent's written permission, except when receiving vaccines. (Written permission must be received in our office before the patient's appointment)

Our Mission:

- To provide innovative, personalized, quality service for your child to improve their health and overall well-being.
- To create a comfortable, compassionate atmosphere where the relationship between the practice and the patients is one of trust and mutual respect.
- To encourage patient education, disease prevention, and healthy lifestyles as critical aspects to optimal long term health.
- We practice medicine as a team and value the contributions of all of our staff in providing excellent medical care and service.
- The values that guide us are:

Kindness; Respect; Accountability; Excellence; and Stewardship.

New Patient Registration Form

Date of Application: _____/_____/_____ **How did you hear about us?**_____

Name: _____ **Gender**: Male Female
First *Last* *MI*

Date of Birth: _____/_____/_____ **Home Phone**: _____-_____-_____ **SSN:** _____-_____-_____

Address: _____

City, State & Zip: _____

MOTHER'S NAME / CUSTODY GUARDIAN (NAME):		**FATHER'S NAME:**	
ADDRESS		ADDRESS	
CITY/STATE /ZIP		CITY/STATE/ZIP	
HOME #	CELL #	HOME #	CELL #
DOB	SSN	DOB	SSN
EMAIL		EMAIL	

EMERGENCY CONTACT (NAME):	**EMERGENCY CONTACT #2 (NAME):**
HOME #	HOME #
CELL #	CELL #
RELATIONSHIP TO PATIENT?	RELATIONSHIP TO PATIENT?

INSURANCE AUTHORIZATION & ASSIGNMENT

Please initial and sign at the bottom:

_____ **Authorization and Assignment of Benefits:** I hereby give permission to Kent Pediatrics, LLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to Kent Pediatrics, LLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of Kent Pediatrics, LLC. I understand that it is my responsibility to provide Kent Pediatrics, LLC with my current demographic, insurance, and medical information.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from Kent Pediatrics, LLC.

Patient or Guardian Signature:_____ **Relationship:** _____ **Date:** _____

Insurance Information

Insurance Carrier: _____

Policy/ID# _____ Group # _____

Secondary Insurance Carrier: _____

Policy/ID# _____ Group # _____

Previous Medical History

Please check all that apply:

___ Asthma ___Heart Murmur ___Neurological Disorders
___Chicken Pox ___Sickle Cell ___Other (Please Specify) _____
___Seizures ___Diabetes

Hospitalizations:

Date: _____ Reason: _____

Date: _____ Reason: _____

Surgeries:

Date: _____ Reason: _____

Date: _____ Reason: _____

Previous Physician: _____

Please add name and location*

ALLERGIES to **FOOD**

_____

ALLERGIES to **MEDICATION**

_____

Pharmacy Name and Location: _____

Address, Street or Intersection _____

Daily Medicines: _____

_____

_____

PLEASE LIST MEDICATION NAME AND DOSAGE*

Infant Birth History

Name: _____

Type of Delivery: _____ Term: (Weeks) _____

Premature at: _____weeks Pregnancy #: _____

Birth Weight: lbs: _____ Oz: _____ Length: _____

Circumcised: YES / NO (please circle)

Patient Sibling Information

Brothers & Sisters D.O.B. (First & Last name)

1. _____
2. _____
3. _____
4. _____

Family Medical History

Please mark all appropriate boxes.

	MOTHER	FATHER	SISTER	BROTHER	GM (MATERNAL)	GM (PATERNAL)	GF (MATERNAL)	GF (PATERNAL)	OTHER (SPECIFY)
ASTHMA									
BLEEDING DISORDER									
CANCER									
DIABETES									
GENETIC DISORDER									
HEART DISEASE									
HIGH CHOLESTEROL									
HYPERTENSION									
MIGRAINES									
SEIZURES									

If there are any other medical conditions not listed above please list them below along with the relation to the child.

_____

_____

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, KENT PEDIATRICS, LLC, may use and disclose Protected Health Information (PHI) about my child to carry out Treatment, Payment and healthcare Operations (TPO). (Please refer to KENT PEDIATRICS, LLC "Notice of Privacy Practices" for a more complete description of such uses and disclosures.)

With my consent, KENT PEDIATRICS, LLC, may disclose my child's PHI to the following individuals (family, relatives, or friends) who may assist in the care of my child:

Name	Relationship	Home/Cell #:	Work #:

(Please indicate name, contact numbers, and relationship of individuals to whom KENT PEDIATRICS, LLC, may release PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent. KENT PEDIATRICS, LLC, reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, KENT PEDIATRICS, LLC, LLC may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist KENT PEDIATRICS, LLC, in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, KENT PEDIATRICS, LLC, may mail to my home or other designated location any item that may assist KENT PEDIATRICS, LLC, in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, KENT PEDIATRICS, LLC, may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

KENT PEDIATRICS, LLC, may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my childs clinical care, including laboratory results, among others.

I have the right to request that KENT PEDIATRICS, LLC, restricts how it uses or discloses my child's PHI to carry out the TPO, However, KENT PEDIATRICS, LLC, is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to KENT PEDIATRICS, LLC, use and disclosure of my child's PHI to carry out TPO.
I may revoke my consent in writing except to the extent that KENT PEDIATRICS, LLC, has already made disclosure in reliance upon my prior consent. If I do not sign this consent, KENT PEDIATRICS, LLC, may decline to provide services to my child.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Printed Name of Patient or Legal Guardian

(PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

Our Financial Policy

Thank you for choosing us as your Provider. We are committed to providing you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to review it and sign our acknowledgement form prior to receiving treatment from us. If you have any questions about our fees, financial policy or your responsibility, please ask to speak with our Practice Manager. Our practice is committed to providing the highest standard of care for our patients and our fees are considered usual the customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary rates".

Full payment is due and expected at the time of service. You may make your payment by cash, check, or major credit card. It is our policy to charge a fee of $35 for any returned check.

Your insurance coverage is a contract between you and your insurance company. We will file an insurance claim as a courtesy to our patients; however, this does not release you of your financial responsibility. If your insurance company has not paid your account within 60 days from the time of service, the outstanding balance automatically becomes your responsibility. We will not be involved in the disputes between you and your insurance company regarding deductibles, co-pays, covered charges, etc. other than to supply factual information as necessary. Please be advised that some, and perhaps, all of the services provided to you may be considered a non-covered service or medically unnecessary by your insurance. In this case, you will be financially responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

As a patient, it is your responsibility to advise us if you have a change in your demographic and/or insurance information. To protect our patients against identity theft, we require you to present a valid health insurance card and a photo identification card, preferably a state issued one, at each time of visit. We will also need proof that would reflect any demographic or insurance information change. All copays and balances are due at time of visit and will be collected before your child sees the physician. We reserve the right to take lawful actions including terminating our physician-patient relationship for nonpayment.

Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient.

You must notify us at least 24 hours in advance if you need to cancel your appointment.

We are mandated by federal regulations to obtain a written authorization for release of medical information. We follow the below fee schedules set forth by the Delaware Secretary of Department of Health for charging for reproduction of medical records and shall apply for paper copies or reproduction on electronic media whether the records are stored in paper or in electronic format.

Amount charged per record consisting of 1-20 pages	$20.00
Amount charged per record consisting of 20-60 pages	$30.00
Amount charged per page for pages 61 and above	$.50
Flat fee for production of records on CD	$20.00

In addition to the amounts listed above, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records. Payments of all costs are required in advance of release of the records except for records requested to make or complete an application of disability benefits program. We understand that due to a medical condition, you may file an insurance or disability form. Please be aware that we charge $15 per form.

Thanks for taking time to review our financial policy. Please let us know if you have any questions and concerns.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Printed Name of Patient or Legal Guardian

(A copy of this policy is available upon request)

IQHealth

Welcome to Your Secure Patient Portal!

Dear Patient,

We are excited to offer you a new informational system through United Medical Physicians called **IQHealth.** This system allows web-based interactions between patients and our office. You will be able to:

View your test results
Request an appointment
Request medication refills
Update demographic information
Send and receive messages
Keep track of your health

In order to take advantage of this new feature, we will need your email address. You will then receive a one-time secure email invitation from **IQHealth.com** to set up an account. Simply click on the link in your email and follow the prompts to activate your account. For any questions or concerns please contact the office for assistance.

We hope this new system will make communication with our office easier and more convenient. Whether you choose to participate or not, you may always contact the office via telephone and mail.

Sincerely,

Kent Pediatrics, LLC

I wish to participate

Name: _____

Email Address: _____

Last 4 digits of SSN: _____

I do not wish to participate

Name: _____