ADETEJU OGUNRINDE, M.D.,F.A.A.P., CHILDREN'S HEALTHCARE CENTER. P.C.

605 Post Office Road, Suite 102, Waldorf, Maryland 20602.
Phone: (301) 374-2666, Fax: {301} 374-2662

PATIENT REGISTRATION AND UPDATE JAN 2014

DATE_____/____/20_____

PERSONAL DATA

PATIENT'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

PATIENT'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

PATIENT'S NAME_____ ☐ M ☐ F DOB_____/_____/_____
LAST NAME FIRST NAME INITIAL

HOME ADDRESS:_____

HOME PHONE NO: (_____)_____-_____ PATIENT SS. #_____-____-_____

MOTHER'S NAME_____ DOB___/____/_____ SS.#_____-____-_____
LAST NAME FIRST NAME INITIAL

FATHER'S NAME_____DOB__/____/_____ SS.# ____-____-_____
LAST NAME FIRST NAME INITIAL

MOTHERS'S CELL # _____ EMAIL_____

FATHER'S CELL # _____ EMAIL_____

NAMES OF OTHER ADULT(S)
AUTHORIZED TO ACCOMPANY CHILD_____RELATIONSHIP_____CELL#_____

INSURANCE BILLING INFORMATION

PRIMARY INSURANCE: _____ SECOND INSURANCE_____NEED COB

*SUBSCRIBER'S NAME 1ST INS*_____ *SUBSCRIBER'S NAME 2ND INS*_____

SUBSCRIBER DATE OF BIRTH:_____ SUBSCRIBER DATE OF BIRTH: _____

EFFECTIVE DATE 1ST INSURANCE_____/_____/_____ EFFECTIVE DATE 2ST INSURANCE_____/_____/_____

I.D. #_____GROUP #_____ I.D# _____GROUP #_____

WE WILL BILL ALL INSURANCES GIVEN TO US PRIOR TO BILLING YOU EXCEPT FOR MEDICAID SECONDARIES. IF YOU HAVE MEDICAID AS SECONDARY, YOU WILL NOT BE BILLED. FAILURE TO DISCLOSE ALL INSURANCES MAY AFFECT YOUR CLAIM AND WE WILL CHARGE YOU $100 TO REPROCESS THE CLAIM IF YOUR PRIMARY INFORMS US OF YOUR SECONDARY INSURANCE. INITIAL HERE X_____+

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DR. OGUNRINDE FOR SERVICES RENDERED BY HER IN PERSON OR UNDER HER SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I ALSO WILL BE RESPONSIBLE FOR ALL PAYMENTS AND COLLECTION CHARGE FOR FAILING TO DISCLOSE MY SECONDARY INSURANCE OR MEDICAID COVERAGE TO THE OFFICE AT THE TIME OF SERVICE

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE DR. OGUNRINDE TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFITS IN ACCORDANCE WITH HIPPA REGULATIONS.

ACKNOWLEDGEMENT OF OFFICE POLICIES & PROCEDURES

I CERTIFY THAT INFORMATION WAS RECEIVED BY ME, REVIEWED AND UNDERSTOOD CONCERNING THE OFFICE POLICEIS AND PROCEDURES. I WILL COMPLY WITH THESE DIRECTIVES AS WRITTEN.

PARENT/GUARDIAN_____ SIGNATURE_____
PLEASE PRINT

Adeteju Ogunrinde, M.D.,F.A.A.P.,Children's Healthcare Center. P.C.

FINANCIAL POLICY

We are delighted you have chosen our practice for your child's medical care. We wish to have a relationship characterized by understanding and satisfaction while delivering the highest quality of care in a safe environment. If you have medical Insurance, we are here to help you receive the maximum allowable benefits. In order to achieve this goal we need your co -operation and understanding of our financial Policy.

COPAYMENTS AND DEDUCTIBLES:

Co-payments are to be paid at the time of service, Exceptions: Medicaid coverage!
We accept payment by cash, check, Visa or Master card. Please note there will be a $30.00 charge for all checks returned. Failure on our part to collect co-payment and deductibles from patients is considered a violation of contract and fraud. Please help us to uphold the law by making your co-payments at each visit and paying deductibles as billed.

CLAIM SUBMISSSION:

As a courtesy to you, we will submit your claim for services rendered by our practice to your insurance based on the information you have provided to us. It is your responsibility to make sure this office has your correct insurance information. Failure to disclose secondary insurance or Medicaid coverage may affect your claim payment. YOUR PRIMARY EVENTUALLY FINDS OUT ABOUT OTHER INSURANCES AND USUALLY RETRACT THEIR PAYMENT UNTILL COORDINATION IS DONE. WE WILL CHARGE YOUR ACCOUNT $100 FOR REPROCESSING YOUR CLAIM FOR WITHHOLDING SUCH IMPORTANT INFORMATIO FROM US IF THIS HAPPENS.
Your insurance is a contract between you, your employer and/or the insurance group. While we may provide services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
Unfortunately, we will be unable to schedule future appointments if arrangements for outstanding balances have not been made and/or no payments are being made on overdue balances.

NON COVERED SERVICES:

Not all services are covered by insurance; they vary from contract to contract. Some insurance arbitrarily consider some services NOT medically necessarily or experimental, however our primary goal at this practice is the "best preventive care for our patients" and in accordance to the standard of care recommended by American Board of Pediatrics. In the instance where your insurance refuses to pay, you will be responsible for these services. We will make every effort to ascertain coverage before treatment, however this does not guarantee payment, and unpaid balance will become your responsibility. For services that are not covered by insurance we require payment within thirty (30) days of bill statement unless prior arrangement has been made. In cases of financial hardship, we will also offer certain discounted services.

COVERAGE CHANGES

If your insurance changes, or you purchased additional coverage, please notify us immediately or at your visit so we may update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by an insurance that we do accept but you do not have the insurance card for us to ascertain your eligibility, payment is expected in full at time of service until we can verify your coverage.

MISSED APPOINTMENTS:

We require 24-hour notice for appointment cancellations. Please be aware there is a $30 non –cancellation fee for missing an appointment or for cancelling a well -child physical less than 24hours. This is because a missed appointment takes openings away from other sick children. These charges will be your responsibility and will NOT be billed to your insurance company. Those with Maryland Medicaid insurance would be reported to their mco/health department or be suspended from the practice after 2 missed appointments. Please help us serve you better by keeping your scheduled appointment.

NON PAYMENT

If your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full or make payment arrangement with us. Please note that if your account remains unpaid, we reserve the right to refer your account to a collection agency and all the accounts under your name will become inactive until paid. Account balances turned over to collection will accrue at the rate of 30% over the owed amount as collection fee. If your account is turned over to an attorney or pursued legally, you will be responsible for all reasonable attorneys' fee, filling fees and service fees.

Forms And Record Transfer:

We require a written request for all record requests. There is an applicable fee for all record transfer or request. Fees may be charged for some patient requested form completions, we will inform you prior to completion regarding the specific charge, and payments are due prior to performing such duty.

Assignment and Release

I hereby request that my authorized Medicaid or other insurance benefits submitted for payment by Children health Care center be paid directly to them for services rendered to me. I authorize them to release any information required to process submitted claims to my insurance company or if applicable Health Care Financing Administration or its agents. I also agree to be financially responsible for non-covered services, deductibles and co-payment. I am aware that Children Healthcare would post all payments to my responsibility if my insurance or health benefit does not pay within ninety {90} days. I am also responsible for collection fees as well as attorney's fee if my account becomes delinquent as determined by this office.

Thank you for understanding our financial policy. Please let us know if you have additional questions.

We are here to help.

I have read and understood the above financial policy and assignment. I hereby authorize photocopies of this form to be used as valid as the original for all my children registered with this practice.

Signed_____. **Date:** _____

NOTICE OF PRIVACY PRACTICES

Please read our copy of privacy practice posted on our website and in our waiting room. I have read a copy of the Notice of Privacy Practices for the office of Dr. Adeteju Ogunrinde and agree to abide by all disclosures and statements in the notice.

Parent Signature_____. **Date:**_____

EACH VISIT

Please bring a copy of your child's immunization record and insurance card with your picture ID to all visits.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT'S FULL NAME: _____

PATIENT'S DATE OF BIRTH: _____

PREVIOUS FACILITY NAME AND NUMBER: _____

I, _____ (parent or guardian) do hereby authorize Children's HealthCare Center to obtain:
All _____Specific Records ____ of all dates of records:

__ History and Physicals __ Consult Reports

__ Laboratory Reports __ Radiology Reports

__ Immunization Records __ Newborn Reports

PURPOSE OF RELEASE

__ Change of Doctor __ Personal __ Legal Investigation

__ Insurance __ Disability __ Continuation of Care

__ School

I authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to disclosure by the person or facility receiving it and would then no longer be protected by federal regulations.

_____

Signature of parent or guardian (as above) Date

Record Request Contact:_____
Name of employee