Dr. R's Kids

CONFIDENTIAL PATIENT DEMOGRAPHIC INFORMATION - PLEASE PRINT (PAGE 1)

Date: _____

1.Patient Name: _____ Date of Birth: _____ SEX: M___ F___
First MI Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

(Mom)
Parent's Name _____ Social Security #: _____ Date of Birth: _____

Work Phone: _____ Cell Phone: _____ Email Address: _____

(Dad)
Parent's Name _____ Social Security #: _____ Date of Birth: _____

Work Phone: _____ Cell Phone: _____ Email Address: _____

In case of emergency, please notify: _____ Relationship: _____

Address: _____ Phone Number: _____

Pharmacy: _____ Phone: _____ Address: _____

Referral Information – How did you hear about us? _____

PLEASE PRESENT INSURANCE CARD AND A PICTURE ID CARD TO THE RECEPTIONIST.

Primary Insurance Name: _____ Insurance Policy Number: _____

Insurance Subscriber's Name: _____ DOB: _____ Social Security #: _____

Employer Name/Address: _____ Phone Number: _____

Are you covered by Medicaid? Y _____ N _____ Medicaid Number: _____

Dr. R's Kids

CONFIDENTIAL PATIENT DEMOGRAPHIC INFORMATION - PLEASE PRINT (PAGE 2)

Secondary Insurance Name: _____ Insurance Policy Number: _____

Insurance Subscriber's Name: _____ DOB: _____ Social Security #: _____

Employer Name/Address: _____ Phone Number: _____

I, _____ (Parent/Patient/Legal Guardian) consent to all treatment and services being rendered by Dr. Rakhimova, providers and staff of Dr. R's Kids Pediatrics. Treatment and services include, but are not limited to: office visits, consults, vaccinations, injections, ancillary testing and other services deemed appropriate for treatment by Dr. Rakhimova, providers and staff of Dr. R's Kids Pediatrics.

Signature: _____ Date: _____

I, _____ (Responsible Party/Guarantor) request that payment of assigned/authorized insurance benefits be made directly to Dr. R's Kids Pediatrics, LLC for services rendered by Gulbakhor Rakhimova, MD or another provider. If the insurance pays the Guarantor in error, all monies must be reimbursed to Dr. R's Kids Pediatrics, LLC. I agree that I am responsible for all non-covered services. I authorize the release of any medical information to my insurance company and/or its agents as necessary to process claims and to determine the benefits payable for related services. I understand that I am financially responsible for any balance not covered by my insurance. I am aware that I am responsible to pay Dr. R's Kids Pediatrics, LLC for any co-pay, deductible and coinsurance amounts that my insurance applies based on my benefits. I acknowledge the policy of the office to charge or surcharge if co-payments are not paid at the time of visit. A photocopy of this authorization will be as valid as the original.

Signature: _____ Date: _____

Dr. R's Kids

HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

X I,_____, (Guardian/Responsible Party) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness X_____

Printed Name of Individual or Legal Representative X_____

Date: X_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

Dr. R's Kids

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION TO DR. R'S KIDS PEDIATRICS, LLC

Patient Name: X _____ Date of Birth: X _____ Phone: X _____

I authorize the following organization to release patient health information on the above patient:

INFORMATION TO BE RELEASED FROM:

_____
Organization

_____
Address

_____
Phone# Fax#

INFORMATION TO BE RELEASED TO:

Dr. R's Kids Pediatrics, LLC
871 Allwood Road, 2nd Floor
Clifton, New Jersey 07012
Phone: 973-310-2340
Fax: 973-955-4606

INFORMATION TO BE RELEASED:

X Complete Medical Records _____ Immunization Records _____ Last Check-Up/Physical

Please Specify if Other _____

The purpose or need for this request and disclosure is _____

This Authorization will expire in one year from the date it was authorized, or expire on: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this form in order to receive treatment. I understand that any disclosure of carries with it potential for an unauthorized redisclosure and the information may not be protected by federal confidentiallty rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this Authorization.

X _____
Patient/Parent/Guardian Signature

X _____
Relationship to Patient (If not Patient)

X _____
Date

Dr.R's Kids

Cancellation Policy/No Show Policy for Doctor Appointments

please Read First

* 1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appoinment book.

Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show, Cancellation" fee of $25 well visit, and $10 sick appointment. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

* 2. Scheduled Appointments

We understand that delays can happen however, we must try to keep the other patients and doctor on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

* 3. Account Balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to a business office representive with whom they can review their account and concerns.

Patients with balances over $100 must make a payment arrangements prior to future appointments being made..

X _____ X _____

Patient Print Name Date

X _____ _____

Patient Signature/ Guardian Patient Acct # (Office Use Only)