Prem Pediatrics
Parag Medical, Inc.

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (developmental screenings, immunizations, blood tests etc). **These health screenings are tests that can help detect or prevent life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs, Other Tests, and Prior Authorizations.

I understand that my physician's goal is to report my lab and test results to me as soon as possible. I understand sometimes prior authorizations from insurance will be requested for me to receive covered services or benefits. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results or status of prior authorizations.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Signature of patient or legal guardian	Date	Physician Signature

_____
Printed name of patient

PREM PEDIATRICS
Patient Information

Today's Date:___/___/___ Name of person completing form:_____Relation:_____

PATIENT INFORMATION

Name: Last	First	Middle	Date of birth	Male ☐ Female ☐	
Street Address	Apt	City	State	Zip	
Home phone ( )	Primary language:	Do you need interpreter: ☐ YES ☐ NO	Patient lives with:		
Sibling name:			Date of Birth:		
Sibling name:			Date of Birth:		
Sibling name:			Date of birth:		
Sibling name:			Date of birth:		

FATHER'S INFORMATION

Father's name: Last	First	MI	Date of Birth	
Street Address	Apt	City	State	Zip
Home phone ( )	Cell phone ( )	Work phone ( )		
Employer	Work address			
State/Drivers License	Social Security number	Email address for appointment reminders/pt portal		

MOTHER'S INFORMATION

Mother's name: Last	First	MI	Date of Birth	
Street Address	Apt	City	State	Zip
Home phone ( )	Cell phone ( )	Work phone ( )		
Employer	Work address			
State/Drivers License	Social Security number	Email address for appointment reminders/pt portal		

EMERGENCY CONTACT INFORMATION (names of 2 persons NOT living with you)

Full name	Relation	Phone ( )
Full name	Relation	Phone ( )

INSURANCE INFORMATION

Primary Insurance	ID #	Group#	Name of Subscriber
Secondary Insurance	ID #	Group#	Name of Subscriber

PREM PEDIATRICS

MISCELLANEOUS OFFICE POLICIES

The following are office policies with which patients / legal guardians should be familiar. Signature below acknowledges your understanding of the following policies.

- Please arrive fifteen (15) minutes prior to scheduled appointment time to allow our office for check-in, to verify insurance information, and update contact information. Please update contact information each visit as needed.
- If you are late for your appointment, we may have to reschedule your appointment.
- All payments under $30 must be paid in cash. All payments/co-payments must be made at the time of service.
- Please bring your child's immunization record to all well visits.
- Please bring any medications your child may be utilizing to all visits.
- Please DO NOT bring food or drinks, except baby formula, into examination rooms.
- Do NOT use cellular phones in exam rooms. Phones must be turned off when you enter the exam room.
- The doctor may ask only patients and parents be in the examination rooms.
- If requested by a patient or legal guardian, completion of forms or writing of letters may be subject to a fee.
- **VACCINATION POLICY:** For the utmost safety of your child and everyone else in our office, Prem Pediatrics does not accept patients who are unvaccinated. We firmly believe in the vaccine schedule endorsed by the CDC and the American Academy of Pediatrics and discourage alternative schedules. If you choose to vaccinate but have questions about the routine schedule or vaccinations themselves, we are open to discussing concerns with you so you may be fully informed with the most current scientific data available. If you choose not to have your child vaccinated against life-threatening illnesses we will ask you to find another primary care physician.

_____ _____

Signature of Parent / Legal Guardian of minor Date

_____ _____

Printed name of Parent / Legal Guardian Printed name of Patient

Authorization for Medical Evaluation and Treatment of Minor with Non-Legal Guardian

In the event that a parent or legal guardian is unable to bring the patient for evaluation and treatment, please provide us with a list of persons authorized to consent for evaluation and treatment of your child at Prem Pediatrics. These persons must bring legal photo identification at the time of visit. This authorization will remain in effect until further written notice.

I, _____ (Parent/Legal Guardian's name) authorize the person(s) listed below to seek and consent to medical treatment of my child, _____(child's name), at Prem Pediatrics.

Please print:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ _____

Signature of Parent / Legal Guardian of minor Date

_____ _____

Printed name of Parent/ Legal Guardian Printed name of Patient

PARAG MEDICAL, INC.
PREM PEDIATRICS

Consent for purposes of treatment, payment, information release, and health care operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Prem Pediatrics and its physicians, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of this office. I hereby authorize any physician, hospital, medical service organization, insurance company, or other organization to release to each other information acquired, including benefits paid or payable, concerning my protected health information as deemed necessary .

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I acknowledge that a copy of the current notice will be available in the reception area, and a copy of any amended Notice of Privacy Practices will be available at each appointment. The Notice of Privacy Practices describes my rights and the types of uses and disclosures of my protected health information during my treatment, payment of my bills, or in the performance of health care operations. The Notice also describes the duties of Prem Pediatrics and its' physicians with respect to my protected health information. Prem Pediatrics also reserves the rights to change the privacy practices as modified by state and federal laws. I have reviewed the Notice of Privacy Practices prior to signing this document.

I consent to the examination, diagnosis, and treatment of me or my dependents deemed necessary by the providers of Prem Pediatrics, as evidenced by my signature, until revoked in writing.

I hereby authorize payment of benefits directly to Parag Medical, Inc., any insurance benefits due for services rendered on behalf of the named patient. By signing this authorization, I understand that I am financially responsible to the providers of service for all charges not covered by my insurance company. I understand payments including copayments and deductibles are due at the time of service. I understand it is customary for insurance companies to process medical claims within 30-45 days of the date of filing, but I understand that if I am found ineligible for insurance coverage, I am ultimately responsible for payment in full to Parag Medical, Inc. for services rendered. If the account goes to collections, there will be a collection fee (40% of the delinquent balance due plus interest of 1.5% per month) added on to the balance of the account. If any check is returned due to insufficient funds or account closed, there will be a $25.00 charge added to the amount of the check.

A photocopy of this authorization shall be as valid as the original. I hereby certify the statements hereon and those attached are true and correct to the best of my knowledge. I understand that it is fraudulent to fill out this form with information I know to be false or to omit important facts, and that criminal and/or civil penalties can result.

_____ _____

Signature of parent or legal guardian Date

_____ _____

Printed name of parent or legal guardian Printed name of patient