PLEASE PRINT CLEARLY

Patient Information

Name:_____ Date of Birth:_____ Gender: ☐M ☐F

Race:☐ White ☐ African-American ☐ Asian ☐ Multi-racial ☐ Other Hispanic: Y N

Address: _____City: _____ State _____ Zip _____

Primary Phone(____)____-_____(home/cell) Alternate Phone: (____) ____-_____(home/cell)

May Leave Message at: **Primary/Alt/Both** Appointment Reminders will be made to **Primary Phone Number**

E-mail Address: _____

Parent's Information

Mother: _____ S.S#(required) _____ Date of Birth_____

Mother's Maiden Name: _____

Address(if different from Patient): _____

Phone _____ Employment_____ Work#_____

Father: _____ S.S#(required) _____ Date of Birth_____

Address(if different from Patient): _____

Phone _____ Employment_____ Work#_____

Parent Married: Yes/No if divorced, Who has legal custody? _____***(Please provide legal documentation)***

Siblings:

Name:_____ DOB_____ Name:_____ DOB_____

Name:_____ DOB_____ Name:_____ DOB_____

Name:_____ DOB_____ Name:_____ DOB_____

Insurance Information:

In order to file insurance claims, we must have completed information below and a scanned copy of the insurance card(s).

Primary Insurance _____ **ID#**_____ **Group#**_____

Who Carries the Insurance (Subscriber)? Father Mother Other _____

Who is Responsible for payment of unpaid balances on this account (Guarantor)? Father Mother Other_____

Do you have Secondary Insurance? YES NO

Secondary Insurance _____ ID#_____ Group#_____

Subscribe for Secondary? Father Mother Other_____

PLEASE CONTINUE TO THE OTHER SIDE

Consent To Treat

I give the physicians of Chesapeake Pediatrics consent to provide and perform medical care, tests, procedures, and administer medications and vaccines as are considered necessary or beneficial for my child's health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Parent Signature: _____ Date: _____

Authorization to consent for Medical Treatment in my absence:

I hereby grant the following person(s) the authority to bring my child to Chesapeake Pediatrics for medical care, tests, procedures, and immunizations.

_____ _____

_____ _____

_____ _____

Parent Signature: _____ Date: _____
Effective for calendar year 2024.

Electronic Communications:

Automated Calls: As an added convenience, we may offer automated reminders via a text message or an automated call for those who wish to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Chesapeake Pediatrics, LLC and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or e-mails, providing that I have consented below. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

□ Yes, I want to participate. My cell phone number is: _____ My e-mail address is: _____

□ No, I do not wish to participate at this time.

Parent Signature: _____ Date: _____

Release of Protected Health Care Information: (Unless otherwise stated only the Mother and Father may receive protected health care information.)

I give consent and authorization for the medical, or billing staff of Chesapeake Pediatrics to discuss protected Health Care Information about my child with the following person(s):

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

FINANCIAL RESPONSIBILITY: PLEASE READ CAREFULLY!
By signing below, I confirm that all personal information is correct, and I verify that I have provided the most current/accurate insurance information for my child. If I have failed to provide current information and the medical claim is denied, I understand that I could be responsible for payment in full for all services.. I acknowledge that I have read and understand the Financial Payment Policy for Chesapeake Pediatrics and have been offered a copy. I understand that if I do not pay my balance in a timely manner, I authorize the release of any information regarding my child's exam and treatment for the purpose of obtaining insurance compensation, precertification or medical records.

Parent Signature: _____ Date: _____

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

Maryland Healthy Kids Program

Cuestionario de Historial Médico Familiar

Nombre del Paciente:	Fecha de Nacimiento:	Sexo: M F (circule)
Persona que llenó el Formulario: / Fecha de Hoy:	Relación con el Paciente::	

HISTORIAL DURANTE EMBARAZO Y AL NACER

Nombre del Hospital: _____
Enfermedades durante el embarazo No ☐ Si☐
Medicamentos durante embarazo No ☐ Si☐
Abuso de Alcohol o drogas No ☐ Si☐
Problemas al Nacer No ☐ Si☐
Describa: _____
Tipo de Parto ☐ Vaginal ☐ Cesárea
Peso al Nacer_____Peso al darle de alta_____
El bebé recibió vacuna para Hepatitis B No☐ Si ☐
Fecha de la vacuna de Hepatitis B:_____
Examen Auditivo para recien nacidos No ☐ Si ☐

HISTORIAL PSICOSOCIAL

¿Quién vive en el hogar?_____
_____
¿Cuántas personas viven en el hogar?_____
☐ Alquilan ☐ casa propia ☐ refugio
¿Quién cuida el niño/a?_____
Fecha de Nacimiento Madre_____
Padre_____
Trabajan los Padres Madre No ☐ Si ☐
Padre No ☐ Si ☐
Hogar Sustituto _____ Fecha:_____
¿Qué otro idiomas se hablan en la casa?_____

HISTORIAL FAMILIAR

Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:

Alergias (a qué) _____			¿Quién?
Asma	No ☐	Si ☐	_____
TB/Enfermedad del Pulmón	No ☐	Si ☐	_____
VIH/SIDA	No ☐	Si ☐	_____
Intentos Suicidas/Problemas Mentales	No ☐	Si ☐	_____
Enfermedad del Corazón	No ☐	Si ☐	_____
Presión alta/Derrame	No ☐	Si ☐	_____
Colesterol Alto	No ☐	Si ☐	_____
Desórdenes de la Sangre/"Sickle Cell"	No ☐	Si ☐	_____
Diabetes	No ☐	Si ☐	_____
Convulsiones	No ☐	Si ☐	_____
Alergias/Asma	No ☐	Si ☐	_____
Desórdenes Mentales	No ☐	Si ☐	_____
Cáncer	No ☐	Si ☐	_____
Defectos de Nacimiento	No ☐	Si ☐	_____
Pérdida de Audición	No ☐	Si ☐	_____
Problemas de habla	No ☐	Si ☐	_____
Enfermedades Renales	No ☐	Si ☐	_____
Abuso de Alcohol/ Droga	No ☐	Si ☐	_____
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐	_____
Enfermedad de la Tiroide	No ☐	Si ☐	_____
Problemas de Aprendizaje/ Deficit de Atención ("ADD")	No ☐	Si ☐	_____
Violencia Doméstica			

Otras:_____

HISTORIAL DE SALUD

Alguna vez su niño/a ha tenido:

Alergias (a qué)_____

Asma	No ☐	Si ☐
Varicela (año) _____	No ☐	Si ☐
Infecciones frecuentes de oído	No ☐	Si ☐
Problemas de Audición/Infecciones de la Vista	No ☐	Si ☐
Problemas de la Piel/Eczema	No ☐	Si ☐
Asma/Alergias	No ☐	Si ☐
TB/Enfermedad del Pulmón	No ☐	Si ☐
Convulsiones/Epilepsia	No ☐	Si ☐
Hipertensión/Presión Alta	No ☐	Si ☐
Enfermedad del Corazón/Defectos	No ☐	Si ☐
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐
Diabetes	No ☐	Si ☐
Enfermedades del Riñón/Vejiga	No ☐	Si ☐
Problemas Físicos o de Aprendizaje	No ☐	Si ☐
Desórdenes de la Sangre/Hemofilia	No ☐	Si ☐
Enfermedades Transmitidas Sexualmente	No ☐	Si ☐
Problemas Emocionales o de Comportamiento	No ☐	Si ☐
Depresión/Pensamientos Suicidas	No ☐	Si ☐
Hospitalizaciones/Cirugías	No ☐	Si ☐
Abuso /Físico/Emocional/ o Sexual	No ☐	Si ☐
Problemas en las Coyunturas/Huesos	No ☐	Si ☐
Obesidad/Trastornos Alimenticios	No ☐	Si ☐

Otras: _____
Lista de Medicamento/s que toma:_____

Revisado por:	Fecha que fue Revisado:

Chesapeake Pediatrics & Adolescent Associates, P.A.

Parents are required to pay for their child's health care at the time services are provide. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard, Visa and Discover cards.

If is your responsibility to bring your most current insurance card with you to ***every*** office visit. You will be asked to present the card upon arrival along with any applicable co-payment. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, your will be expected to pay at the time of service.

Billing and Nonpayment: Co-payment and deductible are payable in full at the time of service. If you do not have an active/valid insurance card, payment is expected at the time of service. Please check with your plan to verify that we are a participating provider. Any services received and later denied by your insurance carrier are your responsibility. This arrangement is part of your contract with your insurance company. If you balance is 90 days past due, we may refer your account to our collection agency, unless payment plan arrangements are made with our office.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you do not supply this information within a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next appointment so we can make the necessary changes to help you receive your maximum benefits.

Covered/Non-Covered Services: Chesapeake Pediatrics is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover. The billing staff of Chesapeake Pediatrics will file all claims for covered services with your insurance company, if the physician is a contracted provider.

You are responsible for any balances that may be due to the physician as a result of:

- Co-insurance or co-payments
- annual deductible amounts
- non-covered services
- out-of-network charges
- terminated coverage
- exhausted benefits
- no insurance coverage
- failure to respond to insurance company correspondence or inquiries
- failure to list our physician as your Primary Care Physician

Release of Information and Payment Authorization:
All insurance Companies and Third Party Payers: I hereby authorize Chesapeake Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment to Chesapeake Pediatrics and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.
Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Chesapeake Pediatrics to my child(ren) or the patient indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days.
Statement of Responsibility: The policy of this office is the parent or legal guardian who requests treatment for this child is responsible for all fees and services. Insurance co-payments are expected the day of service unless arrangements are made in advance. Any remaining balances after insurance payments are that of the financially responsible party. When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees, and court costs. I Also understand and agree that if my personal check is returned for any reason, I will pay a $35.00 returned fee and my personal checks will no longer be accepted as payment for services rendered.

_____ _____

Patient Name Patient Date of Birth

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 year of age Date

Chesapeake Pediatrics

106 Milford Street, Suite 201 Salisbury, MD 21804

29 Broad Street, Suite 201 Berlin, MD 21811

Tel: 410-543-1616 · Fax: 410-543-8497 · www.chesapeakepeds.com

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____

I authorize CHESAPEAKE PEDIATRICS AND ADOLESCENT ASSOCIATES, P.A. to use or disclose my health information, as described below:

1. Description of health information that may be used and/or disclosed: any records pertaining to health and treatment of your child: including immunizations, school med forms, day care, school forms and camp forms, pharmacies or diagnostic facilities.

2. Name(s) of organization(s) or person(s) who may receive and use the information: Any Physician that Chesapeake Pediatrics and Adolescent Associates, P.A. refer me to for further treatment.

3. The purpose for which the information will be used or disclosed: To enable my physician to receive the maximum amount of information concerning my health in order to treat my condition to the full extent of their ability.

4. To be able to leave text message, or voice message on personal voicemail boxes, or at places of employment pertaining to appointments for this office and/or for specialist appointments.

5. To retrieve prescription history if available, and reconcile medications.

6. Authorize consent to participate in a telemedicine appointment with provider. During the telemedicine appointment:

   a. Details of your medical history will be discussed through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recording may be taken of you during the procedure(s) or service(s)

7. I understand what I may revoke this authorization in writing at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment or payment. I understand that I am not required to sign this authorization as a condition for obtaining treatment or payment. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed the information would no longer be protected by federal privacy rule.

By Signing below, I acknowledge that I have read, and I understand this authorization form.

_____ _____

Signature of Patient or Guardian Date

If signed by Patient's Guardian, please print name and describe that relationship to the patient.

_____ _____

Chesapeake Pediatrics

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PATIENT ACKNOWLEDGMENT FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I understand that patient's health information is private and confidential. I understand that this practice and its physicians work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health.

I understand that this practice may use and disclose my personal health information to help provide health care, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses or disclosures of this information without my permission. The situations are very unusual.

The practice has a detail document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my patient privacy and is at my disposal at any time. I understand that I have the right to read the notice before signing this acknowledgement.

The practice may update this acknowledgement and "Notice of Privacy Practices". If I ask, the practice will provide me with the most current "Notice".

Within this "Notice" is contained a complete description of my privacy/confidentiality right. These rights include, but aren't limited to my medical records; Restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specific methods or to alternative location.

The practice has established procedures which help them meet their obligations to me as a patient. These procedures may include other signatures requirements, written acknowledgments; and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist the Practice by following these procedures if I choose to exercise any of my rights described in the "Notice".

My signature below indicates that I have been given the chance to review a current copy of this practice's "Notice of Privacy Practices".

_____ _____

Parent Signature Date