Vineland Pediatrics, P.A.
1138 E. Chestnut Ave. Bldg. 5B
Vineland, NJ 08360
Phone: 856-692-1108

TODAY'S DATE: _____

CHILD'S FULL NAME: _____ DOB: _____ AGE: _____ SEX: M/F

ADDRESS: _____

TELEPHONE: _____ CHILD'S SOCIAL SECURITY #: _____

HOSPITAL WHERE BORN: _____ BIRTH WEIGHT: _____

PREVIOUS DOCTOR: _____ SCHOOL NAME: _____ GRADE: _____

	NAME	DOB	OCCUPATION/EMPLOYER	SCHOOL NAME/GRADE (CHILDREN ONLY)	HEALTH HISTORY
FATHER/GUARDIAN					
MOTHER/GUARDIAN					
OTHER CHILDREN					

Check (✓) if anyone in the immediate family has or has had: __ None Apply

☐ Tuberculosis ☐ Asthma ☐ Seizures ☐ Mental Illness ☐Hypertension ☐ Diabetes ☐ Cancer ☐ Heart Disease

☐ Smoking ☐ Alcoholism/substance abuse ☐ other (specify)_____

Check (✓) if the following has or had applied to this child: (Skip any item that does not apply)

☐ Child Adopted
☐ Premature
☐ Recurrent Severe abdominal pain
☐ Asthma
☐ Difficulty Breathing
☐ Bronchitis
☐ Heart Problems
☐ Seizures
☐ Bone Illness
☐ Skin Problems
☐ Hives
☐ Wheezing
☐ Anemia (past or present)
☐ Mother ill during pregnancy with this child
☐ Problems in the nursery
☐ Chronic Headaches
☐ Hearing Problems
☐Chicken Pox
☐ Persistent Cough
☐ Kidney or Bladder infections
☐ "Slow Learner" for age
☐ Illnesses of Joints (Arthritis)
☐ Diabetes
☐ Eczema
☐ Disease of Endocrine Glands (Thyroid, etc.)

GIRLS ONLY

☐ Menstruating (having periods) ☐ Severe pain with periods

☐ Other problems with periods (specify)_____

☐ Drug/Alcohol ☐ Tobacco Use ☐ Severe or Unusual Behavior Problems ☐ Treatment by Psychiatrist/Psychologist

☐ Could not say 3 words by 20 months ☐ Could not say sentences by 3 yrs ☐ Could not sit without support by 8 months

☐ Could not walk well alone by 14 months ☐ Failing School ☐ Excels ☐ Above Average ☐ Average ☐ Below Average

___ Allergy to any drugs or medicines: If yes, please list:

___ Allergy to any food or other substances: If yes, please list:

___ Taking any Medication now: If yes, please list:

HOSPITALIZATIONS

DATE	HOSPITAL	DOCTOR	PROBLEM

__ Any other significant illnesses or serious injuries: Please list:

__ Child having any problems now (If yes, describe problem stating first when it began):

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BILLING AUTHORIZATION

Patients Name: _____ **DOB:** _____ **Social Security #:** _____

	NAME	DATE OF BIRTH	OCCUPATION/EMPLOYER	HEALTH HISTORY
FATHER/GUARDIAN				
MOTHER/GUARDIAN				

MEDICAL INSURANCE POLICIES

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME		
SUBSCRIBER NAME		
SUBSCRIBER DATE OF BIRTH		
POLICY ID #		
GROUP ID #		
COPAY		

AUTHORIZED PERSON'S SIGNATURE REQUIRED:

I certify that the above information is complete and accurate.
I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits to Vineland Pediatrics, P.A. for any services they provide.
I accept financial responsibility for services or charges not covered by insurance including copayments, coinsurance, and deductibles.

It is my responsibility to furnish this office with changes in insurance information or full payment may be require by me.

Signed: _____ Date: _____

Relationship to Patient: _____

Acknowledgement of Receipt of Privacy Practice Notice
I certify that I have received a copy of Vineland Pediatrics, P.A. Notice of Privacy Practices

Signed: _____ Date: _____

Relationship to Patient: _____

ARCHNA JAIN, MD OLABODE OGIDAN, MD

EXCEL CARE VINELAND PEDIATRICS
1138 E. Chestnut Ave. Bldg. 5B
Vineland, NJ 08360

Immunization Consent

Patients Name (Please Print): _____ DOB: _____

I have read the accompanying information about HIB, DTaP, Hepatitis A, Hepatitis B, Polio, MMR, Influenza, Varicella (chicken pox), Pneumococcal (Prevnar 20), Meningococcal (MenQuadFi), Rotavirus, RSV (Beyfortus), Human Papillomavirus, and Meningococcal Serogroup B (Trumenba), and Tdap. I have had a chance to ask question which were answered to my satisfaction. I believe I understand the benefits and risks for the above named vaccines.

By my consenting signature below, I request that the vaccines be administered when due, to me, or to the person named above, for whom I am authorized to make this request. Also, by my signature below I give permission to report immunization data to NJIIS.

X_____ _____
Print Parent/Guardian Name Relationship to Patient

X_____ _____
Signature of Parent/Guardian Name Date

Archna Jain, MD Olabode Ogidan, MD

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Excel Care Vineland Pediatrics. When you schedule an appointment with Excel Care Vineland Pediatrics we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

1. Effective July 1, 2018 any patient who fails to No Show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice will be considered a NO SHOW and charged a $15.00 fee.

2. Any patient who fails to No Show or Cancels/Reschedules an appointment with less than 24 hour notice a second time will be charged another $15.00 fee.

3. If a third No Show or Cancels/Reschedule with less than 24 hour notice should occur the patient will be charged another $15.00 fee and sent to Collection.

4. If a fourth No Show or Cancels/Reschedule with less than 24 hour notice you may be discharged from the practice.

5. The fee is charged to the patient, not the insurance company, and is **DUE AT THE TIME OF THE PATIENT'S NEXT OFFICE VISIT.**

6. There is a $15.00 fee every time you No Show or Cancel/Reschedule with less than 24 hour notice.

7. As a courtesy, when time allow, we make reminder calls for appointment. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager.

Excel Care Vineland Pediatrics: (856) 692-1108

I have read and understand the Medical Appointment Cancellation/ No Show Policy

_____ _____

Signature of Parent/Legal Guardian Relationship to Patient

_____ _____

Patient Name Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION
TO EXCELCARE VINELAND PEDIATRICS

I hereby authorize:
(previous MD) _____

(address) _____

_____

to release, full details of medical and surgical care, including history, treatments, immunization dates, reports of laboratory and other diagnostic tests, consultations, evaluations, and hospitalizations of:

	Patient's Name	Birthdate
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

This authorization includes dates of care __ birth to the present
or __ specific dates _____ through _____
or __ related to event/accident which occurred _____

to: EXCELCARE VINELAND PEDIATRICS
1138 E. CHESTNUT AVE #5B
VINELAND, NJ 08360-5062
Attention: Medical Records
Phone 856-692-1108
Fax 856-692-2077

This protected health information will be used to maintain a complete health care record for this individual, for health care operations and payment, and to assist the primary care physician with ongoing health care management.

This authorization is in effect until the records described above are released. I understand that I have the right to revoke this authorization at any time before it is carried out, by writing directly to the above party authorized to release the information. The revocation must include my name, patient's name and birthdate, address, telephone number, and my signature.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and, in that case, may no longer be protected by state or federal law.

Signature of adult patient or parent/guardian: _____
Printed name of adult patient or parent/guardian: _____
Relationship of above authorized person to patient: _____
Date: _____

Please do not fax files more than 10 pages long. Our system freezes with large files and loses the entire transmissions. When this happens we also cannot identify the sender so we don't know which files we didn't get. Please send such files by postal mail via paper, flash drive or CD. Thank you.

Archna Jain, MD Arnold Solof, MD Olabode Ogidan, MD

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Ph: 856-692-1108
Fax: 856-692-2077
Email: vpeds2@gmail.com

Authorization – Non-Parent/Guardian to Accompany Patient

There may be times when you are unable to bring your child to the office for an appointment and need someone else to bring them. We understand these circumstances; however, we must have a written authorization letter allowing someone to accompany your child(ren). The person bringing your child will need to present a photo identification at time of service.

This authorization gives permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medications, procedures and make health decisions.

I, _____, give the person(s) listed below permission to bring my child(ren) to Excel Care Vineland Pediatrics and to discuss and share medical information about my child(ren).

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) DATE

INSURANCE EXCLUSIONS
4/1/14

The following services may not be covered by your insurance policy.

- Exams, tests (e.g. PPD), vaccines, etc., for such things as sports, camp, employment, school, travel, marriage, life insurance.
- Screenings such as Hearing, Vision, MCHAT, etc.
- Obesity/ Weight reduction services
- ADHD, school/ learning problems, behavior problems, developmental delay
- Supplies (e.g. Ace bandages, splints, etc.)
- Medical reports/ services for 3rd parties (e.g. life insurance, employment, litigation, etc.)
- Some plans have limitations on how frequently they will cover check-ups, such as no more than once every 1-year (365 days) or 2-years (730 days) from the last check-up, or the number of well-child check-ups in the first one or two years of life. Some plans do not cover checkups for certain ages such as between 7 and 19 years of age.
- Work-related conditions must be billed to Workman's Compensation Insurance before any medical policy. The insurance information must be presented when checking in for that visit. If not provided, payment for our service is expected directly from guarantor.
- Auto Accident-related services must be billed to auto insurance before any medical policy and is usually applied to deductible. The deductible is not generally covered by the patient's medical policy* and therefore payable by the patient/guarantor. Auto insurance info including Claim number, address to send claims, and signed assignment of benefits form if applicable must be presented when checking in for the visit. If the information is not provided, payment for our service is expected directly from the patient/guarantor. *If you have a question about this please call your medical insurance company.
- Some immunizations may not be covered by your policy. If your policy does not cover ANY immunizations, tell us at check-in and also when taken back to the exam room.

This list is not all-inclusive and serves as a general guide. Every insurance policy is different. Refer to your insurance policy for your complete list of exclusions.

If you have specific questions about your plan, please call your insurance company before your visit.

PATIENT NAME: _____

I have been informed by Excel Care Vineland Pediatrics that there are services that may not be covered by my child's medical insurance. I accept financial responsibility for the non-covered services.

_____ _____
(Signature) (Date)

_____ _____
(Printed Name) (Relationship to Patient)

If other than patient or parent: Address _____

_____

Phone _____

Excelcare Alliance, LLC
Vineland Pediatrics | PediaPlace Pediatrics | Dr. Manske |
Dendrinos Medical Associates |Dr. Sehgal | Dr. Narvel | Vineland Medical Associates |
Dr. Ahmed | Tri County Medicine |Mullica Hill Medical Associates |
Allied Physicians of South jersey | Your Kidney & High Blood Pressure Doctors |

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

<u>How we may use and disclose health care information about you:</u>

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Excelcare Alliance, LLC. If you have questions and would like additional information, you may contact us at 856-205-1112.

Signature: _____

Print: _____

Date: _____