AMBOY PEDIATRICS

321 State Street, Perth Amboy, NJ 08861
PHONE: (732) 719-4333 - FAX: (732) 719-4332

Date: _____

PATIENT REGISTRATION FORM

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____ Sex: F / M

Address: _____ City: _____ State: _____ Zip Code:_____

DOB: _____ Pharmacy Name: _____ Pharmacy Town: _____

Cell # _____

Parent/Guardian 1 Information: Relationship to patient: ***(Circle One)*** Mother / Father, Other: _____

Last Name: _____ First Name: _____ Middle Name: _____ Sex: F / M

Address: _____ City: _____ State: _____ Zip Code:_____

DOB: _____ Cell#: _____ Home#: _____ E-mail: _____

Parent/Guardian 2 Information: Relationship to patient: ***(Circle One)*** Mother / Father, Other: _____

Last Name: _____ First Name: _____ Middle Name: _____ Sex: F / M

Address: _____ City: _____ State: _____ Zip Code:_____

DOB: _____ Cell#: _____ Home#: _____ E-mail: _____

☐ By checking this box, you agree to receive SMS messages related to patient appointments (confirmations, rescheduling, cancelling) from Amboy Pediatrics. Messages will be sent to the phone numbers specified above. You can reply 'STOP' at any time to opt-out. Message and data rates may apply. Message frequency may vary, text HELP for assistance. For more information, please refer to our privacy policy (amboypeds.com/privacy-policy) on our website.

Primary Insurance Information:

Insurance Company: _____ ID# _____ Group# _____

Secondary Insurance Information:

Insurance Company: _____ ID# _____ Group# _____

PAYMENT AUTHORIZATION: I, _____, hereby authorize ***Amboy Pediatrics*** to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician all benefits due to him as a result of his claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of this authorization will be valid as the original.

ALL PAYMENT/COPAY IS DUE AT THE TIME OF THE VISIT/SERVICE

If Patient is Uninsured parents/Guardian are responsible for visit cost. Any test or Vaccine performed in the exam room is not included in the visit Price. If blood work performed it will be billed by Laboratory (*LabCorp*).

Prices Subject to change.

Annual/Sport Physical **$100**	New Patient Sick **$100**	Sick Establish **$65**	Follow-Up **$65**	Vaccine Administration Fee **$20**

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Emergency Contact Information:

Last Name: _____ First Name: _____ Cell#: _____

Relationship to Patient: _____ Comment: _____

Medical Authorization:

I, _____, being the parent and/or legal guardian of my child do hereby authorize the following people to seek and obtain medical care for my child under this Authorization:

*1.*_____ Relation to Patient: _____ Phone#_____

2._____ Relation to Patient: _____ Phone# _____

3._____ Relation to Patient: _____ Phone# _____

ATTENTION:

WALK-INS only between 9am – 3pm

WALK-INS wait times may vary between **15 MINUTES to 3 HOURS**

We have a **20-minute grace period** if you are running behind, but if you are later than this and have not called and made arrangements, we cannot guarantee that you will be seen, and you may have to be rescheduled.

Parent/Guardian Signature: _____ Date: _____

MEDICAL RELEASE FORM

HIPAA AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Date: _____

Name of Prior Healthcare Provider/Facility _____

Phone# (of Prior Provider/Facility) _____ Fax# (of Prior Provider/Facility) _____

Patient Full Name: _____ DOB: _____

Patient Address: _____

Parent Phone Number: _____

***Parent Signature**:* _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

___ All medical records
___ All Lab Results
___ All Vaccine Record
___ All Radiology Results

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I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Comments:

_____

_____

****** Confidentiality Notice ******

The documentations accompanying this facsimile transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity. Any other party is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for the return of these documents.

PRIVACY NOTICE

Your Privacy Is Important

Patient's Name: _____ DOB: _____

AMBOY PEDIATRICS understands your privacy is important. You have received this notice in accordance with applicable state and federal laws and because you are a current or potential patient. This notice will help you understand what types of non-public personal information about you is not publicly available – we may collect how we use it and how we protect your privacy.

Privacy Policy Highlights

a.) We collect non-public personal information to process and administer our patients' business.
b.) We have policies and procedures in place to protect non-public personal information about our patients or their families.
c.) We do not sell non-public personal information about our patients or their families to third parties, i.e. companies or individuals that are not affiliated with us.
d.) We do not disclose any non-public personal information about our patients or their families to anyone, except as permitted by law.
e.) We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment and healthcare operations.
f.) For all other purposes, we will either obtain your authorization or remove all information that could identify you as an individual.
g.) Our Privacy Policy applies to both current and former patients.

Questions and Answers

What types of non-public personal information does Amboy Pediatrics collect?

Amboy Pediatrics' employees, representatives, agents and selected third parties may collect non-public personal information about our patients or their families, including:
a. Information provided to us, such as application or other forms.
b. Information about transactions with affiliates, our third parties or us.
c. Information from others, such as credit reporting agencies, employers and federal agencies.
d. The types of non-public personal information Amboy Pediatrics collects vary according to the products or services provided and may include, for example: account balances, insurance premiums, marital status and health history.

What does Amboy Pediatrics do to protect non-public personal information? We restrict access to non-public personal information to those employees, agents, representatives or third parties who need to know the information to provide products and services to our patients or their families.
We have policies and procedures that give direction to our employees, and agents and representatives acting on our behalf, regarding how to protect and use non-public personal information. We maintain physical, electronic and procedural safeguards to protect non-public personal information.

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With whom does Amboy Pediatrics share non-public personal information, and why? We do not share non-public personal information about our patients or their families with anyone, including other affiliated companies or third parties, except as permitted by law.

We may disclose, as allowed by law, all types of non-public personal information we collect when needed, to affiliated companies, agents' employees, representatives and third parties that market our services and products and administer and service and service customer accounts on our behalf. Examples of the types of companies and individuals to whom we may disclose non-public personal information include attorneys, trustees, third-party administrators, insurance agents, insurance companies, insurance support organizations, credit reporting agencies, registered broker/dealers, auditors and regulators.

We do not share personally identifiable health information unless the customer or the applicable law authorizes further sharing.

Does Amboy Pediatrics' Privacy Policy apply to its agents and representatives?

Amboy Pediatrics' Privacy Policy applies, to the extent required by law, to its agents and representatives when they are acting on behalf of Amboy Pediatrics.

Please note: There may be instances when these same agents and representatives may not be acting on behalf of Passaic Pediatrics, P.A. in which case they may collect non-public personal information on their own behalf of another. In these instances, Amboy Pediatrics' Privacy Policy would not apply.

Will Amboy Pediatrics' Policy change?

Amboy Pediatrics reserves the right to change any of its privacy policies and related procedures at any time, in accordance with applicable federal and state laws. You will receive appropriate notice if our Privacy Policy changes.

I hereby acknowledge that I have been presented with a copy of Amboy Pediatrics' Notice of Privacy Practices.

PLEASE NOTE:
THE PRIVACY NOTICE IS PROVIDED TO YOU FOR INFORMATION PURPOSES ONLY. YOU DO NOT NEED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THIS NOTICE. WE RECOMMEND THAT YOU READ AND RETAIN THIS NOTICE FOR YOUR PERSONAL FILES.
07/02/2024

X_____
Signature of Legal Guardian

Date: _____