PATIENT INFORMATION: ☐ Do you immunize?

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Sex: ☐ Male ☐ Female Suffix on insurance card:_____

Ethnicity: Hispanic ☐ *Non-Hispanic* ☐ *Race: Asian* ☐*Black* ☐*Pacific Islander* ☐ *White* ☐*American Indian* ☐ *Alaskan*

Patient Cellphone (15+) _____

Child 2: Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Sex: ☐ Male ☐ Female Suffix on insurance card:_____

Ethnicity: Hispanic ☐ *Non-Hispanic* ☐ *Race: Asian* ☐*Black* ☐*Pacific Islander* ☐ *White* ☐*American Indian* ☐ *Alaskan*

Patient Cellphone (15+) _____

Child 3: Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Sex: ☐ Male ☐ Female Suffix on insurance card:_____

Ethnicity: Hispanic ☐ *Non-Hispanic* ☐ *Race: Asian* ☐*Black* ☐*Pacific Islander* ☐ *White* ☐*American Indian* ☐ *Alaskan*

Patient Cellphone (15+) _____

Preferred Provider:

Kavle MD ☐ *Perkel MD* ☐ *Grogean MD* ☐ *Benjamin APRN* ☐ *Blair APRN* ☐ *Joerg APRN* ☐ *Pesce APRN* ☐*Gilbert PA* ☐

Mailing Address:_____

Home Phone: (____)_____-_____ Cellphone: (____)_____-_____

Insurance(s)

Primary Policy:

Policy Holder's Name: _____

Policy Holder's Birthdate: ___/___/___ Sex: ☐ Male ☐ Female

Insurance Carrier: _____ID#_____

Group# _____

Address:_____

(Located on the back of the card)

Secondary Policy: ☐ Check if HUSKY/Medicaid and skip to next section

Policy Holder's Name: _____

Policy Holder's Birthdate: ___/___/___ Sex: ☐ Male ☐ Female

Insurance Carrier: _____

ID# _____ Group# _____

Address:_____

(Located on the back of the card)

CONTACTS

All routine contact will be made to parent/guardian #1 unless otherwise requested below

Parent/Guardian #1: Name: _____ Birthdate: ___/___/___
Relation to Patient: _____ Lives with patient Yes ☐ No ☐
Home Phone: (____)_____-_____ Cellphone: (____)_____-_____
Work Phone: (____)_____-_____ Preferred Email: _____
Employer: _____ Occupation: _____
Address (if different from patient):_____
How would you prefer to be contacted regarding the following:

Medical Issues: Home Phone ☐ ***Work Phone*** ☐ ***Cellphone*** ☐ ***Preferred Email*** ☐
Can we leave a voicemail ☐ *Yes or* ☐ *No. If yes, brief message* ☐ *or detailed message* ☐
Appointment Reminders: Home Phone ☐ ***Work Phone*** ☐***Cellphone*** ☐ ***Preferred Email*** ☐

Parent/Guardian #2: Name: _____ Birthdate: ___/___/___
Relation to Patient: _____ Lives with patient Yes ☐ No ☐
Home Phone: (____)_____-_____ Cellphone: (____)_____-_____
Work Phone: (____)_____-_____ Preferred Email: _____
Employer: _____ Occupation: _____
Address (if different from patient):_____

If this contact will need to be notified in addition to parent/guardian #1 for routine care, please check the preferred method: *Home Phone* ☐ *Work Phone* ☐ *Cellphone* ☐ *Preferred Email* ☐

Additional Contact Questions:

Who should receive billing statements? _____
May all contacts have access to the patient's records electronically? Yes ☐ No ☐

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment Yes ☐ No ☐

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

How did you hear of us? Family/Friend ☐ Web search ☐ Social Media ☐ Other ☐

Assignment of Benefits and Release of Information:

I hereby authorize my insurance benefits to be paid to Northwest Hills Pediatrics P.C. and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Northwest Hills Pediatrics PC to release information requested concerning my care to insurers paying such benefits.

Signature:_____ Date:_____

FINANCIAL AND INSURANCE POLICY

✓ **Co-Pay's**

It is our Policy to collect your insurance co-pay at check-in, on every visit.
Co-Pay is due regardless of who brings the child in for the services. Grandparents, Aunt, Babysitter etc., will be expected to bring in payment for your co-pay. If you are reachable by phone, we can take you credit card information over the phone and send the receipt home with your child's caregiver.

✓ **Deductible/HSA**

If you have a deductible / co-insurance plan, we require a payment of $75 at the time of the visit on all visits excluding well visits.

✓ **Combined Visits**

If you are scheduled for a Well Child Visit, and other health concerns are brought up that would typically require a sick visit, your insurance may consider these two separate visits and bill your copay and other charges accordingly**.**

✓ **Billing**

As a courtesy, Northwest Hills Pediatrics bills your health insurance carrier on your behalf, with the following guidelines/exceptions:

INSURANCE CARD: It is critical that the most current insurance card is brought to **EVERY** appointment**.** We must have the correct information at the time of service. If you do not have this information you will be considered self-pay. You must report ALL insurance coverage. Failure to do so is considered insurance fraud. This will also result in full responsibility for the bill on your part.

We will bill your insurance company. We will send your insurance company the original claim soon after your visit. We will be happy to follow up if payment is not received within 45-60 days. If it becomes necessary to continue follow up we will at that point turn the bill over to you to continue pursuing payment from your insurance company. At this point, the bill will become patient responsibility until we hear from you.

AUTO INSURANCE: We do NOT bill auto insurance for visits and medical care related to auto accidents. Payment will be required at the time of service, and we will provide you with paperwork needed for you to submit to the auto insurance carrier for reimbursement.

STATEMENTS: Failure to receive your statement **DOES NOT** relieve you of your financial obligations. It is your responsibility to notify us of any changes in your billing and/or contact information.

NEWBORNS: Proof of application will be expected by the 30 day mark of those still not added to the insurance. Most commercial insurance companies allow only 30 days to add your newborn to your plan. Please do this ASAP.
If your insurance requires you to choose a primary care provider, you **MUST** contact your carrier and select our provider.

SELF PAY: Self pay patients are required to make an advance payment on their sick visit charge. If we do any additional testing, there will be additional charges that we will bill you for. If we have to send any LABS, the LAB will bill you directly for those services. Well Child Visits have to be paid in full at the time of service

ADMINISTRATIVE FEES:

Northwest Hills Pediatrics charges various fees for the following items:

Copies of Medical Records - $25

Completions of additional sports physical forms (free during Well Child Visit) - $5

Completion of FMLA paperwork - office visits

Returned Check (of insufficient funds) - $20 applied to account

"No Show" Fees: If you miss or cancel your appointment without at least 24 hours notice, you may be charged the following:

Well Child Visit $50.00
Well Child Visit Teen/New Visits $75.00
Behavioral Visit $75.00
You must cancel "Sick Visit" you cannot keep at least two hours prior to your scheduled time or you will be assessed $20 missed appointment fee

Please be advised that chronic no-shows (3 or more) may result in a dismissal from the practice

BALANCES: In order to improve our office efficiency and ensure that we can financially sustain ourselves while provide services our patients are accustomed to, the following are our policies regarding outstanding balances. We send out statements monthly. If the account gets more than 120 days past due, you will receive a phone call from our billing department to make a payment or set up a payment plan. Your account will be flagged and no appointments will be able to be booked until balance is paid or payment plan is set up.

I hereby authorize payment directly to the provider from my insurance carrier.
I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims.

I have read and understand the above stated policies. All questions have been answered by the staff at Northwest Hills Pediatrics prior to signing this agreement. (Please list multiple children below if applicable)

Patient Name	**DOB**
Patient Name	**DOB**
Patient Name	**DOB**
Patient Name	**DOB**
Patient Name	**DOB**

Parent/Guardian Signature (unless 18 years or older)	**DATE**

Consent to Treat Minor Patient – Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____ Date of Birth: ___/___/_____

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which the authorization is given. (If none, state "none")_____

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. This consent may ONLY apply to minors age 16 and older.

AUTHORIZATION:

I (parent/legal guardian name)_____ request and authorize Northwest Hills Pediatrics Providers and its staff to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient's portion due at the time of service.

I have the legal right to preauthorize Northwest Hills Pediatrics and its staff to deliver routine medical treatment and services to my child. ***Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment, and minor burns)***.

I have read, understand, and give my consent as stipulated above. My signature means I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____

Parent or Legal Guardian (Please Print) Relationship

_____ _____

Parent or Legal Guardian Signature Date

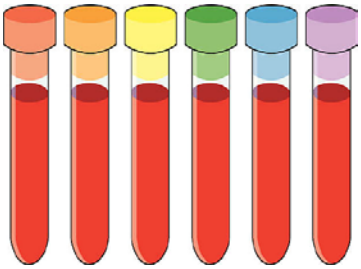
TESTING IS IMPORTANT

Your child's CHECK UP may include many different forms of testing in the office

VISION

HEARING

LAB



It might even be a paper test or a survey you fill out and the providers then scores

Unfortunately, they MAY not be covered by your health insurance.
If your insurance does not pay, you may receive a nominal bill for the negotiated insurance reimbursement amount for these services.

Our Providers feel all these are very important to your child's health and follow AAP recommendations to perform these tests during your child's annual checkups

School, Sports & Camp Forms Policy

Northwest Hills Pediatrics strives on patient satisfaction. It is our offices goals to reduce delay in reviewing and completing all patient form requests. Please understand that each form that we need to complete takes time on the part of the staff to fill out as well as by our Providers to review, amend and sign.

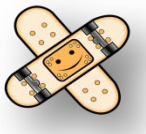
Completion of all forms will incur a charge of $5 dollars per form. We encourage you to make copies of all forms. Providing all school, camp or athletic forms during the patient's well visit will allow for our office to complete them in a timely manner. You will still be entitled to one school/camp/daycare form per child per calendar year. Please be aware of our form completion policy; that all forms will be completed within 48 hours. All completed forms will be ready at each office locations from desk.

Any urgent or immediate requests for forms to be completed on the same day or within 24 hours will incur a fee of $10 dollars.

PREVENT UNNECESSARY Urgent Care / ER VISITS

Please call us before you to go Urgent Care / ER

Each year hundreds of Urgent Care / ER visits and expensive co-pays for Northwest Hills Pediatrics patients might be avoided with a phone consultation and office or home based treatment



LACERATIONS: Many cuts can be closed in our office without stitches using special glue for the skin called *"DERMABOND"*
CALL US FIRST – to help assess your child's laceration

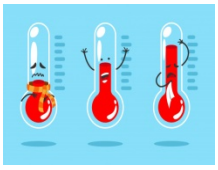
BELLY PAIN: Serious causes of abdominal pain exist but are rare. Many children with pain are in face constipated… even with a daily BM.
CALL US FIRST – to discuss your child's symptoms

CROUP: A barking cough can often be calmed with steam, cold freezer or night air.
CALL US FIRST – to help decide which treatment your child needs

FINGER, WRIST & ANKLE INJURIES: Lots of sprains and strains can be treated with RICE (Rest, Ice, Compression and Elevation)
CALL US FIRST – to help assess your child's injury

BUMPED HEAD: The majority of concussions does not need imaging and heal spontaneously over time with physical and cognitive rest
CALL US FIRST – to review your child's symptoms

FEVER: Fever helps the body fight infection and is rarely harmful.
CALL US FIRST – to discuss when to schedule a visit



EAR & THROAT: Both ear and throat pain is often soothed with ibuprofen. Most ear infections resolve without antibiotics.
CALL US FIRST – to help assess your child's pain

WORRIED ABOUT WAKING UP A PROVIDER AT NIGHT?

Don't be! At Northwest Hills Pediatrics a provider is available 24/7 to discuss your child's symptoms.
CALL THE ON-CALL PROVIDER TO HELP DECIDE WHETHER A TRIP TO URGENT CARE / ER IS NEEDED

Edward C. Kavle, MD **Jason M. Perkel, MD** **Timothy M. Grogean, MD**

Sherry Blair, NP **Kate Pesce, NP** **Kimberly Joerg, NP** **Sara Benjamin, NP** **Alison Gilbert, PA**

Name: Northwest Hills Pediatrics, P.C.

Primary Address: 538 Litchfield St, Suite G02
Torrington, CT 06790

Phone: 860-489-5068
Fax: 860-489-3725

Pay Location: 538 Litchfield St, Suite G02
Torrington, CT 06790

Satellite Address: 49 Spencer St
Winsted, CT 06798

Phone: 860-738-6230
Fax: 860-738-3725

Pay Location: 538 Litchfield St, Suite G02
Torrington, CT 06790

Satellite Address: 40 Dale Rd, Suite 200
Avon, CT 06001

Phone: 860-693-5850
Fax: 860-693-5854

Pay Location: 538 Litchfield St, Suite G02
Torrington, CT 06790

Satellite Address: 29 Hospital Hill Road, Suite 600
Sharon, CT 06069

Phone: 860-364-5585
Fax: 860-364-5078

Pay Location: 538 Litchfield St, Suite G02
Torrington, CT 06790