Meridian Pediatrics

12065 Old Meridian Street, Suite 100
Carmel, IN 46032
(317) 844.5351
(317) 844.0310 (FAX)
www.meridianpediatrics.net

Dr._____

Patient Information Sheet

1) Parent / Legal Guardian Legal Name:	Date of Birth:
Address:	
City / State / Zip:	
Home Phone #:	Mobile Phone #:
Email Address:	
Employer:	

2) Parent / Legal Guardian Legal Name:	Date of Birth:
Address:	
City / State / Zip:	
Home Phone #:	Mobile Phone #:
Email Address:	
Employer:	

SELF (Legal Name):	Date of Birth:
Address:	
City / State / Zip:	
Home Phone #:	Mobile Phone #:
Email Address:	
Employer:	

Primary Insurance:
Secondary Insurance:

CHILD(REN) Legal Name (Under age 18)	Date of Birth	CHIRP

EMERGENCY CONTACT NAME:
Best Contact Phone #:

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OUR OFFICE MAY REFER YOU TO A SPECIALIST. THIS SPECIALIST MAY BE A NON-PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY. IF A NON-PARTICIPATING PROVIDER (OUT OF NETWORK) IS USED, THEY ARE NOT BOUND BY THE PAYMENT PROVISIONS THAT APPLY TO HEALTH CARE ITEMS OR SERVICES RENDERED BY A PARTICIPATING PROVIDER (IN-NETWORK PROVIDER) UNDER THE COVERED INDIVIDUAL'S HEALTH PLAN. THEREFORE, WE ENCOURAGE YOU TO CONTACT THE HEALTH PLAN BEFORE RECEIVING HEALTH CARE SERVICES BY ANY PROVIDER.

I HAVE VERIFIED THAT THE PERSONAL INFORMATION IS CORRECT.

I HAVE VERIFIED THAT THE INSURANCE INFORMATION IS CORRECT. IF THE INFORMATION IS NOT CORRECT, I UNDERSTAND I WILL BE BILLED FOR THE ENTIRE AMOUNT. I ACKNOWLEDGE THAT I WILL BE RESPONSIBLE FOR ANY ADDITIONAL COSTS IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS.

I WILL PAY ANY CO-PAYMENTS THAT ARE DUE AT THE TIME OF THE VISIT. IF I DO NOT PAY MY CO-PAY, I ACKNOWLEDGE THAT I WILL BE BILLED AN ADDITIONAL FEE OF $10.00.

I ACKNOWLEDGE THAT I WILL BE CHARGED AN ADDITIONAL $50.00 FOR ANY CHECK RETURNED BY MY BANK.

I ACKNOWLEDGE THAT I WILL BE CHARGED $50.00 FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS MISSED NOTIFYING US WITH LESS THAN 24 HOURS NOTICE.

SIGNATURE **DATE**

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information.

Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI.
Please feel free to discuss any questions with our staff.

YOU HAVE THE RIGHT TO RECEIVE, AND WE ARE REQUIRED TO PROVIDE YOU WITH, A COPY OF THIS NOTICE OF PRIVACY PRACTICES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at anytime, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

YOU HAVE THE RIGHT TO AUTHORIZE OTHER USE AND DISCLOSURE

This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOU HAVE THE RIGHT TO REQUEST AN ALTERNATIVE MEANS OF CONFIDENTIAL COMMUNICATION

This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF YOUR PHI

This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI

This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

YOU HAVE THE RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION

This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

YOU HAVE THE RIGHT TO REQUEST A DISCLOSURE ACCOUNTABILITY

You may request a listing of disclosures we have made on your PHI entities or persons outside our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

YOU HAVE THE RIGHT TO RECEIVE A PRIVACY BREACH NOTICE

You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

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Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

TREATMENT
We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

PAYMENT
Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

HEALTHCARE OPERATIONS
We may use or disclose, as needed, your PHI in order to support the business activities of our practice.

This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

SPECIAL NOTICES
We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications.

Each fundraising notice will include instructions for opting out.

HEALTH INFORMATION ORGANIZATION
The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

TO OTHERS INVOLVED IN YOUR HEALTHCARE
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES
We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

PRIVACY COMPLAINTS
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at 317-844-5351.

We will not retaliate against you for filing a complaint.

Effective Date: January 1, 2018

Publication Date: January 1, 2018

Acknowledgment of Receipt of Notice of Privacy Practices

(Federal HIPAA Privacy Regulations)

By my signature below I am acknowledging that this office has provided me with a copy of their Notice of Privacy Practices.

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

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

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

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

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

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

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

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

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

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

Parent or Guardian Printed Name: _____

Signature: _____

Date: _____

A copy of this form must be kept in the patient's chart.

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☐ **Parent / Legal** **or** ☐ **18 Year Old / Self**

COMMUNICATION AUTHORIZATION

Because of new Federal Regulations, we must have your authorization as to where to leave messages. It is our office policy to NOT release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We may simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize the physicians of this practice and/or staff to leave medical information pertaining to the care of my child(ren) by the following methods and will assume responsibility to notify them whenever this information changes. In addition to medical information, information concerning appointment confirmation, rescheduling of appointments or nurses follow-up may be left by the following methods.

Method	Number with Area Code		
Home Telephone	_____	Yes _____	No _____
Work Telephone	_____	Yes _____	No _____
Mobile/Cell Telephone	_____	Yes _____	No _____

The following individuals have permission to receive medical information.
Please do not include yourself!

Name	Relationship

As patients of this practice do we have your permission to display pictures of them on our office walls? *Yes* _____ *No* _____

If there are any changes to the above authorizations in this time period, it is the parent's responsibility to notify the office of any changes.

_____ _____

Parent/Guardian or Self Signature *Date:*

FINANCIAL POLICIES

INSURANCE:

At each visit, parents/guardians are to provide our office with the current insurance information and present an active insurance card. This is a requirement from the insurance. It provides our office with essential information about the financial responsibility of the parents for the services to be provided. In the event that a current card is not available, we will see the child, but our office expects full payment for the services provided that day (unless prior arrangements have been made with the billing office). The insurance company may have further procedures for reimbursing the insured.

Parents/guardians are responsible for understanding their benefits and obligations for payments to our doctors. Some insurance companies have contracts with specific labs, X-ray or hospital-based specialists. If the doctor suggests further testing or referral to another doctor, the parent should inform the doctor about these specifications prior to seeking thee added service.

Parents/guardians are responsible for ALL copayments, coinsurance and deductibles as dictated by their insurance plan. Copays are due at the time of service. If you do not pay your copay, you will be charged an additional fee in addition to your copay.

Our office accepts cash, checks, Visa, MasterCard and Discover. A $25 fee will charged for returned checks. Payments are expected in full unless prior arrangements have been made with the billing office.

Patients without medical insurance or those presenting insurance we are not contracted/participating will be considered as "self-pay." Self pays are expected to pay in full at time of service (a discount will be given these patients as long as the payment is paid on the same day as the visit).

DISMISSAL OF PATIENTS:

The following reasons will be considered as reasons for a patient/family to be dismissed from Meridian Pediatrics:

1. Medical noncompliance
2. Failure to keep scheduled and/or rescheduled appointments
3. Behavior issues by patient and/or guardian(s)
4. Failure to pay for services provided

BILLING/CODING FOR CHARGES:

There are specific regulations for health care service billing. As a health care provider, we are obligated to follow these regulations by reporting the services provided. It is not uncommon for patients, in the course of a routine well visit, to receive management and treatment services for an additional, separate problem. Both services must be reported to the insurance company and may result in an additional copay or charge per the insured's plan.

FORMS:

There is a $5 fee for completing any school, camp, daycare, or sports form. The turnaround time is usually 5-7 business days. If the form is needed prior to this time frame, the fee is $20.

Payment is due prior to the form(s) being completed. Our office policy states we will complete any form as long as the child has had a wellness exam with OUR office in the past 12 months.

Forms will be held for pick-up. If you provide our office with self-addressed stamped envelopes, we will then mail the completed form to you.

The first copy of each child's immunization record is free of charge. However, if you require extra copies, you will be charged $3.

RECORDS RELEASE:

Our office policy is to have your records available for you 30 days from receipt of written notice. However, it is likely that the records may be available prior to the 30 days. Our office adheres to the Indiana code, IC16-39-9, which allows a record transfer fee. The fee is based on their recommended guidelines.

ADDITIONAL RECEIPT OR ACCOUNT HISTORY:

High deductible health plans require a receipt for services in order for the parent to be reimbursed. It is the parents' responsibility to keep copies for this purpose. A $5 fee will be assessed if any additional copies are requested from a family.

COLLECTIONS:

Referral to our professional collection service will be made on delinquent accounts when a payment and/or payment arrangements have not been made. **This could result in dismissal from the practice.**

Outstanding balances are due within 30 days unless prior arrangements have been made with the billing department. After 30 days, a notice asking for payment in full will be sent. After 60 days, a notice stating the account is in jeopardy of going to collections could be sent. After 90 days, a notice asking for payment within 10 days will be sent. If no payment has been received or payment arrangements have not been made, the account may be sent to collections. Once the account has been placed with the collection agency, additional fees may be assessed by the collection agency.

FEES AND CHARGES:

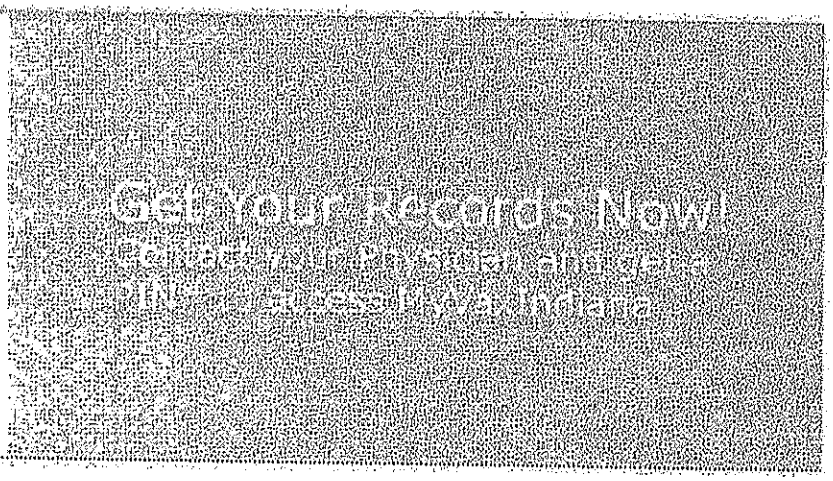
Our fees are subject to change. Fees quoted for future services may not be exact. Overpayments for services are refundable upon written request.

A 24 hour notice is required for appointment cancellation. Missed appointments may be subject to a fee being charged

MYVAXINDIANA

Keeping Hoosiers Connected & Protected

Home | How To Use | Find My Record | Contact MyVaxIndiana | Mobile Vax



How To

Thank you for your interest in using the MyVaxIndiana Immunization Portal. Below are the steps for accessing a record.

Patient ID Number

You will need a Patient ID Number (PIN) to access a record using MyVaxIndiana. A PIN can be requested from your medical provider, local health department, school, and many other CHIRP providers.

Get Your Record

Select Search from the menu bar to begin your lookup. Enter your information., PIN, & review the record release statement. Select the Get MyVaxIndiana button to lookup the record requested.

Print, Fax, Download

You can Print, Download (as a PDF, HL7 VXU, CCD for Personal Health Record), or request a copy to be faxed. Please note: The printed copy, downloadable copy,and fax are all State of Indiana Official Immunization Records..
The HL7 and PHR files are for personal use only and should not be used as an official document from the State of Indiana

Get Help

MyVaxIndiana Email: MyVaxIndiana@isdh.in.gov
CHIRP Help Desk Email: CHIRP@isdh.in.gov
CHIRP Help Desk Support: 1-888-227-4439

The information provided by MyVaxIndiana is supplied by the Children and Hoosier's Immunization Registry Program (CHIRP). For any changes to a record including address changes and missing or incorrect vaccine dates, please contact your Medical Provider, Local Health Department, or the ISDH Immunization Program.

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Dr. James G. Cumming, DO
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Dr. Stephanie A. Bergstein, MD
Dr. Jill S. Mazurek, MD
Dr. Sarah L. Hill, MD
Dr. C. Keith Chitty, MD

TELEMEDICINE ACKNOWLEDGMENT FORM

1. I UNDERSTAND THAT MY HEALTH CARE PROVIDER HAS RECOMMENDED TO ME THAT I ENGAGE IN A TELEMEDICINE APPOINTMENT.

2. MY HEALTH CARE PROVIDER HAS EXPLAINED TO ME HOW THE TELEMEDICINE TECHNOLOGY WILL BE USED TO CONNECT ME WITH MY PROVIDER.

3. I UNDERSTAND THERE ARE POTENTIAL RISKS TO THIS TECHNOLOGY, INCLUDING INTERRUPTIONS, UNAUTHORIZED ACCESS, AND TECHNICAL DIFFICULTIES. I UNDERSTAND THAT MY HEALTH CARE PROVIDER OR I CAN DISCONTINUE THE TELEMEDICINE APPOINTMENT IF IT IS FELT THAT THE VIDEOCONFERENCING CONNECTIONS ARE NOT ADEQUATE FOR THE SITUATION. I UNDERSTAND THAT I CAN DISCONTINUE THE TELEMEDICINE APPOINTMENT AT ANY TIME. I RECOGNIZE THAT THIS DOES NOT SUBSTITUTE FOR FACE-TO-FACE EVALUATION.

4. IN AN EMERGENCY SITUATION, I UNDERSTAND THAT THE RESPONSIBILITY OF MY PROVIDER MAY BE TO DIRECT ME TO EMERGENCY MEDICAL SERVICES, SUCH AS THE EMERGENCY ROOM. MY PROVIDER'S RESPONSIBILITY WILL END UPON THE TERMINATION OF THE TELEMEDICINE CONNECTION.

5. I UNDERSTAND THAT MY HEALTH CARE PROVIDER WILL SUBMIT THIS TELEMEDICINE APPOINTMENT TO MY INSURANCE COMPANY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY FEES DEEMED TO BE THE PATIENT'S RESPONSIBILITY (INCLUDING COPAYS, DEDUCTIBLES, CO-INSURANCE CHARGES, AND NON-COVERED SERVICES).

6. I UNDERSTAND THAT MY HEALTH CARE PROVIDER WILL CHARGE A $25.00 CONVENIENCE FEE FOR MY TELEMEDICINE APPOINTMENT.

PATIENT NAME(S) _____

PRIMARY CARE PHYSICIAN _____

PARENT/GUARDIAN SIGNATURE _____

DATE/TIME _____

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New Patient Agreement

By signing this form, I agree to the following policies of Meridian Pediatrics:

1. Meridian Pediatrics is an immunizing pediatric office. All families accepted into the practice of a physician at Meridian Pediatrics agree to comply with the vaccination schedule of that physician. No modifications are made to vaccination schedules except for immunization appointments rescheduled due to illness.
2. Once accepted into the practice of a physician at Meridian Pediatrics, families may not transfer to the practice of another physician at Meridian Pediatrics. Similarly, patients in the same family may not be split between different physicians at Meridian Pediatrics. Exceptions for older patients seeking well care from a physician of the same gender are made on an individual basis and must be approved by the primary physician and the requested physician.
3. Failure to arrive for an appointment, or failure to cancel an appointment within one business day, may result in a failed appointment fee equal to the cost of a full appointment. This fee may be charged for each patient and upon each occurrence of a failed appointment. These fees are not covered by insurance and are your responsibility.

Failure to comply with these policies may result in dismissal from Meridian Pediatrics.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Guardian: _____

Signature: _____

Date: _____