Parent

Meridian Pediatrics

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

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

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Patient Information Sheet

PLEASE PRINT

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

PLEASE PRINT

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

PLEASE PRINT

For 18 years of age & Older SELF (Legal Name):	Date of Birth:
Address:	
City / State / Zip:	
Home Phone #:	Mobile Phone #:
Email Address:	
Employer:	

Primary Insurance:
Secondary Insurance:

PLEASE PRINT

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

EMERGENCY CONTACT NAME:
Best Contact Phone #:

Dr. _____ Signature _____ Date: _____

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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:** _____

Parent or Guardian Printed Name: _____

Signature: _____

Date: _____

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

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Meridian Pediatrics 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: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Guardian: _____

Signature: _____

Date: _____

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Dr._____

☐ 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!

Children's Name	Contact Name	Relationship to Child

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:*

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FINANCIAL POLICIES

INSURANCE:

INITIAL 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 the added service.

Parents/guardians are responsible for ALL co payments, 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 $50 fee will charged for returned checks. Payments are expected in full unless prior arrangements have been made with the billing offlce.

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:

INITIAL 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:

INITIAL 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.

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FINANCIAL POLICIES (continued)

_____ ***FORMS:***

INITIAL 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:***

INITIAL 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:***

INITIAL 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:***

INITIAL There is a $50 Collection Fee.

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:***

INITIAL 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 charge of $50^{00}. If multiple failed confirmed appointments the entire visit charge will be assesed to your account.

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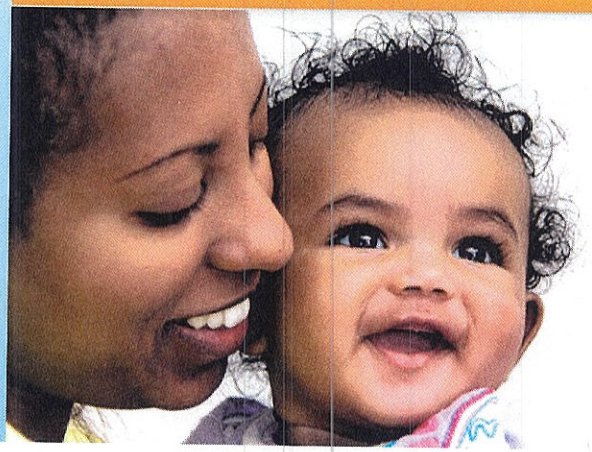
MY VAX INDIANA
Keeping Hoosiers Connected & Protected

CHIRP is Elective

If you choose to opt out please let us know.
There is an additional form you must complete.

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



Get Your Records Now!
Contact your Physician and get a PIN# to access MyVaxIndiana

How To

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

STEP 1

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.

STEP 2

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.

STEP 3

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.

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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.

Date: _____ Signature: _____