Manchester Pediatric Associates LLC
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Telephone: 860-647-8282
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Manchester Pediatrics Policies

Vaccination Policy:

Manchester Pediatric Associates is a pro-vaccination facility. To register as a new patient, please review the birth-18 vaccine schedule provided by the American Acadamy of Pediatrics (AAP). Attached is the vaccine schedule. You must agree to this vaccine schedule for your child to be a part of our practice. Please sign below.

I, _____, agree to follow the vaccination schedule that is put in place by the World Health Organization. I understand that declining vaccines for any reason other than a medical exemption will be cause for immediate discharge from the practice.

Becoming a New Patient:

Prior to booking an appointment for a new patient at Manchester Pediatrics, it is necessary to obtain all previous medical records from other healthcare facilities, covering the period from birth until the present. This requirement ensures that the child receives comprehensive and the best care at our practice.

Cancelation/No show policies for appointments:

A 24-hour notice is required for cancellations to avoid a $50 no-show fee. If the appointment was booked for the same day, notice of at least 2 hours is needed. If a patient arrives more than *10 minutes late to a scheduled appointment*, it will be considered a no-show and rescheduled. These measures are in place to maintain timeliness and organization for providers and patients.

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POLICIES CONTINUED

PHREESIA PRE-REGISTRATIONS:

TO ENSURE OPTIMUM CARE FOR CHILDREN AND GATHER UPDATED FAMILY DEMOGRAPHICS, IT IS MANDATORY TO COMPLETE THE PHREESIA QUESTIONNAIRE BEFORE EACH APPOINTMENT. WHILE PHREESIA OFFERS THE OPTION TO REQUEST RESCHEDULING THROUGH THEIR WEBSITE, IT IS ADVISED TO CALL THE OFFICE DIRECTLY TO AVOID ANY ISSUES OR DELAYS IN RESCHEDULING APPOINTMENTS.

SCHOOL FORMS AND DOCUMENTATION:

THE SCHOOL MANDATED HEALTH ASSESSMENT RECORD FOR THE MOST RECENT WELL CHILD VISIT CAN BE OBTAINED UPON REQUEST. TO RECEIVE THE FORM, THE REQUESTER NEEDS TO PROVIDE A FAX NUMBER OR PICK IT UP FROM THE OFFICE. EMAIL IS NOT AN OPTION FOR SENDING THE FORM DUE TO THE SENSITIVE NATURE OF MEDICAL INFORMATION.

MEDICAL STUDENT POLICY:

MANCHESTER PEDIATRIC ASSOCIATES SERVES AS A TEACHING FACILITY FOR MEDICAL STUDENTS, ALLOWING THEM TO TAKE PART IN EXAMINATIONS UNDER THE SUPERVISION OF DOCTORS. PARENTS AND PATIENTS HAVE THE OPTION TO DECLINE STUDENT INVOLVEMENT BY INDICATING THEIR PREFERENCE THROUGH THE PHREESIA FORM OR DIRECTLY INFORMING THE FRONT DESK IF THEY ARE UNCOMFORTABLE WITH THE STUDENT IN THE ROOM.

I, _____, _____ HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

_____ _____

SIGNATURE OF PARENT/RESPONSIBLE PARTY DATE

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NEW PATIENT INFORMATION

PATIENT INFORMATION

PATIENT'S FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ GENDER AT BIRTH: MALE OR FEMALE

PATIENT'S FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ GENDER AT BIRTH: MALE OR FEMALE

ADDRESS: _____

PARENT/ GUARDIAN INFORMATION

FIRST NAME:_____ LAST NAME:_____ RELATION:_____

CELL #_____ EMAIL:_____

FIRST NAME:_____ LAST NAME:_____ RELATION:_____

CELL #_____ EMAIL:_____

ETHNICITY: _____ PREFERRED LANGUAGE:_____

IF THERE ARE ANY OTHER FAMILY MEMBERS WE MAY SPEAK TO, PLEASE LIST THEIR NAME, NUMBER, AND RELATIONSHIP TO THE PATIENT BELOW:

THIS MAY BE DESIGNATED PERSONS TO BRING THE PATIENT IN FOR APPOINTMENTS OR REACHED IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ ○ ONLY CONTACT IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP:_____

PHONE NUMBER: _____ ○ ONLY CONTACT IN CASE OF EMERGENCY

PLEASE CHECK THE BOX BELOW IF YOU AGREE TO THE FOLLOWING COMMUNICATION FOR THE ABOVE PARTIES:

- ❑ CALL NUMBER LISTED (WITH CALLBACK NUMBER + PATIENT NAME)
- ❑ LEAVE DETAILED VOICEMAILS (INCLUDING LAB RESULTS)

_____ _____

SIGNATURE OF PARENT/RESPONSIBLE PARTY DATE

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HEALTH QUESTIONS

CHILD'S NAME: _____ DATE OF BIRTH: _____

WHERE WAS YOUR CHILD BORN? _____

WHAT WAS YOUR CHILD'S BIRTHWEIGHT? _____

WAS YOUR CHILD BORN VIA C-SECTION OR VAGINALLY? _____

ANY ISSUES DURING PREGNANCY? IF SO, PLEASE EXPLAIN. _____

_____

_____

DURING PREGNANCY: DID YOU SMOKE? YES OR NO DID YOU CONSUME DRUGS/ALCOHOL? YES OR NO

IF YOUR CHILD HAS A DENTIST, WHICH OFFICE ARE THEY SEEN AT? _____

IF YOUR CHILD HAS BEEN HOSPITALIZED, WHAT FOR? _____

HAS YOUR CHILD HAD ANY MAJOR INJURIES OR SURGERIES? IF SO, WHAT WERE THEY? _____

_____

DOES YOUR CHILD HAVE ANY ALLERGIES TO ANY MEDICATIONS? IF SO, LIST BELOW.

_____ _____ _____

ANY ALLERGIES TO FOOD?

_____ _____ _____

_____ _____ _____

PLEASE LIST ANY CURRENT MEDICATIONS – NAME AND DOSAGE

_____

_____

PREFERRED PHARMACY : _____

(PLEASE LIST EXACT STREET ADDRESS OF BRANCH LOCATION)

PLEASE LIST ALL FAMILY MEMBERS LIVING IN THE CHILD'S HOME

NAME	RELATIONSHIP TO CHILD	AGE	HEALTH PROBLEMS

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**If the mother and father are separated, or if the child does not live with the parents, what is the custody status? Court documents may be required.

_____

_____

Are you or your children exposed to domestic violence or abuse?

- ❑ Yes
- ❑ No

Please check off if there is any family history of the following:

- ❑ Diabetes
- ❑ Allergies
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ Cancer
- ❑ Hepatitis

Please check off any other that apply to your child.

- ❑ Colic
- ❑ Dietary issues
- ❑ Weight/height issues
- ❑ Trouble walking
- ❑ Behavioral Issues
- ❑ Issues with school
- ❑ Speech therapy
- ❑ Concussion/unconsciousness
- ❑ Anemia
- ❑ Diabetes
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Chickenpox
- ❑ History of seizures/epilepsy
- ❑ Nail biting
- ❑ Wears glasses or contacts
- ❑ Wears dental bridges/plates/braces
- ❑ Asthma
- ❑ Birth control
- ❑ Miscarriage/Abortion

If your child has a menstrual cycle, at what age did they have their first period? _____

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NEW PATIENT HEALTH HISTORY

GENERAL	HEART/CIRCULATION	MUSCULOSKELETAL	NERVOUS SYSTEM
❑ FEVER ❑ CHILLS ❑ FEELING POORLY ❑ FEELING TIRED ❑ WEIGHT GAIN ❑ WEIGHT LOSS	❑ CHEST PAIN ❑ HEART POUNDING ❑ FAST PULSE ❑ SLOW PULSE ❑ LEG SWELLING	❑ JOINT PAIN ❑ NECK PAIN ❑ JOINT SWELLING ❑ JOINT STIFFNESS ❑ MUSCLE ACHES ❑ BACK PAIN	❑ NUMBNESS ❑ WEAKNESS ❑ DIZZINESS ❑ FAINTING ❑ CONFUSION ❑ HEADACHE
EYES	**EAR/NOSE/THROAT**	**SKIN**	**BLOOD**
❑ EYE PAIN ❑ RED EYES ❑ EYESIGHT PROBLEMS ❑ EYE DISCHARGE ❑ DRY EYES ❑ ITCHY EYES	❑ EARACHE ❑ LOSS OF HEARING ❑ NOSEBLEEDS ❑ RUNNY NOSE ❑ SORE THROAT ❑ HOARSENESS	❑ SORES ❑ RASH ❑ ITCHING ❑ CHANGE IN MOLE ❑ UNUSUAL GROWTH/SPOT	❑ BLEED EASILY ❑ BRUISE EASILY ❑ SWOLLEN GLANDS IN NECK
BREATHING	**GASTROINTESTINAL**	**PSYCHIATRIC**	**ENDOCRINE**
❑ COUGHING ❑ WHEEZING ❑ SHORTNESS OF BREATH ❑ TROUBLE BREATHING DURING EXERCISE ❑ TROUBLE BREATHING WHILE LYING DOWN ❑ SNORING	❑ STOMACH PAIN ❑ VOMITING ❑ DIARRHEA ❑ CONSTIPATION ❑ HEARTBURN ❑ BLOOD IN STOOL ❑ TROUBLE POTTY TRAINING	❑ THOUGHTS OF HARMING SELF OR OTHERS ❑ SLEEP PROBLEM ❑ NIGHTMARES ❑ ANXIETY ❑ DEPRESSION ❑ PERSONALITY CHANGE ❑ EMOTIONAL PROBLEMS	❑ HOT FLASHES ❑ MUSCLE WEAKNESS ❑ VOICE CHANGE ❑ GENERAL WEAKNESS
URINATION/MENSTRUAL	**ANY OTHER ISSUES:**		
❑ PAIN WHEN URINATING ❑ ABNORMAL URINATION ❑ URINATE OFTEN AT NIGHT ❑ GENITAL SORES ❑ DIFFICULT/PAINFUL PERIODS	_____ _____ _____ _____ _____		

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Billing Policies

At time of appointment:

To properly bill insurance for each visit, we ask that you present the following documents to the receptionist upon arrival to all appointments:

- Insurance card
- Photo ID for address verification
- Any changes in demographics (i.e. phone number, address)

If you do not have the child's insurance card at the time of the appointment, you will be considered a **self-paying patient** and must pay for the appointment.

These charges would be as following:

- Annual physical would be $150 plus an additional $20 per vaccine.
- Acute (sick) visits would be $110.

Copayment/Deductibles:

All copays and deductibles are due at the time of service. If you have any questions regarding the payment allowance by your insurance company, please contact the insurance company directly before the visit.

Patient Balance:

Manchester Pediatrics will submit claims to your insurance company based on the services you received. You must present primary and secondary insurance cards, as well as any changes to contact information at the time of your visit to ensure proper billing. If we are unable to successfully send a claim, you **will** be charged for the open balance on the patient's account. For any vaccinations provided outside of a well child visit, you may be charged a copay per your insurance policy. **All copays are due at check-in.**

If you have an open balance, payment will be required by the next appointment's check in. To schedule a yearly physical, any unpaid balance must be paid before the appointment is booked. If you have an open balance of $200 or more or have received three statements without payment, **we reserve the right to discharge you from the practice**. If you cannot make payment at the time of your appointment, we require payment within 14 calendar days from your appointment.

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HIGH DEDUCTIBLE INSURANCE PLANS:

IF YOU HAVE A HIGH DEDUCTIBLE INSURANCE PLAN, YOU WILL BE REQUIRED TO MAKE A MINIMUM OF 30% OF YOUR EXISTING PATIENT BALANCE OR, IF NO EXISTING BALANCE, $100 PER CHILD AT THE TIME OF VISIT. ANY REMAINING BALANCE AFTER THE INSURANCE CLAIM HAS BEEN COMPLETED WILL BE BILLED AS STATED IN THE PATIENT BALANCE SECTION.

BILLING STATEMENTS:

THE PATIENT BALANCE IS DUE UPON RECEIPT OF YOUR BILLING STATEMENT. IF NO PAYMENT HAS BEEN RECEIVED WITHIN 30 DAYS, YOU WILL BE SUBJECT TO A LATE FEE OF $20.00, AND AFTER THE SECOND NOTICE, THERE IS A $25.00 FEE THAT WILL BE ADDED TO THE BALANCE OF EACH MONTH UNTIL RESOLVED. IF WE CANNOT REACH YOU REGARDING THE UNPAID BALANCE, THE ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY. ALL ACCOUNTS SENT TO COLLECTIONS WILL INCUR A ONE-TIME FEE OF $50.00, WHICH WILL BE ADDED TO THE ACCOUNT'S BALANCE. RETURNED CHECKS WILL RESULT IN A $25.00 FEE THAT WILL ALSO BE POSTED TO THE ACCOUNT.

NOTICE OF CLAIMS BILLING

IF THE PATIENT IS HERE FOR A WELL CHILD VISIT, AND DURING THIS VISIT, AN ACUTE (SICK) HEALTH CONCERN COMES UP AND IS ADDRESSED, THIS MAY BE BILLED AS A SEPARATE CLAIMS SUBMISSION AS IT IS NOT A PART OF THE WELL CHILD VISIT. ONCE THE ENCOUNTER HAS BEEN COMPLETED, WE WILL BILL AND SUBMIT A CLAIM FOR ALL SERVICES RENDERED TO YOUR INSURER FOR PROCESSING ACCORDING TO YOUR BENEFITS. ANY RESULTING PATIENT BALANCE WILL BE YOUR RESPONSIBILITY TO PAY.

I,_____ , HAVE READ, ACKNOWLEDGE, AND AGREE TO ALLOW MANCHESTER PEDIATRIC ASSOCIATES TO SUBMIT MY CLAIM TO MY INSURER FOR ALL SERVICES RENDERED. I AM AWARE THAT ANY RESULTING PATIENT BALANCE WILL BE MY RESPONSIBILITY.

_____ _____

SIGNATURE OF PARENT/RESPONSIBLE PARTY DATE

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INSURANCE INFORMATION

PRIMARY INSURANCE: _____

MEMBER ID/POLICY #_____ GROUP #_____

POLICY HOLDER NAME: _____

HOLDER'S DOB (MM/DD/YYYY): _____

SECONDARY INSURANCE: _____

MEMBER ID/POLICY #_____ GROUP #_____

POLICY HOLDER NAME: _____

HOLDER'S DOB (MM/DD/YYYY): _____

I REQUEST THAT THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, AND OTHER HEALTH INSURANCE TO MANCHESTER PEDIATRIC ASSOCIATES. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY I, THE RESPONSIBLE PARTY, IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE INCLUDING ALL REASONABLE COSTS AND EXPENSES, INCLUDING ATTORNEY'S FEES INCURRED IN PURSUING COLLECTIONS OF SUCH CHARGES. I AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION RELATED TO AN ILLNESS, INJURY, CARE, OR TREATMENT TO MY INSURANCE COMPANY. I HEREBY AUTHORIZE AS ASSIGNEE TO ALL NECESSARY INFORMATION TO SECURE PAYMENT.

_____

SIGNATURE OF PARENT/RESPONSIBLE PARTY DATE