BRIGHT OAKS
Pediatric Center

2111 Laurel Bush Rd. Ste H
Bel Air, MD 21015
(p) 410-569-3300 (f) 410-569-8199
www.BrightOaksPediatrics.com

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

Please read the form carefully and fill out completely.

1. I authorize	**2. To release information to**
Name of Sending Person/Organization:	Name of Receiving Person/Organization: **Bright Oaks Pediatric Center**
Full Address: Phone: Fax:	Full Address: **2111 Laurel Bush Rd. Ste. H. Bel Air, MD 21015** Phone: **410-569-3300** Fax: **410-569-8199**

3. Information to be released: (Check All Applicable)

☐ Immunization Record ☐ Most Recent Well Visit Note ☐ Growth Charts ☐ Lead Test Results

☐ Lab Reports ☐ All Progress Notes ☐ Records relative to: _____ ☐ Others: _____

4. Records from the time frame of _____ to _____.

5. Purpose or need for disclosure:

☐ Continued Medical Care ☐ Payment of Insurance/Workers Comp Claims ☐ Legal ☐ Personal

☐ Other (If you are transferring out of our practice, please let us know why):_____

Please initial the following:

_____6. I understand that this authorization shall be valid from _____ to _____, and I that I may revoke this consent in writing at any time except to the extent that the action has already been taken.

_____7. The requester may be provided with a copy of this authorization.

_____8. I understand that if my protected health information is disclosed to someone who is not required to comply with federal health insurance probability act and accountability act of 1996(HIPAA) regulations, then such information may be re-disclosed and would no longer be protected.

_____9. If this release pertains to alcohol, drug information, mental health problems, or psychotherapy, please note that this information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.

_____10. I understand that I have the right to inspect my child's protected health information and make authorization changes and copies, if needed.

_____11. I understand that a reasonable fee may be charged for duplication of records. The fee will include $0.76 per page for photocopying plus the actual cost of the postage and handling PLUS $22.88 for retrieval of records, if applicable.

_____ _____ _____
Patient name Date of Birth Date of Request

_____ _____
Current Address Daytime Phone Number

_____ _____ _____
Signature Printed Name of Authorized Parent/Guardian Relationship to Patient

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Consent for Treatment of a Minor

I, _____, being the parent or legal guardian of _____
Parent/Guardian Name Child's Name/DOB

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, including laboratory tests, which in the judgment of Bright Oaks Pediatric Center, LLC's licensed physicians, nurse practitioners and designees are considered necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor(s) named in this Consent may receive all medical care provided according to generally and currently accepted standards of pediatric care.

Please list Parent(s)/Legal Guardian(s)

Name: _____ Relationship to minor: _____ Phone: _____

Name: _____ Relationship to minor: _____ Phone: _____

In the absence of a parent/legal guardian listed above, the following people are authorized to bring the minor(s) for medical treatment and have access to his/her medical information (You may name relatives, friends, grandparents, stepparents, non-custodial parents, daycare providers, foster parents or others.)

Name: _____ Relationship to minor(s): _____
Name: _____ Relationship to minor(s): _____
Name: _____ Relationship to minor(s): _____
Name: _____ Relationship to minor(s): _____

If no other person is authorized, please write NONE: _____

Please initial the following:

_____ If a minor is brought by any other person not recorded above, Bright Oaks Pediatric Center, LLC will make reasonable attempts to contact Parent/Guardian for verbal consent to treat.

_____ I understand that consent from the parent(s)/legal guardian(s) or authorized person(s) name above is required for all **non-emergent situations**.

_____ If the parent(s)/legal guardian(s) or authorized person (s) named above cannot be reached in an **emergent situation**, I consent to Bright Oaks Pediatric Center, LLC to render medical care as **deemed necessary**.

_____ I have the right to revoke or change this consent to treat in writing.

_____ If the custody or guardianship of this minor has changed, I will furnish Bright Oaks Pediatric Center, LLC with the **legal forms** that are required to be included in the minor's medical record to explain the change.

_____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian

_____ _____
Date Email Address

Parent/Guardian Contact Information

Child(ren) Name(s):_____

Name: _____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad, Legal Guardian, Other(specify): _____

Primary Phone number:_____ Alternate Phone number:_____

DOB:_____ Email:_____

Address:_____

Billing address (if different):_____

Name: _____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad, Legal Guardian, Other(specify): _____

Primary Phone number:_____ Alternate Phone number:_____

DOB:_____ Email:_____

Address:_____

Billing address (if different):_____

Name:_____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad, Legal Guardian, Other(specify): _____

Primary Phone number:_____ Alternate Phone number:_____

DOB:_____ Email:_____

Address:_____

Billing address (if different):_____

Emergency Contact

Name:_____

Relationship to Child:_____ Phone Number:_____

Privacy

Initial all that apply:

_____ OK to leave voice messages; appointment reminders, non-urgent messages/lab results

_____ OK to send email reminders

_____ OK to send text reminders

_____ Person to person contact only

_____ Other Restriction:_____

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Financial Policy Statement

Thank you for choosing Bright Oaks Pediatrics Center, LLC. as your child's healthcare provider. The following is our Financial Policy. Please read and sign each statement, prior to us treating your child.

Please initial each statement indicating your agreement.

_____ 1. It is the policy of Bright Oaks Pediatrics Center, LLC. to help keep your healthcare costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways: Always bring your child's current health insurance card to the office. Please notify us at the time of Check-In of any changes in insurance, address, telephone or family status. Failure to notify us of any changes may result in incorrect billing for which you may be responsible.

_____ 2. Co-pays, deductible balances and co-insurance balances are part of your contract with your insurance, and are due at the time of service. Failure to comply could jeopardize your insurance coverage. You will be expected to pay in full if you do not have insurance, or Bright Oaks Pediatrics Center, LLC. does not participate with your health plan, or you are unable to present a valid member identification card from your insurance carrier at your visit, or we are unable to verify your insurance coverage. If you do not have medical insurance, or elect to self-pay your account, payment is due at the time of service, at a discounted rate.

_____ 3. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for such charges. It is your responsibility to ensure our providers actively participate with your insurance plan; know your benefit coverage, as well as your dependents, prior to receiving services. Make sure that all individuals on your policy have the correct primary care physician selected. Ensure that all pre-approval requirements, if any, are met to avoid denials or out-of-network benefits.

_____ 4. You may receive a separate bill for medical care for lab, x-ray or other diagnostic services from another facility. You are financially responsible to pay that facility for any co-pay or balance due for those services. Such bills are not generated from Bright Oaks Pediatric Center, LLC. so you will need to call the facility where services were provided.

_____ 5. A $35 fee will be charged for all returned checks. Immediate remittance in the form of cash, money order, credit card or certified funds is required for a returned check in the original amount plus the $35 fee. After two returned checks, families will be required to pay in the form of cash, money order, credit card or certified funds for subsequent visits.

_____ 6. Full payment of your account balance is expected within 30 days from the billing date. Delinquent accounts (unpaid balances past 90 days from the due date), will be sent to our collection agency. Collection costs and attorney's fees will be added to the balance due, for each child with a past due balance. Thirty days after an account has been turned over to our collection agency the family will be discharged from our practice.

_____ 7. Do not ignore billing statements. If you receive a statement which you believe is incorrect, please contact us immediately. If we do not hear from you, we will assume that you have accepted responsibility for the statement.

_____ 8. Any family that files for bankruptcy, and includes any balances due to Bright Oaks Pediatrics Center, LLC., will be dismissed from our practice 30 days after we receive such notification.

_____ 9. Bright Oaks Pediatrics Center, LLC. does not get involved in financial, legal, separation or divorce disputes. Therefore, if the guarantor is delinquent in paying the account, the balance will be transferred to the person who registered the child at the time of the visit. If a divorce decree or such requires the other parent to pay all or part of the treatment costs, it is the registering party's responsibility to pay the balance and collect from the other parent.

_____ 10. Bright Oaks Pediatrics Center, LLC. does not get involved with any visits related to on-the-job or motor vehicle injuries. The patient will need to pay in full at the time of the visit.

_____ 11. There is a $10 fee for filling out various forms, including, but not limited to: school, camp, sports and daycare forms. The fee must be paid before or at the time of pick-up.

_____ 12. We require 24 hours notice to cancel appointments you are unable to keep. This allows us the ability to schedule another patient in that time slot. Failure to cancel an appointment properly may result in a $50 missed appointment fee. If you are more than 15 minutes late for an appointment, your appointment may be rescheduled.

_____ 13. Medical records are our documentation that services were rendered to your child. Copying records requires staff time, equipment usage, supplies and postage. Maryland State statute permits providers to charge for retrieval and preparation, a per page copying charge, and the actual cost for postage and handling. You will be notified of the fee prior to release of records and payment is required prior to the release of the records. Only the records generated by our practice will be released.

I have read this financial policy, and I understand and agree to the terms stated above for today and any future visits, and the agreement will be in full force and effect.

_____ Parent/Guardian Printed Name

_____ Parent/Guardian Signature

_____ Date

Child Name & DOB _____

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Vaccination Policy

At Bright Oaks Pediatric Center, we strive to provide the best care that is based on the most up-to-date and accurate literature for our patients and families. In order to do this, we ask that all of our patients receive the recommended immunizations based on the guidelines by the Centers for Disease Control and Prevention and The American Academy of Pediatrics.

While we respect one's choice to not vaccinate, we feel we would be doing a disservice to our patients and community, and feel uncomfortable as a practice caring for children who do not receive these recommended immunizations.

Vaccines are a simple and easy way to prevent deadly illnesses and diseases. We ask that should you have questions or concerns regarding immunizations, ask your child's healthcare provider. Unfortunately, there is a lot of misinformation on the internet, as anyone can publish or post an article. When researching, ensure you are looking at reputable and quality resources, such as information from the Centers for Disease Control and Prevention or the American Academy of Pediatrics.

We look forward to caring for your child(ren) at Bright Oaks!

Please read the following statement and sign & date below to acknowledge your understanding:

I acknowledge that I will be given a copy to read or have explained to me the Vaccine Information Statement(s) about the vaccine(s) my child/I will receive, and the disease(s) they prevent.
I further acknowledge that upon receipt of the Vaccine Information Statement(s) I will have a chance to ask any questions and have them answered to my satisfaction, so that I may understand the risks of the vaccine(s) to be administered to my child/myself, for whom I am authorized to make this decision.

Child/Patient Name: _____

Parent/Patient Signature: _____

Date: _____

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(410) 569-8199 (fax)

Patient's Name: _____

Date of Birth: _____

Information Release

Please read and initial the following:

_____ I authorize the release of any medical information necessary to process claims for benefits. Bright Oaks Pediatric Center, LLC and its employees are hereby released from all liability of any nature that may arise from the release of such information.

Assignment of Benefits

Please read and initial the following:

_____ I authorize the payment of any and all insurance, PIP, third party settlement and/or government benefits directly to Bright Oaks Pediatric Center, LLC for services rendered. I understand and agree that I am financially responsible for any charges not paid by the insurance company.

Medical Assistance Waiver

Please read and initial the following:

_____ I am aware that Bright Oaks Pediatric Center, LLC does not participate with Maryland State Medicaid programs. This includes Medicaid held as a secondary insurance Bright Oaks Pediatric Center, LLC will not bill Medicaid under any circumstances, and the Parent/Guardian will be responsible for any balance due after the primary insurance has paid their portion.

Parent/Legal Guardian:

_____ _____
Signature Print Name

_____ _____
Relationship to Patient Date

Patient Name & DOB: _____

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

PLEASE REVIEW THE PROBLEM LIST AND ANSWER ACCORDINGLY FOR THE CHILD/PATIENT

PROBLEM	CIRCLE ONE	COMMENTS
Significant Birth History/Complications	YES or NO	
Serious Injuries or Accidents	YES or NO	
Surgeries	YES or NO	
Hospitalizations	YES or NO	
History of Chickenpox	YES or NO	
Frequent Ear Infections/Sinus Infections	YES or NO	
Pharyngitis/Tonsillitis	YES or NO	
Other Infectious Illnesses	YES or NO	
Food Allergies	YES or NO	
Rashes/Skin Problems	YES or NO	
Outdoor/Indoor Allergies	YES or NO	
Asthma/Wheezing	YES or NO	
Bronchiolitis, Pneumonia or Croup	YES or NO	
Sleep Apnea	YES or NO	
Heart Problems or Heart Murmur	YES or NO	
Hypertension	YES or NO	
Abdominal Pain or Reflux	YES or NO	
Chronic Diarrhea	YES or NO	
Constipation	YES or NO	
Bladder or Kidney Infections/ Urologic Problems	YES or NO	
Bedwetting (After Age 5)	YES or NO	

Patient Name & DOB: _____

PROBLEM	CIRCLE ONE	COMMENTS
Eye Conditions/Corrective Lenses	YES or NO	
Problems with Ears or Hearing	YES or NO	
Chronic or Recurrent Skin Problems (Acne, Eczema, etc.)	YES or NO	
Anemia or bleeding problems	YES or NO	
History of Blood Transfusion	YES or NO	
Frequent Headaches	YES or NO	
Fainting	YES or NO	
Seizures	YES or NO	
Neurologic Disorders	YES or NO	
Mental Health Concerns	YES or NO	
ADD/ADHD	YES or NO	
Developmental Delays	YES or NO	
Muscle, Joint or Bone Problems	YES or NO	
Broken Bones	YES or NO	
Diabetes	YES or NO	
Thyroid or other Endocrine Problems	YES or NO	
Use of Alcohol or Drugs	YES or NO	
School/Learning/Behavioral Problems	YES or NO	
Emotional Problems	YES or NO	
If Female, Have menstrual periods started? If so, at what age?	YES or NO	
If Female, Are there any issues with periods?	YES or NO	
Any Other Significant Health Problems?	YES or NO	

PATIENT NAME: _____

NEW PATIENT FAMILY HISTORY QUESTIONNAIRE

PLEASE REVIEW THE PROBLEM LIST AND CHECK ANY FAMILY MEMBER THAT HAS THAT PROBLEM

PROBLEM	Natural Mother	Natural Father	Sibling (Specify)	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
Allergies Specify Type											
Anemia											
Asthma											
Attention Disorder Specify Type											
Birth Defects Specify Type											
Bleeding/ Clotting Disorder Specify Type											
Cancer Specify Type											
Crohn's/Colitis/ Intestinal Problems Specify Type											
Diabetes Specify Type											
Emotional Disorder Specify Type											
GERD											
Heart Attack Under Age 50											

PATIENT NAME: _____

PROBLEM	Natural Mother	Natural Father	Sibling	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
High Blood Pressure											
High Cholesterol											
Kidney Disease											
Learning Disability Specify Type											
Developmental Disability Specify Type											
Migraines											
Peptic Ulcer											
Seizure											
Sudden Cardiac Death											
Sudden Infant Death Syndrome											
Tuberculosis											
Urinary Reflux											
Any Other Significant Family History Please be as specific as possible.											