HERE WE GROW
PEDIATRICS

Patient Information

If all of your children have the same insurance, home address, and primary contacts you may use one form per family, if any of this information differs between patients, please request a new form per patient from our front office staff.

Child #1
Patients Name: DOB: Male/Female (please circle one)
Race:
Family's Preferred Language: Primary Care Physician:

Child #2
Patients Name: DOB: Male/Female (please circle one)
Race: Primary Care Physician:

Child #3
Patients Name: DOB: Male/Female (please circle one)
Race: Primary Care Physician:

Child #4
Patients Name: DOB: Male/Female (please circle one)
Race: Primary Care Physician:

Child #5
Patients Name: DOB: Male/Female (please circle one)
Race: Primary Care Physician:

If you have more than 5 children as patients at our practice, please request an additional patient information form from our front desk.

Home Address
Street name: City:
State: Zipcode:

Your families preferred pharmacy: (if pharmacy info differs between children, please notify our front desk staff)
Pharmacy Name:
Pharmacy Address:

Primary Contact #1

First and Last Name: Primary Phone Number:
Relationship to Patient(s): Primary Email Address:
Would you like us to register this information and create an account for you in our patient portal?
Please choose whichever applies Yes _____ No _____
Already Registered _____

Primary Contact #2

First and Last Name: Primary Phone Number:
Relationship to Patient(s): Primary Email Address:
Would you like us to register this information and create an account for you in our patient portal?
Please choose whichever applies Yes _____ No _____
Already Registered _____

Other notes or information your physician/physician's office should be aware of for your family (example: Any non traditional household dynamics or guardianship) Information such as this will help our office treat you and your family with the care and sensitivity you deserve. (for any instances regarding legal name changes, or changes in custody please provide our office with the proper legal documentation):

How did you hear about Here We Grow? (referred by friend/family, google, hwgpediatrics.com, OBGYN, social media, previous patient of one of our physicians etc..):

For Newborns:

What hospital was your newborn delivered at? _____

Did your newborn have to stay in the hospital's NICU? If so, for what reasons, and how long after birth?: _____

Who was your OBGYN during pregnancy? _____

Family History: Do biological mom or dad have any diagnosed health problems, or disorders?

Patient History: if you have more than one child, please fill out patient history per child.

Patient Name:
Birth Gestation (weeks pregnant): Birth Weight: Complications during pregnancy or birth:
Has the patient ever had any previous surgeries or hospitalizations?

Any problems with developmental, motor skills, or speech and language?

Current Medical Problems? Please list:

Is your child being treated by any specialists? If so, please provide the specialists name, practice name, and for what reasons your child is seeing them.

Concerns with patient:

Drug Allergies: Food Allergies:

Current Medications:

Patient History: if you have more than one child, please fill out patient history per child if necessary.

Patient Name:
Birth Gestation (weeks pregnant): Birth Weight: Complications during pregnancy or birth:
Has the patient ever had any previous surgeries or hospitalizations?

Any problems with developmental, motor skills, or speech and language?

Current Medical Problems? Please list:

Is your child being treated by any specialists? If so, please provide the specialists name, practice name, and for what reasons your child is seeing them.

Concerns with patient:

Drug Allergies: Food Allergies:

Current Medications:

If you have more than 2 children you are needing to provide patient history for, please request an additional patient history form from our front desk.

INSURANCE INFORMATION:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

All Information is Required in order to Properly Bill Your Insurance

Please Provide Insurance Card

Primary Insurance (Co-pays/or coinsurance is due at time of service)

Subscriber Name: _____

Date of Birth: _____/_____/_____

Social Security #:_____

Company:_____

ID #:_____

Group #: _____

Effective Date: _____ /_____ / _____

Insurance Phone: (__ __ __) __ __ __ - __ __ __ __

Secondary Insurance (We do not file secondary for primary co-pays. Primary co-pay must be paid at time of service.)

Subscriber Name: _____

Date of Birth: _____/_____/_____

Social Security #:_____

Company:_____

ID #:_____

Group #: _____

Effective Date: _____ /_____ / _____

Insurance Phone: (__ __ __) __ __ __ - __ __ __ __

Insurance Authorization and Assignment (Please Read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. I understand that I am responsible for my entire bill unless this form is complete.

Date Signed: _____

Signature of Responsible Party: _____

Alternate Caregiver Consent Form

Except for life threatening emergencies, we are not able to treat your minor child unless they are accompanied to our office by a parent, legal guardian or designated adult. In order to designate an adult to bring your child into our office for medical care in your absence please complete the following form and we will keep it on file for care of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form or a signed note from a parent may need to be rescheduled.

I _____, parent/legal guardian of _____

print name print child's name and dob 00/00/000

authorize the following individual(s) to bring in my children to their appointments:

Alt #1 Name: _____ Relationship to patient: _____
Phone Number: _____ Email Address: _____ Would you like us to create a patient portal account so this person may access your child's medical records? Yes _____ or No _____

Alt #2 Name: _____ Relationship to patient: _____
Phone Number: _____ Email Address: _____ Would you like us to create a patient portal account so this person may access your child's medical records? Yes _____ or No _____

Alt #3 Name: _____ Relationship to patient: _____
Phone Number: _____ Email Address: _____ Would you like us to create a patient portal account so this person may access your child's medical records? Yes _____ or No _____

- I authorize the above named individual(s) to consent to treatment for all my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures and hospitalization. This practice may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.
- I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary.
- I agree to hold Here We Grow Pediatrics and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment decisions.
- I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.
- I am aware that this release will be valid for 3 years from the signed date unless I complete a new copy to update, change, or remove an authorized party.

_____ _____

Signature of Parent/Legal Guardian Date Signed

Acknowledgement and Agreements to Here We Grow Pediatrics Office Policies

All office policies are accessible on our website for review. If you have not reviewed our office's policies prior to checking in for your first visit, please request a Policy Binder from our front desk staff for your review. When done, please return the binder to the front desk along with your signed and completed agreement form.

Acknowledgement of Receipt and Review of Financial Policy

I have reviewed, understand and agree to Here We Grow Pediatrics Financial Policy

_____ _____

Signature of Parent/Legal Guardian Date Signed

Acknowledgement of Receipt and Review of Privacy Practices

I understand that as part of mine or my children's healthcare, Here We Grow Pediatrics originates and maintains records regarding health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I hereby acknowledge that I have reviewed a copy of Here We Grow Pediatrics Privacy Policy that provides a complete description of protected health information and its uses and disclosures. I understand that Here We Grow reserves the right to change its practices and to make new provisions effective for all protected health information maintained by the office.

_____ _____

Signature of Patient/Legal Guardian Date Signed

Acknowledgement of Receipt and Review of Immunization Policy

I have reviewed, understand and agree to Here We Grow Pediatrics Immunization Policy

_____ _____

Signature of Parent/Legal Guardian Date Signed

Acknowledgement of Receipt and Review of Email/SMS Correspondence Policy

Please sign and date below to acknowledge you have reviewed, and been informed of our office's correspondence policy.

I acknowledge and accept if I reach out by text or email to Here We Grow Pediatrics, it is an exception to my choice here and the office will not always respond through the same form of communication. I acknowledge I have the choice to use portal messaging for secure HIPAA compliant correspondence with the office.

_____ _____

Signature of Parent/Legal Guardian Date Signed

The final pages are condensed versions of our office policies in which you are signing off on above. Please read and understand these policies thoroughly to avoid confusion on any of the stated matters in the future. Once you have completed your patient demographics packet, feel free to tear off and keep this page and those following this one to reference as needed.

To review our policies in full feel free to request a policy binder to review from our front desk or look online at hwgpediatrics.com where they are always available!

Here We Grow Pediatrics Privacy Policy

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent:
We may use and disclose your Protected Health Information as follows without your permission:

For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays.

To obtain payment. We may disclose your health information in order to collect payment for your health care. For instance, we may release information to your insurance company.

For health care operations. We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.

When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For activities related to death. We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

Uses and Disclosures of Your Protected Health Information That Require Your Consent
The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

To your family, friends or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition.

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took the notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice. Your Rights Regarding Your Protected Health Information You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. HWG will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you., We will review any suspected breach to determine the appropriate response under the circumstances.

How to Complain about Our Privacy Practices if you think we may have violated your privacy rights, or if you disagree with a decision we made about your Protected Health Information

You may file a complaint with our Privacy Officer by writing to your physician either by mail, or in person. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington, D.C. 20201 or by calling 1-877-696-6775. We will take no action against you if you make a complaint to either or both of these persons. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Your health information will not be written or disclosed except as described in this notice.

Immunization Policy

At Here We Grow Pediatrics we are committed to providing the highest quality of evidence- based medical care to our patients. This includes adherence to the vaccine schedule recommended by the American Academy of Pediatrics (AAP). **Please be aware that our physicians recommend all children to be fully immunized according to the AAP vaccination schedule unless there are medical contraindications.** If you don't vaccinate, we worry that this decision puts your child(ren) at risk for vaccine-preventable diseases and increases the health risks for others. This decision was made with much thought and careful consideration, and is based on our knowledge and all of the available scientific evidence of the safety of vaccines and the danger to our patients and our community caused by outbreaks of these diseases. We do accept new patients with variations to the vaccine schedules on a case by case basis after review by one of our Healthcare Providers. Our goal is to protect our patients to the best of our ability. We will not recommend a vaccination if there is a medical contraindication. We recognize that parents have many decisions to make regarding their child's medical care, and we will do everything we can to protect your child's health as they grow and develop.

Telemedicine Visits

To offer our families our very best Here We Grow Pediatrics has the option for telemedicine visits available to evaluate your child(ren) and provide care through video calls. This availability will limit office visits, urgent care visits and make seeing your child's Primary Care Physician as convenient as possible. Please keep in mind not all visits are eligible to be done as telemedicines and the decision will be up to the review and approval of your child's PCP.

- By using telemedicine, you understand that the decisions which are made reflect the fact that a physical exam cannot be performed. Some problems will still require an office visit to provide the best care possible for your child(ren).
- These video visits are billed to insurance exactly like if you were in the office, so you will have a copay and/or deductible if that is typical for your in-person visits. If you are self pay, you may request an estimate but it will be the same as if you were in the office and billed at the level of care provided. 30 minutes prior to your appointment time a staff member will call to collect any copays or balances if needed.
- 10 minutes before your appointment time you will join the virtual waiting room in preparation of your visit. You can use a computer, phone, or tablet as long as it has a working camera and microphone. Open any browser and go to the address for your provider listed below to check-in. When checking in please be sure to use the name of the patient the appointment is for. Bear in mind that just as in person your physician may be behind or ahead. If for some reason your physician is more than 10 minutes behind, someone from our office will call to update you.
- Here We Grow Pediatrics uses a specific technology which is heavily encrypted and verified to be HIPAA compliant. There are no recordings of the visit made.
- Visits require the presence of your child, unless otherwise specified by your child's physician prior to appointment time. If you have the ability to check your child's weight and temperature, please do so prior to the visit. This is usually very helpful for us to document and may be needed to prescribe medications.

Email/SMS Correspondence Policy

Patients may want to use email or other electronic formats to facilitate communication. Federal regulations impose a "duty to warn" patients of risks associated with unencrypted email. Here We Grow Pediatrics must document in the medical record that patients have been advised that email and text communications could potentially be read by a third party. Upon receipt and documentation of this notification, the patient has the right to request communication via email.

Risk of using email/text include, but are not limited, to:

- Email may be forwarded, printed, and stored in numerous paper and electronic forms.
- Email may be sent to the wrong address by either party.
- Email may be easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails.
- Email may be intercepted, altered, or used without detection or authorization.
- Email delivery is not guaranteed.

Patients are responsible for:

- Agreeing not to use email for medical emergencies or sending time-sensitive information.
- Following up with our office if they have not received a response to an email within a reasonable time period.
- Informing our office of any changes to an email address.
- Informing our office in writing if they decide to discontinue using email or text communications.

Secure electronic communications:

- Where feasible, patients should be directed to use their patient portal for messaging with their providers.

Here We Grow Pediatrics is able to receive text messages and in some instances emails but will not correspond or exchange patient information by text or email. Our office prefers for any exchanges of patient information or records to be done by fax or through your patient portal. For any questions, scheduling, or updates we urge you to take advantage of your patient portal and all it offers to bring simple and quality medical care to your fingertips!

Financial Policy

- Insurance:
    - Insurance is your responsibility. You must present a valid insurance card for your initial visit, and anytime you have a change or update in insurance. Our office is not responsible for maintaining ID numbers or knowing the details of your plan.
    - In the event that we cannot verify your insurance, we expect payment in full at the time of the visit. We will then either provide you with a receipt so you can seek reimbursement yourself or in some instances we may refile the claim for you when up-to-date information is available. However, please remember most insurance companies have filing deadlines and if you provide the information past the deadline we cannot file the claim for you.
    - Please confirm PRIOR to appointments if your insurance requires an up to date PCP be assigned to the patients account. All PCP changes have to be done prior to services rendered, and we will be unable to provide services or see patients until it is accurately updated. You are responsible for updating your child's PCP with their insurance.
    - For newborns - it is imperative that you add your child to your insurance policy within 30 days. Please do this as soon as possible to avoid any unpaid claims.
- Copays:
    - All copays, deductibles, and balances will be due at the time of service unless a payment arrangement has been made prior to appointment with our billing department. To make things as convenient as possible for our patients, we accept cash, checks, and credit cards to take payments. Any returned checks will result in a $35 service fee and all future payments are required to be cash or credit/debit card.
- Deductibles:
    - Deductibles and fees for non covered services are due at time of service, in most cases our front office staff will collect a $50 flat fee for high deductible plans, the visit will be billed to your insurance, and we will collect the rest of the balance owed after processing.
- Balances:
    - If your account reaches a balance of $250 or more, we will be unable to see your child in the office until a payment or payment arrangement has been made with our billing department.
- Self Pay:
    - Our office will offer a 20% discount on office visits for all self pay visits, as long as payments are made the same day of appointment.
- After Hours Nurse Line Fee:
    - Our office offers a 24/7 after hours nurse line when calling on weekends, holidays, and after 9pm on normal business days. This nurse line remains available for questions and assistance when the office is not open. Please be aware there is a $20 fee to utilize the nurse line that

will be billed to your account after calling. For non urgent matters that can be attended when we are back in office feel free to send us a portal message instead.

- Ear Piercings:
    - Our physicians will have ear piercing appointments available. Ear piercings are $85 and come with your choice of crystal, or pink hypoallergenic studs. Payment for ear piercings is due prior to service.
- Late/Missed Appointments:
    - Our office has a late and missed appointment policy with a 3 strike rule per family. We allow 15 minutes after your appointment time before counting it as a late or missed appointment. Our office will give you a courtesy call and if you are not coming or do not answer the appointment will be canceled and you will have to reschedule. We ask if you know you will not make it to an appointment, please call our office at least 24 hours prior for cancellations and rescheduling. Any missed or late appointments without 24 hour notice will be subject to the missed appointment fee. After your first late or missed appointment you will receive a warning, and the fee will be waived. After the initial warning and further late or missed appointments will result in a **$35 fee**. We hold ourselves accountable for staying on time, as well as our patients and their parents. Late and missed appointments take away opportunities for other families to be seen and receive care in a timely manner. After three late or missed appointments per family, you will receive a warning and if incidents continue it may result in dismissal from the practice.
- Medical Records/Document and Forms fees:

  Because we give our patients many ways to access and receive patient records, either online through the patient portal, or during in office appointments, there are fees for any requests for physical forms, records, or other documents outside of an appointment.

    - Medical records requested by the patient for the purposes of transfer of care to another physician will be provided at no charge for the first copy once we receive a completed medical record release form. There is a $25 fee for additional copies. For medical records requested from parents for personal use outside of an appointment there is a $25 fee.
    - Any physical, sports, or school forms brought to and signed during an in office visit have no charge. Any requests for signatures outside of a visit will result in a $10 physical form fee.
    - FMLA form requests are $25
    - Any specialty or custom letters signed and completed by our physicians or staff are $10.

- Portal Messaging Fee:
    - For simple, quick response questions most portal messages wont incur a fee. For detailed portal messages covering several questions, in depth questions, or that require extended time to respond and a detailed medical response from our physicians they can incur a fee of $20 that is billed to your insurance. Any remaining balance is left as patient responsibility.