Annapolis Pediatrics
Patient Registration - Under 18 Years Old

Section I **Patient Information** **Date______________**

Social Security #:___________________________________

Patient Name: ____
(First Name) (Middle Name) (Last Name)

Preferred Name: ___________________________________ Suffix: ____________________________

Sex: ☐ Male ☐ Female Date of Birth: _____________

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other
Ethnicity: ☐ Latino ☐ Not Latino ☐ Refused
Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other ________________

Address: _______________________________________City:_____________State:_____________Zip:__________

Email Address: ______________________________________

Home Phone: (_____) _______________ Work Phone: (_____) _______________ Cell Phone: (_____) _______________

Best number to contact me is on my ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Person to contact in case of emergency: _______________________________ Phone: _____________________________

Pharmacy Name: _______________________________________ Phone: _____________________________

School: ____

Whom may we thank for referring you? : ☐ Sibling is a patient ☐ Friend ☐ OB/GYN Referral ☐ Online Pediatrician Search
☐ Magazine Ad ☐ Online Advertisement ☐ Yelp ☐ Gym Advertisement ☐ Social Media

Parent/Guardian #1	Parent/Guardian #2
Name: _____________________________________	Name: _____________________________________
DOB: _____________________________________	DOB: _____________________________________
Address: __________________________________	Address: __________________________________
__________________________________	__________________________________
Phone: _____________________________________	Phone: _____________________________________
Alternate Phone: ______________________________	Alternate Phone: ______________________________
Employer: ___________________________________	Employer: ___________________________________

Parents are: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Custodial parent is: ☐ #1 above ☐ #2 above ☐ Both Patient lives with ______________________________
*Please provide court paperwork if there are custody orders we should be aware of regarding who may bring children to be seen.

Mother's Maiden Name ____
Do you have any specific communication requirements due to hearing, vision or cognitive? ☐ Yes ☐ No
Please list: ____

The following two questions screen for challenges accessing healthcare. You may prefer to leave blank.

Within the past 12 months, have you had difficulty getting to and from your medical appointments? ☐ Yes ☐ No

Within the past 12 months, have you been unable to pay your monthly utility bill? ☐ Yes ☐ No

Annapolis Pediatrics
Patient Registration - Under 18 Years Old

Section II **Responsible Party**

Social Security #:____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ______________________________ Sex: M ☐ F ☐ Date of Birth: ____________

Address: ____

City: ____________________ State: ________ Zip: __________ Phone: (____) ____________

Employer: ______________ Work Phone: (____) ____________ Cell Phone: (____)____________

Section III **Insurance Information**

Subscriber Name: ____________________ Date of Birth: __________ Relationship to Patient: ____________

Social Security #: ______________ Name of Employer: ______________________________

Insurance Company: ____________________ Group #: __________ ID #: ________________

Insurance Company Address: ____

Insurance Company Phone: ____________________

Prescription Plan: ____________________ Prescription ID#: ____________________

Is Medical Assistance Pending: ☐ Yes ☐ No

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE INFORMATION BELOW:

Subscriber Name: ____________________ Date of Birth: __________ Relationship to Patient: ____________

Social Security #: ____________________ Name of Employer: ______________________________

Insurance Company: ____________________ Group #: __________ ID#: ________________

Insurance Company Address: ____

Insurance Company Phone: ________________

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby authorize payment directly to Annapolis Pediatrics the health insurance benefits otherwise payable to me. I consent to apply to my account(s) all monies received by Annapolis Pediatrics on my behalf. I authorize the use of my signature on all insurance submissions, whether manual or electronic.

I also give permission to Annapolis Pediatrics to release medical information when required by the Insurance Company or the government agencies responsible for the payment of the bill. I understand that I am financially responsible for charges not covered by the insurance benefits hereby authorized.

X____

Signature of Guarantor Date

Annapolis Pediatrics

CONSENT FOR MEDICAL CARE

Permission is granted to the physicians, nurse practitioners and employees or Annapolis Pediatrics of Maryland to do such procedures as may be necessary to diagnose, treat, and care for the needs of myself (if 18 years old or older) or of my dependent minor child including but not limited to routine office and laboratory procedures such as strep tests and throat cultures, urine studies, complete blood counts (CBC), hematocrits, bladder catheterization, removal or cerumen (ear wax), removal or foreign bodies, drainage of abscess, fracture care, medication injections, and treatment of skin lesions, warts, burns and lacerations.

Patient Name: ____ Date of Birth: _____________
(Please Print)

Signature of Custodial Parent or Guardian: ____

Date: ____

This authorization shall remain effective until such time that it is revoked in writing and delivered to Annapolis Pediatrics.

Annapolis Pediatrics
Patient Health Intake - Under 18 Years Old

Patient Name: ______________________________________ DOB: ______________________

GENERAL – Please complete for all patients

Question	Yes/No	Explain
Does your child have any serious illness or medical condition?	__Yes No__	Explain:____________________
Has your child had serious injuries or accidents?	__Yes No__	Explain:____________________
Has your child had any surgery?	__Yes No__	Explain:____________________
Has your child ever been hospitalized?	__Yes No__	Explain:____________________
Is your child allergic to any medicines or drugs?	__Yes No__	Explain:____________________

DEVELOPMENT

Question	Yes/No	Explain
Are you concerned about your child's physical development?	__Yes No__	Explain:____________________
Are you concerned about your child's mental or emotional development?	__Yes No__	Explain:____________________

FOR SCHOOL AGE PATIENTS

How is his/her behavior in school?

____

Has he/she failed or repeated a grade in school?

____

How is he/she doing on academic subjects?

____

Is he/she in special or resource classes?

____

FAMILY HISTORY

Have any family members had the following:

- ❑ Stroke
- ❑ Sudden or unexplained death before 30
- ❑ Diabetes (Before age 50)
- ❑ High blood pressure (Before age 50)
- ❑ Arthritis
- ❑ High cholesterol
- ❑ Thyroid disease
- ❑ Nasal Allergies
- ❑ Cancer (type)
- ❑ Deafness
- ❑ Bleeding disorder
- ❑ Heart disease (Before age 50)

Who/Explain:

- ❑ Birth defects
- ❑ Genetic Disease
- ❑ Metabolic Disease
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Epilepsy (seizures)
- ❑ Bed Wetting (after 10 yrs old)
- ❑ Kidney disease
- ❑ Kidney Stones
- ❑ Anemia
- ❑ Inflammatory Bowel Disease
- ❑ Jaundice
- ❑ HIV/AIDS

MENTAL HEALTH

- ❑ Depression, bipolar disorder
- ❑ Alcohol abuse
- ❑ Drug abuse
- ❑ Intellectual Disability
- ❑ Autism
- ❑ Learning disorder
- ❑ Attention Deficit Disorder

____

Additional family history:____

____

Reviewed by: ________________________

Date: ________________________________

Annapolis Pediatrics
Patient Health Intake - Under 18 Years Old

Patient Name: ______________________________________ DOB: ______________________

Does your child have, or has he/she ever had?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Frequent ear infections
- ❑ Problem with ear or hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Poor vision
- ❑ Glasses
- ❑ Glasses

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Heart problem/ heart murmur
- ❑ Asthma, bronchitis, bronchiolitis
- ❑ Pneumonia
- ❑ Fainting/lightheadedness/chest pain
Or shortness of breath with exertion
- ❑ Nasal allergies
- ❑ Swollen legs or feet
- ❑ Cough

NEUROLOGIC
- ❑ Frequent Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Seizures or other neurological problems

GASTROINTESTINAL
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Jaundice
- ❑ Constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Poor Appetite

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Acne
- ❑ Eczema

BLOOD
- ❑ Anemia
- ❑ Transfusion

Bleeding/Easy Bruising

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine
- ❑ Bed wetting (after 5yrs)

OTHER PROBLEMS:
- ❑ Chickenpox
- ❑ Diabetes
- ❑ Thyroid or other Endocrine problems

MENTAL HEALTH
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

For girls only:
Has she started her period? ___ Yes ___ No
Are there any problems with her periods?
____

Any other significant problem?
____

Reviewed by: ________________________

Date: ______________________________

Annapolis Pediatrics
Patient Health Intake - Under 18 Years Old

Patient Name: ___________________________________ DOB: ____________________

Please complete this section only if you are a new patient to the practice:

Did the mother have any illnesses or problem with her pregnancy? Yes __ No __
Explain:____
During pregnancy, did mother: Smoke Yes__ No__
Drink alcohol Yes __No__ Use drugs or medications? Yes__ No__
If yes, list names:____
Were prenatal ultrasounds "normal"? Yes__ No__
Explain: ____
Was the delivery: Vaginal __ Cesarean__
If cesarean, why? ____
Did your baby have any problems right after birth:
Yes__ No __ Explain:____
Was your baby in the NICU (Neonatal Intensive Care Unit? Yes____ No____

Was initial feeding: Breast___ Bottle___

BIRTH HISTORY
Birth Weight ___________________
Was the baby born at: Term___ Early___ Late___
If, early how may week's gestation?
____

Reviewed by: ______________

Date: ____________________

Annapolis Pediatrics
Notice of Privacy Practices

Dear Parent, Guardian or Patient,

This notice describes how medical information about you may be used and disclosed. It will also tell you how to get access to this information. Please review it carefully.

Due to changes in State and Federal regulations governing privacy practices and in order to update our records, we ask that you complete our registration form for each patient. Please provide the current information regarding your telephone numbers (home and work) and home address. This allows us to make direct contact when trying to reach you.

The practice has implemented policies and procedures so that the confidentiality of your personal and/or medical information remains confidential. Your healthcare provider(s) as well as all other employees working in this practice will keep any information related to you or your child (medical and/or non-medical) in a confidential manner.

We may need to contact you, by telephone, to discuss your appointments, test results, treatment, and referrals, account balance and/or return your telephone call. We will first attempt to contact you at home; however, if you are not available and you provide us with your work telephone number, we may attempt to contact you at work. If you are not available, we may leave a message for you to either call the office or we may leave information to remind you of an appointment time.

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail other correspondences to your home noting that we are trying to contact you regarding a scheduled appointment, to schedule an appointment, to mail test result information or other medical and/or non-medical information that you may have requested or information regarding your account in order to collect a debt.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your coinsurance and co-pay requirement.

When you arrive at our practice for your appointment, we will ask you to sign in. If you would like information sent to another physician or medical facility, you must authorize the release of this information, in writing (we will provide the necessary form to complete) upon registration. Also, you must provide written authorization for the release of information to your life, disability, or future health insurance carrier.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

You must submit a medical records release form in person in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you or your child's care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing a written request to the practice at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Annapolis Pediatrics to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices: Annapolis Pediatrics has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected heath information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Annapolis Pediatrics, Attention: Privacy Officer
200 Forbes Street, Suite 200, Annapolis, MD 21401
Telephone: 410-263-6363
Facsimile: 410-263-7551

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Annapolis Pediatrics. Annapolis Pediatrics is authorized to use and disclose health information about the following patients for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices.

Name: ________________________________ D.O.B: ____________________

______________________________________ ______________________
Signature of Patient or Parent/Guardian if Minor Date

Rev. date 12.17.2017

PROXY CONSENT TO TREAT MINORS FORM

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at Annapolis Pediatrics.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

AUTHORIZATION:

I hereby appoint ____ ______________________________________

Name Relationship

as a proxy decision maker to consent to and authorize routine health care treatment and services for my child listed below.

Routine medical care and interventions may include, but not limited to: medical evaluation, physical exam, lab work (examples include: throat or nasal swabs, finger sticks, wart treatment, minor suturing of lacerations, urine tests). Annapolis Pediatrics also may give immunizations or intramuscular/intravenous antibiotics pursuant to the consent of the proxy.

I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. (More than one child may be listed)

Patient's Name: ____ DOB: ___________________________

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given (If none, state "none")

____

____

Parental contact information for questions regarding treatment:

Parent's Name: _____________________________________ Daytime Phone: ____________________________

Cell Phone: ____ Evening Phone: ____________________________

Parent's Name: _____________________________________ Daytime Phone: ____________________________

Cell Phone: ____ Evening Phone: ____________________________

I hereby indemnify and hold harmless Annapolis Pediatrics and all their officers, agents, employees, attorneys, administrators, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Annapolis Pediatrics or restricted by time frame as noted above. *Only one parent's signature is required.*

______________________________ __________ ______________________________ __________

Signature of parent Date Signature of parent Date

Annapolis Pediatrics Vaccine Policy

The healthcare providers at Annapolis Pediatrics carefully reviewed our approach to vaccinations in our practice. We support the vaccination of all children and young adults. Vaccines saved more lives in the past century than any other medical intervention. Our vaccine recommendations are based on the schedule published by the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP). The recommended vaccines and their schedule are the result of many years of scientific study and data gathering from the billions of children who were immunized. We firmly believe that those studies correctly conclude that vaccines are safe.

The vaccine campaign is truly a victim of its own success. This success has made some parents complacent about vaccinating. We recognize that the choice to vaccinate your child may be a complex one, but failing to vaccinate can lead to tragic results. It is precisely because vaccines are so effective at preventing illness that parents are even questioning whether or not they are necessary. As a result of vaccines, most people in this country have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox. Unfortunately, the healthcare providers in our office have seen children suffer and/or die from these vaccine preventable illnesses.

Immunizations are crucial to preventing disease among the general population. Vaccines benefit both those who receive them and the vulnerable, unvaccinated people around them. In our office, we have many patients who are too young to be vaccinated and are at risk for contracting a vaccine preventable disease from a child who is unvaccinated. While you may choose to assume risk that you or your child might contract a vaccine-preventable illness, we cannot assume risk for our patients. Adhering to the vaccination schedules recommended by the AAP and CDC is the right thing to do, and we are happy to direct you to the resources supporting that.

We also rely on the studies that show delaying or “breaking up the vaccines” to give fewer at each visit goes against expert recommendations. Deviating from the recommended schedule can put your child at risk for serious illness or even death and goes against our medical advice. For these reasons, it is our expectation that all of our patients be up-to-date with their infant/toddler vaccines by two years of age. In addition, we firmly believe that all of our patients should have their recommended childhood vaccinations by the age of six years. Furthermore, all adolescent and young adult vaccinations should be administered in accordance with the current CDC and AAP schedule recommendations.

We feel very strongly that vaccinating children on schedule with currently available vaccines is the right thing to do for all children and young adults. Our conviction is best demonstrated by the fact that our own children are fully immunized and vaccinated on schedule. **If despite our recommendations, you feel you cannot follow the AAP and CDC vaccine schedule recommendations, we will ask you to find another health care provider who shares your views.** Please feel free to discuss any questions or concerns that you have about vaccines with any of the providers during your office visit. We look forward to providing the best care possible for our patients and their families.

Sincerely,
Annapolis Pediatrics

______________________________ _______________
Patient Name (Please Print) Patient Date of Birth

______________________________ _______________
Signature of Patient or Parent/Guardian if Minor Date signed

Rev. date 12.27.2017

ANNAPOLIS PEDIATRICS FINANCIAL POLICY

INSURANCE RELATED TOPICS AND FINANCIAL RESPONSIBILITY

Your insurance plan requires that you present your current Insurance card at each and every visit. Although we will assist you, it is ultimately your responsibility to be aware of the extent of your coverage, limitations, and exclusions before the time of service. This Includes well child care and immunizations.

We understand that there are occasional circumstances that may keep you from the appointment. When this happens, we request 24 hours advance notice for physical exams, consults, behavioral health visits, medication checks and two hours for sick visits. It is our policy to charge $25 for an office visit that is missed without advance notice for all visits except for consults and behavioral health visits. Consults and Behavioral Health visits are subject to a $50 no show or late cancellation fee. We reserve the right to dismiss a patient from the practice who misses more than three appointments without notice. If you arrive late to your scheduled appointment, we reserve the right to reschedule the appointment.

At Annapolis Pediatrics we care for ALL children according to nationally recognized standards of care. Even when recommend and medically necessary, some of these screenings and treatments may not be covered by your insurance. Depending on your family's plan you may receive unanticipated or unreimbursed charges for these services, and you will be responsible for these charges. For questions regarding your plan please contact your insurance company and/or employer. If services received are not covered by your plan, it is ultimately your financial responsibility to provide payment for these services. If you have a co-pay or deductible, your plan's contract with both our practice and you as the patient requires us to collect this at the time of service. Your insurance coverage and benefits are a contract between you and your insurance company, and therefore all disputes must be handled directly with your carrier.

Certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. Some insurance carriers are classifying these procedures as "surgery" and applying the charges to a higher deductible amount. The result may be an insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Examples of in office procedures include but are not limited to: Ear wax removal, foreign body removal, Penile/labial adhesion, Umbilical cauterization, Wart treatment.

Any outstanding balance after 90 days may be referred to an outside collection agency. Patients with continually delinquent accounts or those whose accounts have been sent to a collection agency are subject to discharge from Annapolis Pediatrics.
If any of our physicians and/or providers are asked to be involved in any legal matter requiring our participation pertaining to you or your child via telephone, court deposition, and/ or court appearance we will charge you a fee for these services. This will include preparation time, professional time, and transportation costs. The fee for these services of three hundred dollars ($300.00) per hour will be billed to the parent whose attorney is requesting the information.

ADMINISTRATIVE FEES

Form completion (up to 2 pages) *forms take 7-10 business days to complete	$7.00
Form completion (3 or more pages or complicated forms)	$10.00
Stat forms: those requested to be completed within 48 hours	$20.00
Immunization records only	No Charge
Returned check fee	*$35.00
After hours telephone charge	$15.00
Medical Records	**$25.00 Per patient

*After Hours Telephone Charge - No charge isf call is related to an Illness for which services were provided within the previous 7 days nor an illness leading to assessment within the next 24 hours -which includes In the office and/or in the Emergency Room.

** Medical Records - In the state of Maryland, the physician who creates the patient's medical records Is the owner of the records and is permitted to charge a processing fee and copying fee per patient plus actual postage. The fee is an out of pocket expense and cannot be billed to your insurance carrier. If records are being provided to someone other than patient or physician(for example an attorney), there is an additional preparation fee of $22.88. The Medical Record Fee must be received before records will be released. Upon receipt of fee, requests for release of medical records will take up to 14 business days to process. See our website for record release form. See www.odg.state.md.us for additional information regarding the Maryland State Law.

Patient/Parent Initial _________

APPOINTMENTS

We understand that there are occasional circumstances that may keep you from the appointment. When this happens, we request 24 hours advance notice for physical exams, consults, behavioral health visits, medication checks and two hours for sick visits. It is our policy to charge $25 for an office visit that is missed without advance notice for all visits except for consults and behavioral health visits. Consults and Behavioral Health visits are subject to a $50 no show or late cancellation fee. We reserve the right to dismiss a patient from the practice who misses more than three appointments without notice. If you arrive late to your scheduled appointment, we reserve the right to reschedule the appointment.

SEPARATED/DIVORCED PARENTS

For parents who are separated or divorced and need care for their child/children, the parent bringing the child to the office authorizes treatment, and therefore is responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the authorizing parent's responsibility to collect from the other parent. Annapolis Pediatrics will not make special provisions or act as a mediator in collection of payment.

Unless Annapolis Pediatrics has a court order(s) that states the contrary, Annapolis Pediatrics is legally obligated to disclose medical information to both parents/legal guardians. If at any time legal matters become too Intrusive for our staff, we reserve the right to dismiss the patient from the practice.

FAMILY NEED SERVICES

For the visual and hearing impaired parents/patients, we will provide appropriate means of communication when necessary including written materials and/or qualified interpreters. We require one week advance notice If you or your child Is In need of interpretation services.

If you or your children are in need of language translation, you may want to bring your own translator. The office has limited translation services.

VACCINE ADMINISTRATION

Annapolis Pediatrics will administer vaccines in accordance to the American Academy of Pediatrics guidelines. Our Provider staff will give you information about these vaccines and the opportunity to discuss them prior to administration. Patients who do not wish to follow the AAP schedule for vaccine administration will not be able to be cared for by Annapolis Pediatrics. Please see our vaccine policy posted on our website.

PRESCRIPTIONS

Annapolis Pediatrics will only process prescription refills Monday-Friday 8am-5pm. We do not process refills on Saturday or Sunday. Refills can take up to 72 hours to process.

GROUNDS FOR DISMISSAL (Include but not limited to)

Non-payment of patient responsible balances in timely manner
Multiple missed appointments
Profane, abusive, or demeaning language to staff
Failure to abide by AAP guidelines for immunizations

Responsible Party:

Print Name: ____________________________________ Relationship to Patient: ________________

Signature: ______________________________________ Date: _________________________

Patient Name: ___________________________________ Patient Date of Birth: ______________________
(Please print patient name)

Patient/Parent Initial _________