Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

New Patient Registration

Please fill out one form for each child

Today's Date:	Previous Pediatrician (if any):	
PATIENT INFORMATION		
Patient's full name:	Date of birth:	Sex: □ Male □ Female □ Other
Street address:		
City:	State:	Zip:
Primary Phone #:	Patient cell # (if applicable and 12+ years old):	
E-mail address (if applicable and 12+ years old):		
Primary language:	School:	Grade:
Ethnicity: □ Hispanic □ Non-Hispanic	American Indian/Native American: □ Yes □ No	Race:
Siblings (names and birthdates):		

INSURANCE INFORMATION (Please give your insurance card to the receptionist)		
Primary Insurance: Is this patient covered by insurance? □ Yes □ No (self-pay)		
Policy Holder Name:	Date of Birth:	Social Security #:
Insurance Name:		
PPO/HMO?: □ PPO □ HMO	Group #:	Policy #:
Does the patient have secondary insurance? □ Yes (please give card to receptionist) □ No		

Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

PARENT INFORMATION		
Person responsible for bills: □ Mother □ Father □ Other (please specify):		
Patient primarily resides with: □ Both parents □ Mother □ Father □ Legal guardian (please specify): Parents are: □ Married □ Live together but not married □ Separated □ Divorced		
Parent #1:		
Name and Date of Birth::	Occupation:	
Address (if different from above):	Cell Phone #:	E-mail:
Parent #2:		
Name and Date of Birth::	Occupation:	
Address (if different from above):	Cell Phone #:	E-mail:

I give permission for Star and Fox Pediatrics, PLLC to contact me via e-mail and/or text message.

Parent/Guardian Signature: Date:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any outstanding balance. I authorize Star and Fox Pediatrics, PLLC or the insurance company to release any information required to process my claims.

Parent/Guardian Signature: Date:

Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

PATIENT MEDICAL HISTORY

Current Medications (Name and Dosage):

Allergies:
□ Medication(s): □ Food(s): □ Other:

Immunization History:
To the best of my knowledge, my child is up to date on his/her immunizations □ Yes □ No

If no, please explain:

Medical History: please list any known medical conditions

Surgical History/Hospitalizations: please list any surgeries or hospitalizations and dates

Family History: if yes, please write which family member

□ ADD/ADHD
□ Alcohol/drug abuse
□ Allergies
□ Anxiety
□ Asthma
□ Birth defects
□ Blood disorders
□ Cancer
□ Heart disease
□ Hearing problems/deafness
□ Depression
□ Developmental delay
□ Diabetes
□ Genetic disorder
□ Hepatitis/liver disease
□ High cholesterol
□ High blood pressure
□ Learning disability
□ Mental illness
□ MIgraines
□ Scoliosis
□ Seizure disorder
□ Speech problems
□ Tuberculosis/lung disease
□ Stroke
□ Thyroid disease
□ Other

Does anyone in your home smoke? □ Yes □ No	Do you have pets? □ Yes □ No
Do you have guns in your home? □ No □ Yes (□ locked/□ unlocked)	

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

Authorization for Star and Fox Pediatrics to RECEIVE Medical Records

Patient Name:	Date of Birth:

I, _____, hereby authorize the release of medical information **TO**

Star and Fox Pediatrics, PLLC
257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622/Fax: (508) 785-6120

FROM:

Doctor/Clinic/Hospital:		
Street Address:		
City:	State:	Zip:
Phone #:	Fax #:	

Information to be released:
□ Complete medical record **including** protected health information (see below)

Purpose of disclosure:
□ Treatment/continuing medical care

Authorization to release protected information (required):

I **DO NOT AUTHORIZE** the release of the following protected or privileged information that I have initialed below (only initial if you do NOT want to release this information):

□ Mental health/psychotherapy notes/information
□ Social work counseling/therapy
□ HIV tests and related information
□ Alcohol/substance abuse
□ Developmental disability
□ Sexually transmitted disease (STD)
□ Sexual abuse/rape
□ Domestic violence victims' counseling
□ Genetic testing

I understand that I may revoke this authorization in writing at any time. This authorization shall remain in effect for 90 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 years old then the signature of the legal guardian is required.

Patient/Parent Signature: Date:
Print Name: Relationship to patient:

Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

Spruce Health Texting Agreement

We are excited to offer direct messaging using Spruce Health. Messaging us in Spruce is as easy as texting which is often more convenient than calling and can be complementary to communications using the Patient Gateway.

This service can be used to request or change appointments, ask brief medical questions and check in with us regarding test results. You can also upload photos and videos and we can also send you links to documents. Additionally, Spruce has an option for HIPAA secure telemedicine which can only be accessed within the Spruce application. The Spruce application is a HIPAA compliant and secure messaging platform that we offer at no cost to you. It is free for you to download and easy for you to use.

We will send you a link for downloading the application to your smartphone.

Please write your preferred phone number for Spruce messaging: _____

While you could choose to text us outside Spruce at our regular number, please understand regular texting is not HIPAA compliant nor secure and we ask you to be careful to limit your questions so that private medical information is not included.

I acknowledge the above opportunity to use HIPAA compliant secure Spruce messaging and the limitations on privacy that using regular texting rather than the Spruce application may pose.

Signature_____ Date_____

Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

Financial Policy

Insurance
As a courtesy to our patients, we will file the necessary forms to your insurance company so that you may receive the full benefits of your medical coverage. Please note that it is your responsibility to review your insurance policy and be aware of what your insurance may or may not cover. If your insurance company denies coverage, or we do not receive payment within 60 days from filing your claim, the amount will be billed to you and you will be responsible for payment. Please remember that your insurance coverage is a contract between you and your insurance company and/or your employer and your insurance company. We will make a good faith effort to assist you in obtaining your benefits but we cannot force your insurance company to pay for the services provided to you.

Copayments (Co-Pays) and Deductibles
If your insurance policy requires a copayment or deductible, this payment is due at the time of service. Payment may be made by cash, check or credit card.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by our office. If your insurance is a High Deductible Health Plan and you have not yet paid your deductible in full, any non-preventative care visits will likely require payment at the time services are rendered. Please note that even after you meet your deductible you may still be responsible for any balances due to the office.

Financial Arrangements
For your convenience, we accept all major credit cards and checks (returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will need to contact our office within 7 days to arrange an alternate form of payment.

Appointments/Cancellations
No show policy: Star and Fox Pediatrics requires 24-hour advance notice for all cancellations or reschedules. Failure to notify our office or a no-show may result in a $50.00 fee. Emergencies will be considered on a case by case basis for waiver of this fee. Repeated cancellations or missed appointments will result in loss of future appointment privileges. After the third no show, the patient may be discharged from the practice.

Late policy: Any patient arriving more than 15 minutes late to their scheduled appointment may be asked to reschedule in order to ensure that you receive the appropriate level and attention to care as well as to respect other patients' time.

Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

Regular scheduled well visits (also known as preventive exams or physicals) are a crucial part of your child's physical, developmental and mental health evaluation. The information below is to help you understand the difference between what is covered within a well visit vs. a problem oriented visit.

Screenings
During well visits, we perform recommended screenings appropriate to age and seek to uncover any conditions that may lead to suboptimal health in the years to come. In our experience, most insurance plans cover these screenings but some do not. Because there are so many different insurance companies and plans, we do not know in advance what will and will not be covered. It is your responsibility to understand what screening services are covered by your insurance plan. That said, screenings not filled out electronically or via paper must still be reported to the insurance company since the questions will then be covered during the visit.

Insurance Coverage for Well Visits vs. Problem-Oriented Visits
Well visits may uncover or revisit problem oriented issues that require evaluation or management (ex. ear infection, ADD concerns, wart treatments). Whenever possible we try to address such problem-oriented issues at the same office visit. This is also an additional convenience so that families do not have to return to the clinic for another appointment. In compliance with insurance company billing policies, this then prompts charges for both categories. While preventive services may not require a copay/deductible, problem-oriented services do typically prompt a copay/coinsurance/deductible.

Weekend/Evening/Holiday visits
As an added convenience to our families, we will at times see patients after hours in the evenings or on the weekends/holidays for urgent matters. These visits require an additional code to be sent to your insurance company and may incur an additional fee, depending on your insurance policy and deductible plan.

We accept a variety of insurance, including MassHealth (MGB ACO only). We ask that you always come to our office with the appropriate insurance information including your insurance card and that you be prepared to pay any co-payments or co-insurance that is your responsibility each time your child comes to the office. Payments can be in the form of cash, check or credit card. If you prefer we can place your credit card on file for these payments. Payments can also be made on our patient portal. Please contact our office during regular business hours in regards to any insurance questions or payment plan options. Payment plans can be arranged on a case-by-case basis for any financial hardship.

If you have a balance of $300 or more and have not made prior arrangements with us for a payment plan, we will require a credit card on file to ensure payment in a timely fashion. Repeated failure to pay in a timely fashion could be grounds for dismissal from our office. If you need further explanation about incurring additional fees for services provided during your visit today, please do not hesitate to ask.

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
Fax: (508) 785-6120

Financial Policy Acknowledgement

Assignment and Release
I authorize payment to be made directly to Star and Fox Pediatrics by my insurance company. I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Late Fees
I understand that my account will become delinquent if not paid within 30 days after billing and the unpaid balance will be subject to a monthly finance charge of $30 until the full balance is paid. If the balance continues to be unpaid, the balance and any administrative fees will be assigned to a collection agency. My signature below acknowledges that I have read and understand this information.

Acknowledgement of Wellness Services Billing Procedures
I acknowledge that during my well visit, there may be a problem-oriented service or screenings performed in addition to the wellness services. In this case, I understand that separate charges may be submitted to my insurance company and that, when applicable, a co-pay, deductible and/or co-insurance may be required for charges generated. My signature below acknowledges that I have read and understand this information.

My signature below acknowledges that I have read the financial policy in its entirety and understand and agree with the above.

Notice of Privacy Practices Written Agreement
I acknowledge that I have read a copy of Star and Fox Pediatrics' Notice of Privacy Practices. I understand Star and Fox Pediatrics has a link to the Notice of Privacy Practices on the practice website (www.starandfoxpediatrics.com). I understand that a written copy will be provided to me at any time upon my request.

Patient name:_____ DOB:_____

Parent/guardian name (if under 18):_____

Relationship to patient: □ Parent □ Guardian □ Self

Parent/guardian signature (if under 18):_____ Date:_____

Patient signature (if 18 or older):_____ Date:_____