PEDIATRIC PATIENT REGISTARTION

Patient Information

Name: _____ DOB: _____
Address: _____ Apt._____
City: _____ State:_____ Zip:_____
Home#_____ Alternate#_____

Pediatrician _____ Phone_____
Referring Physician _____ Phone_____
Pharmacy Name _____ Phone_____

Mother

Name: _____
DOB: _____S.S #_____
Address: _____Apt._____
City: _____State:_____Zip:_____
Home#_____Alternate#_____

Father

Name: _____
DOB: _____S.S #_____
Address: _____Apt._____
City: _____State:_____Zip:_____
Home#_____Alternate#_____

Insurance Information (note if child is covered by more than 1 policy please provide Information for both)

Primary Insurance: _____ Policy #: _____

Group #: _____ Phone #:_____

Name of Policyholder:_____ Relationship to child : _____

Birth Date of Policyholder: _____ Social Security #:_____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Phone #:_____

Name of Policyholder:_____ Relationship to child : _____

Birth Date of Policyholder: _____ Social Security #:_____

PARENT /GUARDIAN_____ RELATION _____

SIGNATURE_____ DATE_____

CHILD PROFILE

Patient Name _____ Date _____

Primary Pediatrician_____

CHILD DEVELOPMENT

Please indicate the approximate age your child performed the following: ☐ All Normal

Smiled _____ Rolled over _____ Sat up without help _____ Walked _____
Walked up stairs _____ Spoke first words _____
Spoke words besides Mama or Dada _____Was potty trained _____

Has the child ever…

Had a seizure?	☐ Yes ☐ No
Suffered a head trauma?	☐ Yes ☐ No
Had meningitis or encephalitis?	☐ Yes ☐ No
Used alcohol or drugs?	☐ Yes ☐ No
Been physically, sexually or emotionally abused?	☐ Yes ☐ No

Review of Systems: Please circle all those that apply:

Abdominal pains	Constipation	Hostile/Angry	Stares off into space
Abnormal growth	Cough	In trouble at school	Tremor
Aggressive	Daydreaming	Insomnia	Trouble hearing
Allergies	Depression	Joint pain/ swelling	Trouble learning
Anemia	Diarrhea	Nasal congestion	Trouble seeing
Anxiety	Dizziness	Neck pain	Trouble sleeping
Asthma	Easy bruising	Numbness/tingling	Vomiting
Back pain	Excessively sleepy	Pain in arms/ legs	Weakness
Behavior problems	Faint/pass out	Pain with urination	Weight change
Birthmark	Fatigue	Poor coordination	Wets self during the day
Chest pain	Fever	Shortness of breath	Wets self during sleep
Chills	Frequent falls	Shy	
Chokes easily	Headache	Skin rash	
Clumsy	Heart murmur	Speech problems	

Any other concerns? _____

_____

BIRTH HISTORY: Check all that apply

Birth weight _____

Problems with pregnancy:	**□Infection**	**□ Fever**	**□ High blood**	
	□ Diabetes	**□ Smoked**	**□ Drank alcohol**	**□ Used street drugs**
Delivery:	**□ Vaginal**	**□ C-Section**		
Problems with delivery?	**□ No**	**□ Yes**		
Birth was:	**□ Full term**	**□ Late**	**□ Early (How many weeks? _____)**	
Problems as newborn:	**□ Jaundice**	**□ Breathing**	**□ Infection**	**□ Seizure**
	□ Heart	**□NICU stay**	**□ Feeding**	**□ Birth defect**

MEDICAL HISTORY: Check or fill in as indicated

Hospitalization:	□ No □ Yes	for what _____
Surgery:	□ No □ Yes	for what _____
Immunizations up to date:	□ No □ Yes	

Past medical problems / illness (Please include anything your doctor follows you for):
_____

Tests performed: □ MRI □ CT scan □ Spinal tap □ Genetics □ EEG/Brain wave test

Current Medications: _____

Allergies: _____ Epi-Pen: □ No □ Yes

FAMILY MEDICAL HISTORY:

Check all those apply and write in relationship of **family member** to patient.

Mental retardation_____	Birth defects_____	Attention Deficit Disorder (ADD) _____
Learning difficulties _____	Headaches_____	Depression _____
Bipolar Disorder _____	Anxiety_____	Stroke _____
Behavior problems _____	Migraines _____	Seizures with fever _____
Speech problems _____	Fainting spell_____	Seizures without fever _____
Muscle problems _____	Tics _____	Death in infancy or childhood _____

Any other medical illnesses not listed which run in the patient's family?

_____

Mother's health problems_____
Father's health problem_____
Brother or sister's health problems _____

SOCIAL HISTORY:

Members of household _____
Current grade placement _____ Grades repeated _____
Name of School _____
Number of brothers _____ number of sisters _____
Pets (types and numbers) _____

Does patient receive:

Physical therapy? □ No □ Yes
Occupational therapy? □ No □ Yes
Speech therapy □ No □ Yes

Mother: Age _____ Occupation _____

Married / Single / Divorced / Separated

Father: Age _____ Occupation _____

Married / Single / Divorced / Separated

Parent or guardian _____ Date_____

Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

_____ _____

Signature Date

I, _____, DO / DO NOT hereby authorize you to leave messages on the answering machine or with an authorized contact at my residence, this information could contain personal information, appointment information and/or results of testing done.

_____ _____

Signature Date

List of Authorized Contacts List of Unauthorized Contacts

EPILEPSY & NEUROLOGY GROUP, LLC

CONSENT TO TREAT

I authorize Epilepsy and Neurology Group, LLC (ENG) to examine me, the patient for which I am legally responsible.

MEDICAL INFORMATION AGREEMENT

1. I authorize release of medical information that may be required to process my insurance claim to the proper insurance company or government agency for payment of medical bills.
2. I authorize release of appropriate medical information to other doctors, hospitals or medical facilities participating in my care.
3. I authorize release of appropriate medical information including test results from other doctors, hospitals or medical facilities to Epilepsy and Neurology Group in order to aid in my care / treatment.

FINANCIAL AGREEMENT

1 Patient's with insurance that ENG does not participate with or with no insurance coverage are responsible for payment at time of service.
2 Patients with insurance which ENG participates with will be responsible for providing necessary referrals at the time of service, as well as paying the co-pay/deductible.
3 ENG requires 24 hours' notice of cancellations; we reserve the right to charge for missed appointments.

ASSIGNMENT OF BENEFITS: I request that assignment of authorized Medicare/Other Insurance Company benefits be paid either to me or on my behalf Epilepsy and Neurology Group for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration any information needed for this or any related Medicare/Other Insurance company claim. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that regardless of my insurance status, I am ultimately responsible for the balance of my account. If I am using out of network benefits, I am responsible for any deductible and/or co-insurance.

PARENT /GUARDIAN_____ RELATION _____

SIGNATURE_____ DATE_____

Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in our main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time and can view a copy of this notice on our Web site at http://www.njepilepsy.com

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

Uses and Disclosures Which Do Not Require Your Authorization.

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

3. For health care operations. We may disclose your PHI, as necessary, to operate this facility and provide quality care. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. To avoid harm. In order to avoid a serious threat to

6. For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

7. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

8. To coroners, funeral directors, and for organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

9. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

12. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in

the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

The list will include the date of the disclosure, to whom PHI was disclosed. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we

writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003. (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12- month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information.

You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time.

approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. Please allow 14 business days for an answer from our practice regarding your complaint. If you are not satisfied with our response to your complaint, you may also notify the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint please contact: Leubna Asad, Administrator, 901 West Main Street, Freehold, N.J. 07728. (732) 414-8585

VII. EFFECTIVE DATE OF THIS NOTICE

This notice is effective April 14, 2003.