COASTAL
PEDIATRIC ORTHOPEDICS

Today's Date_____

## PATIENT INFORMATION

Patient Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Birthday _____ Sex: M ☐ F ☐ Parent E-mail _____

Home Phone _____ Cell Phone _____

Pediatrician _____ Referred By _____

## RESPONSIBLE/INSURED PARTY'S INFORMATION

Name _____
Last First Middle

Birthday _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

## INSURANCE INFORMATION

Insurance Provider _____ Phone Number _____

Subscriber Name _____ Subscriber Birthday _____

Group Number _____ Member ID Number _____

## SECONDARY INSURANCE INFORMATION

Insurance Provider _____ Phone Number _____

Subscriber Name _____ Subscriber Birthday _____

Group Number _____ Member ID Number _____

## PATIENT'S MEDICAL HISTORY

Last Name _____First Name _____ Middle Initial _____

Chief Complaint _____

Date of Injury/Onset of Condition _____

Brief description of the injury or condition _____

_____

_____

Past Medical History _____

_____

Past Surgical History _____

_____

Medications _____

_____

Allergies _____

_____

Was the patient seen in a hospital or an Urgent Care Center? _____

If Yes, which hospital or Urgent Care Center? _____

Was the patient seen by Dr. Plakas in the hospital? Yes ☐ No ☐

If Yes, what was the date of treatment? _____

*If this was a school or sports related injury, please provide the following:*

Name of School/Team _____

Sport _____

Name of Coach _____

Contact number _____

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## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____ (patient) and _____ (guardian) understand that as part of my treatment, Coastal Pediatric Orthopedics will create and maintain health records which describe my child's medical history, symptoms, physical examination, test results, diagnoses, treatment, and future plan of care. This information serves as:

- A basis for planning my child's care and treatment
- A source of information to communicate with other members of my child's healthcare team
- A means by which a third-party payer can verify that services billed were accurately rendered
- A part of a healthcare audit to verify quality and appropriateness of treatment
- A foundation by which we may file an appeal with your insurance

Your child's personal information and medical history is protected by the Health Insurance Portability and Accountability Act (HIPAA). We may not use or disclose your protected health information without your consent. You may choose to revoke this authorization at any time with written notice to our office.

I understand that Coastal Pediatric Orthopedics will take care to ensure that all medical information relating to my child's treatment at this practice will be handled with an emphasis on maintaining privacy and confidentiality.

In addition, I give permission for records to be released to the following family member/friend:

Name _____ Relationship _____

Patient _____

Legal Guardian (please print) _____

Legal Guardian's Signature _____

Date_____

## INSURANCE AUTHORIZATION AND AUTHORIZATION TO FILE APPEALS

I, _____ (patient) and _____ (guardian), authorize Coastal Pediatric Orthopedics and its billing company, Affinity Med Solutions, to file an appeal or complaint to my insurance company on my behalf if there is a question about coverage for services rendered.

I understand that if I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.

I authorize Coastal Pediatric Orthopedics and Dr. Plakas to furnish any information related to the below named patient's medical care as required by any insurance carrier or government agency. I also authorize to the processing of insurance claims generated in the course of treatment on my child's behalf. I allow a photocopy of my signature to be used to process insurance claims.

I further assign to the physician all payments the insurance carriers are obligated to make on my behalf for medical/surgical services rendered by Coastal Pediatric Orthopedics and Dr. Plakas. I understand that in the absence of accepted insurance coverage I am responsible for payment of services rendered

I understand that I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time for me.

I have read this consent and understand it, and it has been explained to me to my satisfaction.

Patient _____

Legal Guardian (please print) _____

Legal Guardian's Signature _____

Relationship to Patient _____

Date _____

## INSURANCE CARRIER PAYMENTS

We will be submitting a claim directly to your insurance carrier for treatment of your child. If we are not an in-network provider with your plan, your insurance may issue payment directly to you to be used as payment for our services.

If you receive a check from your insurance company, please notify us immediately so that we can make arrangements to have the payment posted to your account. You can endorse the back of the check and write “Payable to Coastal Pediatric Orthopedics” beneath it. Checks can be mailed to

Coastal Pediatric Orthopedics
PO Box 359
Long Branch, NJ 07740

Failure to notify us upon receipt of a payment from your insurance company will result in monthly accrual of 5% interest to your account.

In the event that an insurance payment is received by a member and we are unable to coordinate payment for our services, after 90 days, the account will be transferred to our legal team and the member will be responsible for the full payment as well as full interest and collections fees.

I have read the above and understand it, and it has been explained to me to my satisfaction

Patient _____

Legal Guardian (please print) _____

Legal Guardian’s Signature _____

Relationship to Patient _____

Date _____