Louise Tetrick, MD, FAAP
Cathy Wagner, MD, FAAP
Marsha Norris, MD, FAAP
Scott Curnow, MD, FAAP
Victor Nanagas, MD, FAAP
Liz Moore, MD, FAAP
Vicki Roe, MD, FAAP
John Champley, MD, FAAP
Kara Gurchiek, MD, FAAP
Chrissy Adams, MD, FAAP
Stephanie Booms, MD, FAAP

Community Health
Pavilion
9669 E 146th Street, #300
Noblesville, Indiana 46060

Community Hospital
North Campus
8101 Clearvista, Pkwy, #185
Indianapolis, Indiana 46256

(317) 621-9000 Phone
(317) 621-9190 Fax

Patient Registration Packet

New and Established Patients

Thank you for choosing Northpoint Pediatrics for the care of your child. In an effort to save you time at your appointment, we have put together a packet of paperwork to gather information from you that will allow us to treat your child and file claims to your insurance carrier.

The following forms will need to be completed and turned into our office at the time of check-in:

- Northpoint Pediatrics Patient Registration Form
- Northpoint Pediatrics Signature Sheet

The following forms are for you to keep and provide further details about what you have signed:

- Consent for Communication via Electronic Mail
- Northpoint Pediatrics Financial Agreement
- Failed and Cancelled Appointment Policy
- Northpoint Pediatrics Notice of Privacy Practice

We look forward to seeing your family in our office and providing you with a great experience at Northpoint Pediatrics.

Northpoint Pediatrics Patient Registration Form

Patient's Full Name			Acct#
Date of Birth		BOY ☐ GIRL ☐	PCP
Patient's Full Name			Acct#
Date of Birth		BOY ☐ GIRL ☐	PCP
Patient's Full Name			Acct#
Date of Birth		BOY ☐ GIRL ☐	PCP
Patient's Full Name			Acct#
Date of Birth		BOY ☐ GIRL ☐	PCP

PLEASE CIRCLE ONE - Children live with both parents, mother, father, other - please list________________

Father's Name / Domestic Partner - circle one		Mother's Name / Domestic Partner - circle one	
SSN	Date of Birth	SSN	Date of Birth
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Employer	Occupation	Employer	Occupation
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager	Cell Phone	Pager

Insurance Policy Holder's Name:	**Relationship to child**

Step Mother's Name / Domestic Partner - circle one		Step Father's Name / Domestic Partner - circle one	
SSN	Date of Birth	SSN	Date of Birth
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Employer	Occupation	Employer	Occupation
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager	Cell Phone	Pager

Parental Relationship - please circle one - Married Separated Divorced Never Married Widowed

LEGAL PARENT / LEGAL GUARDIAN SIGNATURE	**PRINTED NAME**	**DATE**
X		

Today's Date	Entered by:		

Northpoint Pediatrics Signature Sheet
PLEASE READ AND INITIAL EACH SECTION AND SIGN AT THE BOTTOM

Child's Name:___________________________________ DOB:______________/ Acct #:_______________
Child's Name:___________________________________ DOB:______________/ Acct #:_______________
Child's Name:___________________________________ DOB:______________/ Acct #:_______________
Child's Name:___________________________________ DOB:______________/ Acct #:_______________

________**initials** **CONSENT FOR COMMUNICATION VIA ELECTRONIC MAIL**
I have read and agree to the Northpoint Pediatric consent for communication via electronic mail.

Email address (personal email address only)____

Email address (personal email address only) ____

________**initials** **CONSENT FOR MEDICAL TREATMENT OF A MINOR**

I (we) the undersigned legal parent(s) or guardians of stated child(ren), a minor(s), do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of any Northpoint Pediatric Physician or Nurse Practitioner, a duly licensed physician or nurse practitioner, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, recommended treatment or recommended medical care being required but is given to provide authority and power to render care, which the aforementioned physician or nurse practitioner in the exercise of his or her best judgment may deem advisable.

Restrictions: ____

________**initials** **NORTHPOINT PEDIATRICS' FINANCIAL AGREEMENT**
I have received, read and agree to adhere to the Northpoint Pediatrics' Financial Responsibility Agreement.

________**initials** **FAILED/CANCELLED APPOINTMENT POLICY**
I have received, read, and agree to adhere to the Northpoint Pediatrics' Failed/Cancelled Appointment Policy

________**initials** **INSURANCE PLANS AND COVERAGE**
I understand and agree that it is my responsibility to confirm with my insurance carrier that the provider my children are seeing and the services that my children are receiving are covered under my policy.

________**initials** **CHECK-IN/CHECK-OUT PROCEDURES**
I understand that I will be asked to provide proof of insurance at each appointment that my child has. I agree to pay any necessary copays at check-in and deductibles at check out.

________**initials** **WELL CHILD/PREVENTATIVE VISITS/ILL EXAMS**
I understand that during the course of being seen for a wellness/preventative visit that if an acute illness, problem, or pre-existing condition is addressed/treated, that these services will be coded in accordance to the American Medical Associations coding and documentation guidelines and billed in addition to the wellness exam. This may result in additional out of pocket expenses. I understand that charges are not bundled and separately billed out such as but not exclusive to (hearing test, vision screen, blood draws, immunizations, urine screens, strep screens, and developmental paperwork MCHAT/ASQ).

________**initials** **NORTHPOINT PEDIATRICS' NOTICE OF PRIVACY PRACTICE**
I have been provided a copy of the Northpoint Pediatrics' Notice of Privacy Practices to review and a copy made available to take if requested.
A copy of the Notice of Privacy Practice may be printed from our website.

Legal Parent / Legal Guardian Signature: X____

Printed Name: ____

Relationship to Child: ____________________________________**Today's Date:** ________________________________

****Office Use Only – Form entered by** _____________________ **Date entered** ___________________

Louise Tetrick, MD, FAAP
Cathy Wagner, MD, FAAP
Marsha Norris, MD, FAAP
Scott Curnow, MD, FAAP
Victor Nanagas, MD, FAAP
Liz Moore, MD, FAAP
Vicki Roe, MD, FAAP
John Champley, MD, FAAP
Kara Gurchiek, MD, FAAP
Chrissy Adams, MD, FAAP
Stephanie Booms, MD, FAAP

Northpoint
PEDIATRICS

Community Health
Pavilion
9669 E 146th Street, #300
Noblesville, Indiana 46060

Community Hospital
North Campus
8101 Clearvista, Pkwy, #185
Indianapolis, Indiana 46256

(317) 621-9000 Phone
(317) 621-9190 Fax

Consent for Communication via Electronic Mail.

I give my consent for Northpoint Pediatrics business office staff to communicate with me via email in regard to my child(ren).

By providing this email address the providers and staff at Northpoint Pediatrics will assume that they are communicating ONLY with the legal parent or legal guardian of the patient named above. Once the information to be communicated is sent to the above email address, the legal parent/legal guardian of the patient will be responsible for maintaining the security of the information. The legal parent/legal guardian must recognize that the information transmitted cannot be considered secure and that there is some risk to the patient that their personal protected health information may be accessed by others.

Email questions will be answered within 48 hours.

All questions regarding the care and health of your child should be directed to your primary care doctor by calling 317-621.9000.

Northpoint Pediatrics does not provide any medical advice or treatment via e-mail

Louise Tetrick, MD, FAAP
Cathy Wagner, MD, FAAP
Marsha Norris, MD, FAAP
Scott Curnow, MD, FAAP
Victor Nanagas, MD, FAAP
Liz Moore, MD, FAAP
Vicki Roe, MD, FAAP
John Champley, MD, FAAP
Kara Gurchiek, MD, FAAP
Chrissy Adams, MD, FAAP
Stephanie Booms, MD, FAAP

Community Health
Pavilion
9669 E 146th Street, #300
Noblesville, Indiana 46060

Community Hospital
North Campus
8101 Clearvista, Pkwy, #185
Indianapolis, Indiana 46256

(317) 621-9000 Phone
(317) 621-9190 Fax

Northpoint Pediatrics' Financial Agreement

Financial Agreement

In order to obtain reimbursement for services provided to my child by Northpoint Pediatrics, I authorize disclosure of my child's record for treatment, payment, and healthcare operations.

If my primary care physician is a participating provider in my insurance plan, I hereby assign medical benefits due be paid directly to Northpoint Pediatrics.

"I/we hereby designate Northpoint Pediatrics and its employees as my/our representative to file grievances and to represent me/us in accordance with the Indiana Code, Title 27, Chapters 8 and 13."

I understand that I am financially responsible for any unpaid balances for services if I fail to provide complete and current insurance information within 60 days of the date services are provided. If no Secondary Insurance information is provided, I attest and affirm that I have no other insurance other than that listed as Primary Insurance.

I understand that if my child's account becomes delinquent it will be assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection and my family will be asked to seek medical care elsewhere.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Routine Care

We follow The American Academy of Pediatrics schedule of visits for routine well child care (see the schedule on the web at aap.org under preventive schedule). This schedule *may not* be the same as the one your insurance company follows.

Additional services (listed below) are separate charges from the wellness exam and have separate fees. This is not an exclusive list of charges and other charges may apply. Many insurance plans require that their members use the specialists, laboratories and outpatient facilities that they have special contracts with. Please be familiar with your policy and advise us where we should direct you for any additional tests, screening or procedures if your insurance does not permit them to be performed in the office setting.

- **Vision Screens**
- **Hearing Screens**
- **Urinalysis**
- **Developmental Screenings (ASQ, MCHAT)**
- **Lead Screenings**
- **Immunizations**

Please be aware that a physician may bill an office visit (99202-99205, 99212-99215) in addition to a previously scheduled preventative visit. Per CPT coding rules the well child visit code applies only to preventative medical care but does not include any issues related to chronic diseases or acute illness. Insurance companies process these claims according to their policy guidelines and the patient may have a balance due for the unrelated office visit.

Coding and Documentation Guidelines

*Northpoint Pediatrics physicians follow the **AMA CODING AND DOCUMENTATION GUIDELINES**. If your child comes in for a well child visit, but in the course of this routine visit "an abnormality/ies is encountered or a preexisting problem is addressed" the appropriate office/outpatient problem-oriented evaluation and management, E/M service will be coded in addition to the preventive code; which may result in additional charges. Examples of this would be patients with asthma and ADD/ADHD coming in for a well child exam.*

Lab Work

Please be familiar with your insurance policy and advise us where we should direct you for lab work if your insurance does not permit them to be performed at Mid America Clinical Laboratories. (MACL)

Newborn Hospital Charges

Newborn charges are put to patient responsibility until the baby has been added to the plan. We will file hospital charges to your insurance company after you have provided proof of insurance coverage. It is the parent's responsibility to contact our office once the baby is added to the policy so we may submit the charges to the correct insurance. If the parent fails to contact the office within insurance filing limits, the charges will remain patient responsibility.

Newborn Coverage is NOT automatic! *Most insurance plans only allow 30 days after the baby's birth to add your newborn to the policy. Please call your benefits department or your insurance company to add your baby to the policy.*

Insurance and Payments

Payment in full is expected at time of service if we do not have a contract agreement with your insurance company and we are considered out of network providers.

Co-payments and/or any non-covered service amounts are due at the time of service regardless of who brings the child to the appointment. There is an additional $10 processing fee if co-payments are not paid on the day the service is provided.

- ***Deductibles: If your deductible has not been met we will ask for payment of 50% of the total charge of the visit at the time of service.***
- ***Filing Claims****: We file claims on all services provided by Northpoint providers.*
- ***Balance****: We will take applicable contracted discounts after receiving payment response from your insurance company. The remaining balance on your child's account will be billed to you.*
- ***Network Discounts:*** *According to the contract Northpoint Pediatrics has with your insurance company – network discounts MAY NOT apply to non-covered services. This includes calendar year routine benefits that are exhausted.*
- ***Finance Charges****: Finance charges are added to the balance when it is 30 days past due.*
- ***Payment Plans:*** *We recognize that there are times when you cannot pay your balance in full within the 30-day period. We offer payment arrangements for special circumstances. Please contact our Patient Accounts department at (317) 621-9183 to set up a payment plan contract.*
- ***Past Due Balances and Bankruptcy filing:*** *If your account balance ages 90 days (3 months) past the due date (and is not on a payment plan) - your doctor will request that your family seek medical care elsewhere.*

***ER/Urgent Care Facility* Services**

Please notify your insurance company and primary care doctor prior to seeking medical care from an ER, Medcheck or Urgent Care facility if possible. If care is sought out in a life threatening or emergent situation, please contact Northpoint Pediatrics within 24 hours so that we may obtain authorization for your visit. Most insurance company agreements require pre-authorization for using emergency services for non life-threatening conditions. Please notify our Patient Account office within 24 hours if you visit an urgent care facility or ER.

My signature on the signature sheet confirms that I have read this policy and agree to be held financially responsible for all charges on my child's account.

Louise Tetrick, MD, FAAP
Cathy Wagner, MD, FAAP
Marsha Norris, MD, FAAP
Scott Curnow, MD, FAAP
Victor Nanagas, MD, FAAP
Liz Moore, MD, FAAP
Vicki Roe, MD, FAAP
John Champley, MD, FAAP
Kara Gurchiek, MD, FAAP
Chrissy Adams, MD, FAAP
Stephanie Booms, MD, FAAP

Northpoint
PEDIATRICS

Community Health
Pavilion
9669 E 146th Street, #300
Noblesville, Indiana 46060

Community Hospital
North Campus
8101 Clearvista, Pkwy, #185
Indianapolis, Indiana 46256

(317) 621-9000 Phone
(317) 621-9190 Fax

Failed and Canceled Appointment Policy

The failed appointment and cancellation policy was written by the Northpoint physicians and reads as follows:

Missed appointments are a loss to everyone, please cancel ill and checkup appointments within the time frame listed below, or a charge may be assessed.

CANCELLING ILL APPTS: Please cancel at least 2 hours before your appointment.

CANCELLING CHECK-UP APPTS: Please cancel by 4:30 p.m. the day before your appointment. *Monday appointments must be cancelled by 3:30 p.m. on Friday.*

CHARGES FOR CANCELLATION WITHOUT SUFFICIENT NOTICE AND FAILED APPOINTMENTS

$0………..*First missed appointment or cancellation with insufficient notice.

$50………*Second missed appointment or cancellation with insufficient notice.

$100……..*Third missed appointment or cancellation with insufficient notice.

$100……..*Subsequent missed appointments or cancellations with insufficient notice.

*Missed appointments or cancellations without sufficient notice are counted per family, not per child.

Please NOTE: If account is not paid within 30 days, your account will be subject to collection proceedings and your family will be requested to seek medical care elsewhere.

My signature on the signature sheet confirms that I have read this policy and agree to be held financially responsible for all charges on my child's account.

Notice of Privacy Practices **Form 7.20**

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

____

We will not retaliate against you for filing a complaint.

Effective Date 04/01/2017 Publication Date 04/01/2017