Infant Acid Reflux Solutions
New Patient Forms

Dr. Jennifer Prince Pediatrician   Jeffrey Phillips Pharm D.

Welcome to Infant Acid Reflux Solutions! Thank you for choosing us to provide your child's medical care. We take helping your family seriously and will do everything we can to get your baby healthy, smiling and happy.

A "Patient Information form" is needed for every patient. Please notify us of any change in information. One appointment per child is necessary. For medical emergencies contact 911, go to your nearest emergency room, or contact your local primary care doctor.

Date:________________ Primary Spoken Language: ______________________

CHILD: ____
Last, First, MI

ADDRESS:

____
Street/City/Zip

Date of Childs Birth _______________ Childs Current Weight ____________Gender: M/F

List of current medications	Dose	# per day

____
List of any allergies

What is your out come for this appointment? _____________________________________

____

PHONE: (   ) ____________________________ (Circle one) Cell or Home

IN CASE OF AN EMERGENCY CONTACT: Please include name & phone number: (Other than parent)

____

____
Parent's Signature & Date

PAYMENT and REFUND POLICY

All services are pre-paid:

INSURANCE: Because this service is a pre-paid service we do not require any insurance information.

We can assist you in getting reimbursed if policy coverage allows. You can submit the following CPT codes to your insurance company for reimbursements. Sometimes adding the modifier **GT** to the end of the code helps get reimbursement.

CPT CODE	99204	99214	99244	99245
PHYSICAL EXAM	First Time	Follow Up	Specialist First Time	Specialist Follow Up

Or these specialty provided services CPT codes. Again, Sometimes adding the modifier **GT** to the end of the code helps get reimbursement.

CPT CODE	99212	99213	99214	99215
PHYSICAL EXAM	Problem-focused	Expanded Problem Focused	Detailed	Comprehensive

If you do not get your CPT code during or after the consultation, please email us info@infantacidrefluxsolutions.com

There are NO REFUNDS FOR MISSED APPOINTMENTS. Please contact us at least 4 hours in advance to cancel for full refund or to reschedule. Any appointments missed without 4 hours prior notification the full payment for appointment is forfeited.

By signing this agreement (required for consultation) **you are agreeing to this term for service.**

____

Parent's Signature & Date

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

·Your protected health information is accessed and used for healthcare related purposes only.

·Your protected health information is never sold, rented, transferred, exchanged, and/or used for non- healthcare related purposes including marketing activities without your written authorization.

·Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations. **Certain Circumstances** Your protected health information can be disclosed without your written authorization in certain limited circumstances,

·Medical emergencies

·In situations required by law

·Individuals involved in your care

·When requested by public health agency

·When requested by a law enforcement agency For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorizations before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time. **Patient Rights**

·You have the right to request in writing to inspect and/or receive a copy of your health information. *

·You have the right to request an alternate means of location to receive communications regarding your health information. *

·You have the right to request in writing to amend, correct, or delete

any recorded health information within our possession. *

·You have the right to request in writing to restrict some of the uses and disclosures of your health information. *

·You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

** * Conditions and limitations may apply; obtain additional information from the Infant Acid Reflux Solutions Team.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

Acknowledgment of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

____

Name of Patient

____

Name of Parent or Legal Guardian

If the patient is a minor, a parent of legal guardian must sign.

____

(Parent or legal Guardian), acknowledge that I have received a copy of the Notice of Privacy Practices.

____

Signature of Parent or Legal Guardian and Date

____

Relationship to Patient

REQUEST FOR RECORDS RELEASE OF MEDICAL RECORDS AUTHORIZATION (only to be filled out if you would like the medical records forwarded).

I hereby authorize:

___________________________________ Physician's Name (Print)

___________________________________ Address

____

City/State/Zip

____

Phone Number

to release medical records, including immunizations, concerning:

______________________________________ Patient's Name (Print)

To:
Infant Acid Reflux Solutions
6709 W 119th St
Overland Park, KS
66208
(954) 309-0120
www.infantacidrefluxsolutions.com

Dr. Jennifer Prince
Jeffrey Phillips Pharm D.

By signing this authorization I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

____
SIGNATURE DATE

____

Printed Name & Relationship to Patient