WingHaven Pediatrics
5551 Winghaven Blvd.
Suite 240
Ofallon MO 63366
PH. 636-561-5561 Fax 636-561-5557

Ardis Allison, D.O.   Alison Oswald, M.D.   Jennifer Panasci, M.D.
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Welcome,

We are so happy you have joined the Winghaven Pediatrics Family!

We look forward to meeting you and caring for your child(ren). To assist us in serving you most efficiently please do the following:

Complete the included forms in this packet (print and scan) then return **prior** to your appointment.
(The forms may be returned via the email you received them from or by fax to 636-561-5557 or mail to the address above)

The following forms must be returned prior to your appointment:

1. New Patient Form
2. Family History Questionnaire
3. Automatic Payment form (accept or decline)
4. E- billing Authorization form (accept or decline)
5. Signature form indicating you've read our practice policies and HIPPA Privacy Policy (You may keep the policies for your records).

Please arrive at the stated arrival time for your appointment which may be 15-30 mins prior to your scheduled time with the physician depending on the type of appointment.

Save time at check-in!! Include a photo of the front and back of your insurance card and one parent's photo ID when you return your forms.

Need to cancel or reschedule? Please call 636-561-5561 at least 24 hours prior to your scheduled appointment.

Thank you,

Winghaven Pediatrics, LLC

Winghaven Pediatrices New Patient Form

Patient First and Last Name
Patient Date of Birth
Sex Male Female
Patient Address
Patient Cell Phone if 16years of age or older
Primary Insurance (BCBS/UHC etc.)
Primary Insurance ID
Primary Insurance Group
Primary Insurance Claims Address
Primary Insurance Policy Holder Name
Policy Holder Date of Birth
Is the Policy Holder also the Financial Responsible Party for this Patient? Yes or No
If No – Print Name of Responsible Party
Date of Birth of Responsible party (if other than policy holder)
Does the Responsible Party live at same address as patient? Y or N If no please include address for Responsible party

Winghaven Pediatrices New Patient Form

Mother Cell phone
Mother Work Phone
Mother's employer
Mothers Date of Birth
Father's Cell Phone
Father's Work Phone
Father's Employer
Best # to send appointment reminders to
Preferred Pharmacy Phone #
Do you have secondary insurance?

Family History Questionnaire

Patient Name: ______________________________ **Date:** ____________

Family History

Does, or did anyone in your families (you, your children, parents, grandparents, siblings, aunt, or uncle), or any children from other marriages have, or died from:

	AIDS/HIV or other immune deficiency disease		High cholesterol, triglycerides, lipids
	Alcoholism		Intestinal problems, ulcer, colitis
	Allergies, asthma, hay fever		Kidney disease (stone etc.)
	Anemia, blood problems		Liver disease (hepatitis etc.)
	Arthritis, (lupus, juvenile arthritis, gout, etc.)		Lung disease, cystic fibrosis, tuberculosis
	Babies with SIDS, congenital heart disease		Migraine or severe headaches
	Bleeding problems		Muscle or nerve disease
	Cancer or leukemia		Psychiatric illness
	Celiac disease		Scoliosis, bone problems
	Diabetes (less than age 30)		Seizures, convulsions, retardation
	Genetic problems (Tay Sachs, Down's, etc.)		Skin disease (psoriasis, eczema, etc.)
	Hearing/Vision problems (other than glasses)		Testicular, ovarian or uterine problems
	Heart attack or stroke (less than age 60)		Hip dysplasia:
	High Blood Pressure (Hypertension)		Other illness:

Does anyone smoke in the house? Yes ☐ No ☐ Who?____________________

Authorization Form for Automatic Payments

By signing below you authorize Winghaven Pediatrics to process payments for balances incurred after insurance processing for services provided to your family. An emailed receipt will be sent to you when payments are processed.

Date: ________________ Account Number(s) (office use) ______________________

Name: ____

Address: _________________________City______________ State____ Zip__________

Email: ____

______________________/________________________/______________________
Credit/debit card # **Name on card** **Expiration Date**

OR

______________________/________________________/______________________
Name on Checking Acct. **Routing #** **Account #**

Please read and sign below:

By signing below I am authorizing WingHaven Pediatrics to automatically withdraw my account balance anytime a new balance is incurred from my credit card/checking account above.

Signature: _______________________________________ Date: _____________________

If you prefer not to participate please check below and sign to indicate that you understand by not providing this information we will mail/email a statement to you after your insurance processes your claim. If we do not receive your payment within 30 days of the statement you will be charged an additional $10.00 for every 30 days past due. After we have sent 4 statements we will begin the process of collection on your account.

___ I (print name) ____________________________ decline the option to have payments for

balances processed automatically. (Signed) _____________________________Date: _________

WingHaven Pediatrics

Ardis Allison, D.O. Alison Oswald, M.D. Jennifer Panasci, M.D. Abby Kushnir, M.D. Lori Payne, PNP

E- Billing Authorization Form

As an e-billing customer, you will no longer receive a paper bill in the mail. Instead, you will receive electronic notification by e-mail when you have a bill due. The e-mail notification will provide you with a link to view and pay your bill on our secure payment website. *(If you are not interested, in this time and money saving service please check the box at the end of the page. Thanks.)*

Parent First Name: ____________________________ Parent Last Name:________________________

Please list all children in your family that are patients at Winghaven Pediatrics.

Children:____

E-mail address: ____(only one please)

Signature: ____ Date: ______________________

___ DECLINE E-Billing

___ Please contact me about keeping a credit card/Hsa card on file for future payments.

WingHaven Pediatrics

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Patient Name: ___________________________ Patient D.O.B. ___________

I have been provided the following information and by signing below agree that I understand each one of the following items I have checked.

__ HIPPA

__ Missed Appointment Policy

__ Permission for Treatment

__ Financial Policy

__ Sick Vs. Well appointments

Patient/Responsible Party/Guardian Signature ______________________________ Date _____________

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary 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 our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

WingHaven Pediatrics Practice Agreements

Please read all of the agreements below and initial on your sign in sheet that you have read and agree to them. If you would like a copy of any of these policies they are available on request.

PERMISSION TO TREAT

As the parent/guardian of the child specified, I give WingHaven Pediatrics, LLC permission to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctors prefer to have a parent present to obtain a medical history, and to give permission for treatment or vaccinations.

WingHaven Pediatrics Financial Policy:

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your child's visit.

All co-payments are due at the time of service. These fees cannot be waived. All co-pays not collected at the time of service will incur a $10.00 billing fee. Please be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services. For your convenience we accept cash, check, debit card, MasterCard / Visa, and Discover.

If we are a participating provider, we will file your insurance for each visit. Should there be a dispute with your insurance company, our billing department will attempt to resolve it for you. During this time, the balance may be transferred to patient responsibility. Please note that your insurance policy is a contract between you and your insurance company, therefore, your balance is your responsibility.

Payment plans must be set up for balances that cannot be paid in full. We ask that the balance be paid within 6 months. Failure to resolve any past due accounts, including returned checks will result in referral to a collection agency. Any family whose account is forwarded to a collection agency will be dismissed from our practice.

Secondary Insurance - As a courtesy to you, WingHaven Pediatrics will file your secondary insurance. This is done after payment is received from your primary insurance. WingHaven Pediatrics policy is to file the secondary insurance one time. **If payment has not been received from your carrier within 60 days, the balance becomes immediately due and payable by the patient.**

Patient Statements – WingHaven Pediatrics sends statements to patients on a monthly basis. Payment in full is due upon receipt. Regular payments help keep our costs and your charges down. **If you are unable to pay in full, please contact our office to make payment plan arrangements. If payment is not received within 30 days and our office is not contacted a $10.00 rebilling fee will be added to each statement.**

WingHaven Pediatrics accepts payment by check, Mastercard / Visa and Discover.

Questions/Concerns - Your insurance plan is indicated on your statement. To help us process your claims more efficiently, please call our office with any discrepancies or changes.

Please contact our billing office at (636) 561-5561 regarding any additional billing questions or concerns.

Well vs. Sick Appointments

- All physicians/providers must report services using a variety of codes to tell the insurance company what was done and why.
- It is not uncommon for patients in the course of a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventative services at the same visit.
- Both services must be reported to the insurance company and may result in an additional co-payment or charges as per the insurer's plan rules, which we are obligated to follow.
- If you have questions, please check with your insurance plan

What is covered during a Well Appointment?

- Checking height, weight, BMI and blood pressure
- Reviewing medical and family history
- Confirm your other care providers
- Review your preventative care needs
- Order recommended preventative labs and/or imaging
- Review and administer immunizations

What is NOT covered during a well appointment?

- Evaluation and treatment of new health issues/concerns (ie; pain, ear issues, etc.)
- Management of existing health issues (ie; ADD/Asthma, etc.)
- Ordering lab tests or imaging for new conditions or illnesses
- Prescribing, refilling or adjusting medications for existing health issues

Missed Appointment Policy:

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments and by notifying us at least 24 hours in advance when possible if you are unable to do so. When you give us advance notice we are able to accommodate other patients.

Cancellations require a 24 hour notice.

- First missed appointment – Parents will receive a phone call informing them of their child's missed appointment.
- Second missed appointment – Parents will receive a letter informing them that they have now missed two appointments and they will be charged a $40.00 fee. Insurance will not pay for this charge. Insurance will not cover this.
- Third missed appointment - Parents will be charged an $80.00 missed appointment fee. Further missed appointments may result in dismissal from our practice.

Parents bringing in two or more children at the same time will be restricted from scheduling a double or triple well appointment after missing two such appointments for multiple children.

Thank you for your courtesy.