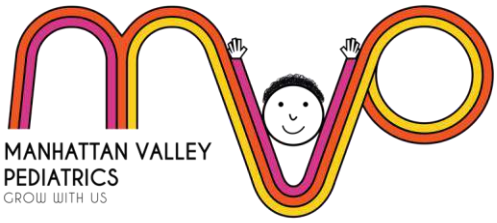

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname: _____ D.O.B.: _____ Sex: _____

_____

(Home Street Address) (Apt) (City) (State & Zip)

Home Phone: _____Cell Phone: _____ Email Address: _____

Parent/Contact 1: Name: _____ Relation to Patient: _____

Date of Birth: _____ Lives with patient? ☐ Yes ☐ No, _____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Parent/Contact 2: Name: _____ Relation to Patient: _____

Date of Birth: _____ Lives with patient? ☐ Yes ☐ No, _____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Primary Policy: Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Insurance Carrier: _____ Insurance Address: _____

Member ID # _____ Category/Group # _____

Co-Pay Amount $: _____ Policy Effective Date: _____

Emergency Contact:

Name & Relationship: _____/_____ Phone: _____

Pharmacy Information:

Name: _____ Address: _____ Phone: _____

This information that I have given is correct and true to the best of my knowledge. Understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of Patient or Parent/Legal Representative **Date**

Manhattan Valley Pediatrics Office Policies

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms by initialing each section.

TREATMENT FORMAT, FEES & PRACTICE POLICIES

☐ I understand that all outstanding payments are required at the time services are rendered. This includes applicable co-insurance, co-pays and deductibles as outlined by my insurance carrier.

☐ I understand that MVP may recommend certain visits such as the two week and three-month visits to assess growth and development which may **not** be considered well visits by my insurance carrier and as such may incur a co-payment, deductible or co-insurance for which I am responsible for.

☐ I understand that TeleHealth visits are subject to the same rules as all other visits including co-payments.

☐ I understand that my co-payment is expected at the time of my visit before my appointment.

☐ I understand that I will be charged a $50 fee if I fail to show for my well-visit.

☐ I understand that MVP reserves the right to cancel a well visit for which I am more than 10 minutes late.

☐ I understand there is a charge of $10 dollars for all school, camp and sports forms to be completed within 7 days forms that are not requested at the time of my child's well visit.

☐ I understand there is a charge $25 for expedited forms to be completed within 48 hrs.

☐ I understand that I need to sign up for the patient portal as a way to communicate non-urgent needs, access forms, and view lab work.

☐ I have read and agree to MVP's vaccine policy as outlined on our website www.manhattanvalleypediatrics.com

I understand and authorize MVP to release any information necessary to my insurance carrier regarding my child's condition or reason for visit to process insurance claims.

[redacted] _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

MANHATTAN VALLEY
PEDIATRICS
GROW WITH US

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers Change as of April 1, 2021

As of April 1st 2021, certain insurance carriers have discontinued in the cost sharing for Covid-19 diagnostic tests for routine testing such as: back to school, stay in school, participation in sports, participation in camps and routine travel.

This means you will be required to pay the entire allowed amount for the services specified in the regulation, including your copayment, coinsurance, and annual deductible.

To obtain carrier specific information please contact your insurance carrier prior to your appointment.

I have read and understand this policy and agree to accept responsibility for any payment that becomes due as outlined above.

Guarantor Name:

Patient Name:

Signature:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Copies are available on our website and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the **Notice of Privacy Practices**. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment
I acknowledge that Manhattan Valley Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed and how I can access this information.

I understand that if I have questions or complaints I may contact: Manhattan Valley Pediatrics at 917-921-6219. I also understand that I am entitled to receive updates upon request if MVP amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

For OFFICE USE ONLY
I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
☐ Patient declined to sign this Written Acknowledgment.
☐ Other (Specify):

_____

_____

_____ _____
Name and Title of Employee Date