Central Avenue Pediatrics

affiliated with Children's & Women's Physicians of Westchester, LLP

CWPW REGISTRATION

PATIENT NAME: _____ MED REC NUMBER: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

RESPONSIBLE PARTY/GUARDIAN:

NAME: _____ RELATIONSHIP: _____ PHONE NUMBERS

MAILING ADDRESS: _____ HOME #: _____

_____ CELL #: _____

PARENT/GUARANTOR: FATHER'S NAME: _____ GUARANTOR PHONE #: _____

MOTHER'S NAME: _____

GUARANTOR ADDRESS: _____ EMPLOYER NAME: _____

_____ ADDRESS: _____

EMERGENCY CONTACT INFO:

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INS NAME AND ADDRESS: ID#{ _____ GROUP #:_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

PRIM INS TEL #: _____

SECONDARY INS NAME & ADDRESS: ID#_____ GROUP#_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

PHARMACY INFORMATION:

PHARMACY NAME: _____ PHARMACY ADDRESS: _____

PHARMACY PHONE#: _____ _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize CWPW to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits by made either to me or on my behalf to CWPW for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

Signature of Parent/Guardian: _____ Date: _____

Children's & Women's Physicians of Westchester, LLP
E-Mail Communication Patient Consent

Dear _____ :

E-mail offers an easy and convenient way to communicate but it is not the same as calling your physician's office. You can't tell when your message will be read or responded to, or even if your doctor is readily available or on vacation. Children's and Women's Physicians of Westchester LLP ("CWPW") will communicate with our patients (or their parents or guardians) by email only if we receive your agreement to the terms set forth in this Consent. Your consent to these terms will apply to all CWPW clinical providers as well as non-clinical personnel of CWPW who are involved in your care, scheduling, billing and other activities.

- **Use of email is never appropriate for urgent or emergency health problems!** You must call your physician's office or go to a hospital Emergency Department.
- **CWPW WILL NOT ENGAGE IN OR RESPOND TO TEXT MESSAGING BY USE OF A CELL PHONE OR SIMILAR MOBILE DEVICE**
- E-mail is not to be used as a substitute for face-to-face consultation with your physician and is at your physician's sole discretion.
- E-mail is appropriate for communicating regarding routine matters that don't require a lot of discussion, such as prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. CWPW may utilize e-mail it its discretion to send you information about our practice and services, including appointment reminders, our patient programs and new services.
- Your use of e-mail is not confidential and it may not be encrypted. It is like sending a postcard through the amil. Our staff (clinical and non-clinical) may read your e-mails in the course of their work duties. If you send e-mails through a work e-mail account, your employer may have the legal right to read your e-mail.
- E-mail should never be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
- E-mail may become part of the medical record when it contains clinical information, and we believe it is appropriate to include it in the medical record. In such case, the message may be retained in the patient health record.
- By signing below, you represent to CWPW that (a) you are the patient or parent or guardian **of the minor child or person lacking capacity to consent to their treatment** listed below; (b)you are an authorized user of the listed e-mail account; (c) you have the authority to consent to our use of the account for communications concerning the patient; and (d) you accept full responsibility for monitoring the security of use of the email account on your end. You agree that CWPW will have no responsibility to use any measure to verify that the recipient or sender utilizing your email address is you.
- Either party can revoke permission to use the e-mail system at any time in writing.
- This email agreement ONLY covers the individual signing below. Each authorized representative of the patient must sign his own email Consent.

I wish to communicate by e-mail with CWPW concerning the patient listed below upon the term of this Consent.

Patient name_____

Patient or Guardian's signature _____ Date: _____

Your E-mail Address: _____ Your state of residence: _____

Children's & Women's Physicians of Westchester, LLP

PATIENT FINANCIAL POLICY

Thank you for choosing Children's & Women's Physicians of Westchester, LLP as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments
We are required to collect your co-payment at the time of the visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. CWPW accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

No Show/Late Cancel Policy
A $25 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to the late cancel period. Please consult with your physician's office for specific information about the late cancel period.

Insurance
We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

Participating plans
CWPW participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductible or non-covered services not paid by your insurance.

Non-Participating Plans
If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

Referrals
If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made by the office manager prior to the visit.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Children's & Women's Physicians of Westchester, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to applicable co-pay charge.

I authorize CWPW to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to CWPW for any services rendered.

_____ _____

Name of Patient | Date of Birth

_____ _____

Signature of Parent or Authorized Person | Print name of Parent or Authorized Person

_____

Date

Children's & Women's Physicians of Westchester, LLP

DEMOGRAPHIC INFORMATION REQUEST

We are required by law to ask patients for the demographic information listed below. ***However, you are not required to disclose this information to us***. If you do not choose to provide the information, we will keep your identity confidential.

1. Which category best describes the patient's ethnicity?
    - ❑ Hispanic or Latino origin
    - ❑ Not Hispanic or Latino origin
2. Which category best represents the patient's race?
    - ❑ American Indian/Alaskan native
    - ❑ Asian
    - ❑ Native Hawaiian or Other Pacific Islander
    - ❑ Black or African-American
    - ❑ White/Caucasian
    - ❑ Other
3. [ ] I do not wish to provide this information

Thank you for your time.