Developmental Pediatrics of Central Jersey
804 West Park Avenue, Building C
Ocean Township, NJ 07712
(732) 660-0220

Date: _____

PATIENT INFORMATION:

Name: _____
(Last) (First) (M.I.)
Date of Birth: _____ Sex: _____ Race: _____
Address: _____
City: _____ State: _____ Zip: _____

Primary Contact Phones:
Cell: _____
Home: _____
Work (optional): _____

Secure Email Address: _____

Permission for Voicemail messages containing medical information (not including scheduling): You will receive appointment reminders/confirmations via email, telephone, and text message.

☐ Yes, I give permission for medical information to be left in voicemail.
☐ No, I do not want messages or medical information left in voicemail.

EMERGENCY CONTACT INFORMATION: (if we are unable to reach you)

Name: _____
(Last) (First) (M.I)
Relationship: _____ Phone: _____

Additionally, the following person(s) have permission to **transport the patient, pick up medical documents (including prescriptions) and to provide information in my absence:**

Name: _____ Relationship: _____
Name: _____ Relationship: _____

MEDICAL INFORMATION:
Primary Physician/Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

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PREFERRED PHARMACY: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

REFERRAL: Were you referred to Developmental Pediatrics of Central Jersey? If so, by whom:

Name/Organization: _____

Address: _____

☐Therapist ☐Friend ☐Physician ☐Teacher/School

Current Medications

NAME	**DOSE**	**START DATE**

Allergies

Medications _____

Food / Other _____

Reason for today's visit:

_____

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, check **twice** for major symptoms)

☐☐Depressed mood
☐☐Unable to enjoy activities
☐☐Sleep Pattern Disturbance
☐☐Loss of Interest
☐☐ Concentration/Forgetfulness
☐☐Change in Appetite
☐☐Excessive Guilt
☐☐Fatigue
☐☐Racing Thoughts
☐☐Impulsivity
☐☐Increased Risky Behavior
☐☐Increased Libido
☐☐Decreased need for Sleep
☐☐Excessive Energy
☐☐Increased Irritability
☐☐Crying Spells
☐☐Excessive Worry
☐☐Anxiety Attacks
☐☐Avoidance
☐☐Hallucinations
☐☐Suspiciousness
Other_____
_____
_____

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PATIENT BILL OF RIGHTS

Welcome to our office. Please be advised that we are legally obligated to provide you with this list of your rights. Please read the following carefully. Feel free to ask questions if there is something you do not fully understand. After you have fully read this list of rights, please acknowledge that we have provided you with this important information by signing below.

IT IS OUR LEGAL DUTY and OBLIGATION TO…

- Treat you with consideration and respect in a safe setting free from all forms of abuse and harassment. Your privacy will be protected.
- Keep all communications and records about your care confidential. In general, you have the right to see all the information in your health records.
- Provide clearly written and spoken information in words you can understand.
- Provide all the information you need to make an informed decision about your care including information about your options, risks and benefits, possible outcomes, possible side effects, who is providing your care and all possible costs.
- Respect your decision to refuse care. To allow you to leave the office even if the physician advises against it.
- Provide you with the freedom from restraints and seclusion of any form that is not medically necessary.
- Provide you with all available information about possible research participation and obtain your informed consent.
- Give you the opportunity to examine and receive an explanation of your bill regardless of source of payment.
- Allow you to express a concern or complaint and receive a prompt response. You also have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.

I have read and fully understand this Patient Bill of Rights.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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CONSENT FOR TREATMENT

Developmental Pediatrics of Central Jersey (DPCJ) is authorized to initiate Evaluative/Diagnostic/Therapeutic procedures on the above-named patient to clarify issues pertinent to the health, development, or adjustment of the patient.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

FINANCIAL POLICY

I understand that Developmental Pediatrics of Central Jersey is a fee-for-service practice and does not accept insurance payment. All payments are made by cash, check, or charge **for the full amount at the time of service.** DPCJ will provide an itemized statement for the patient/family to submit to an insurance company for reimbursement, should you choose to do so.

I have read and understand the above stated policy.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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APPOINTMENT CONFIRMATION AND CANCELLATION POLICY

I understand that when I schedule an appointment at Developmental Pediatrics of Central Jersey (DPCJ) this time is reserved for my child only. Appointment times may be blocked for up to 2 hours. DPCJ sends reminder calls, emails, and texts staring approximately one week prior to the appointment. **If I do not confirm my appointment, DPCJ reserves the right to release my appointment to another patient.**

At least 24 hours advance notice is required to cancel my appointment for any reason. DPCJ understands that illness is unpredictable. **If no prior notification is received (no-show) I may be charged the full fee.** If I cancel an appointment with less than 24 hours' notice, I will be billed 50% for that appointment.

Per best medical practices, **prescriptions will not be written** for patients who have not been seen in the 6 months prior to the request. Consider when if you have to cancel an appointment, and be sure to re-schedule as quickly as possible.

I have read and understand the above stated policy.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health and Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information.

I acknowledge that I have received and read the Notice of Privacy Practices. I understand that DPCJ has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Developmental Pediatrics of Central Jersey is authorized to RELEASE records TO:

1. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

2. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

Developmental Pediatrics of Central Jersey is authorized to OBTAIN information FROM:

1. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

2. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

3. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (cont.)

The type of information to be disclosed:

☐ All Medical Information (Lab Results, X-Ray and/or other Diagnostic tests, Medications, Immunizations, etc.)

☐ Consultation Reports (medical, psychological and/or speech-language evaluation)

☐ Only Dates of Service: From _____/_____/_____ To _____/_____/_____

I understand that this information may include information relating to AIDs or HIV, treatment of drug or alcohol abuse, or mental / behavioral health / psychiatric care. This consent is valid indefinitely or until revoked in writing. I understand that authorization is voluntary and is not required to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rule.

I authorize the use or disclosure of the above-named individual's health information as discussed above.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian