CHILD'S NAME ______________________________ DOB ____________ M OR F

ADDRESS WHERE CHILD RESIDES

____

CITY/STATE/ZIP CODE ____

BEST CONTACT # ____________________ SECOND CONTACT # ____________________

PRIMARY EMAIL ADDRESS (USED TO CONFIRM APPOINTMENTS/PATIENT PORTAL)

____

REFERRED BY ____

PREFERRED PHARMACY NAME & LOCATION ________________________________

PARENT NAME ____________________________ DOB ____________________

ADDRESS (IF DIFFERENT FROM CHILD ____________________________________

BEST CONTACT # ____________________________ WORK # ____________________

PARENT NAME ____________________________ DOB ____________________

ADDRESS (IF DIFFERENT FROM CHILD) ____________________________________

BEST CONTACT # ____________________________ WORK# ____________________

Kathryn Baker, DO ~ Mary Fraga, MD ~ Marnie Frey, APRN
4141 Madison Ave-Trumbull, CT 06611
203-371-8790 F: 203-373-0463
cmaloney@bakerpediatrics.com

INSURANCE & BILLING INFORMATION
ANY COPAYMENTS ARE DUE AT TIIME OF SERVICE

PRIMARY POLICY HOLDER NAME ______________________________

INSURANCE COMPANY NAME______________________________

POLICY ID______________________

GROUP ______________________

RELATIONSHIP TO PATIENT______________________________

The parent or guarantor (insured member of household) is responsible for payment for services at the time they are rendered. Unfortunately, many of our families become involved in divorces/separations. We do our best to provide whatever support we can for the child and the family. However, divorce/separation does not eliminate the parents' financial responsibility for the child's medical care. It is our policy that the parent bringing the child to our office is responsible for payment at the time of the visit; regardless of which parent has the ultimate legal obligation to pay for medical care. It is the parents' sole responsibility to settle these financial matters between themselves.
PERMISSION IS GRANTED FOR BAKER PEDIATRICS, LLC TO RELEASE PERTINENT INFORMATION TO MY INSURANCE COMPANY IF REQUESTED.

PRINT NAME______________________________

SIGNATURE______________________________

DATE______________________

Kathryn Baker, DO ~ Mary Fraga, MD ~ Marnie Frey, APRN
4141 Madison Ave-Trumbull, CT 06611
203-371-8790 F: 203-373-0463
cmaloney@bakerpediatrics.com

Understanding Preventive Care

Thank you for choosing Baker Pediatrics for your child's healthcare. We wanted to provide some information regarding the annual Preventive Exams.

What is part of preventive care?

Preventive care means that you and your doctor work together to maintain your child's health and wellness. During your visit, your doctor will choose what tests, health screenings, and immunizations that are right for your child. The tests, screenings, and immunizations, depend on your child's age, sex and any history. Your health plan can provide what they cover during a preventive visit.

What is NOT part of preventive care?

New or current health problems are not considered preventative care, some examples are ear infections, eczema, stomach aches, allergies, acne and warts. If the doctor diagnoses or treats any new or current health concerns during a preventative visit, you may incur an additional office fee. You will be responsible for paying fees not covered by your health plan. We suggest you contact your plan to know what they will pay for, and we will reschedule the preventative exam for when your child is well.

If your child needs to come back for a follow-up or immunization, an office fee will be assessed.

As always, you can reach out with any questions or concerns.

We are dedicated in providing the best possible care for your child!

PRINT & SIGN____

DATE____________________________

Kathryn Baker, DO ~ Mary Fraga, MD ~ Marnie Frey, APRN
4141 Madison Ave-Trumbull, CT 06611
203-371-8790 F: 203-373-0463
cmaloney@bakerpediatrics.com

Billing & Fees

Failed (no-show) for office visit	$30
Failed (no-show) for preventative visit	$50
*School, Sports and Daycare forms	$10
**Camp & College forms	$10
Transfer Records	$20
Family	$25
Returned Check Fee	$25

*A CT Health Assessment form will be emailed to you after your child's preventative exam and is valid for 1 year. Please be sure to save a copy. If an additional form is needed, there will be an additional fee payable when requested.

**If an additional form is needed other than the CT Health Assessment form given at your child's preventative exam, an additional fee applies payable when requested.

PLEASE ALLOW 10 BUSINESS DAYS FOR ALL FORMS AND PLAN ACCORDINGLY.

4141 Madison Ave., Trumbull, CT 06611
Phone: (203) 371-8790 • Fax: (203) 373-0463
Bakerpediatrics.com • cmaloney@bakerpediatrics

Privacy Practices

I (We) ______________________________ authorize Baker Pediatrics, LLC to deliver medical services

To my child (children) ____.

I/We also authorize the following people to bring my child for treatment:

Name__________________________________Relationship______________________

Name__________________________________Relationship______________________

Name__________________________________Relationship______________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (COPY AVAILABLE UPON REQUEST & FOUND ON WEBSITE)

I hereby acknowledge that I reviewed or received a copy of the medical practice's Notice of Privacy and I may request a copy of any amended Notice of Privacy.

Signed____Date__________________

4141 Madison Ave., Trumbull, CT 06611
Phone: (203) 371-8790 • Fax: (203) 373-0463
Bakerpediatrics.com • cmaloney@bakerpediatrics

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth: [DOB]

I request and authorize ________________________ release
healthcare information of the patient named above to:

This request and authorization applies to:

- (•) Healthcare information relating to the following treatment, condition, or dates
- ( ) All healthcare information ( ) Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

(•) Yes ( ) No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

(•) Yes ( ) No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____ Date signed: __________