Koala Pediatrics

121 Center Grove Rd
Randolph, NJ, 07869
Tel: 973-361-4900
Fax: 973-361-1842

Fiona Pakonis, M.D F.A.A.P

Welcome to Koala Pediatrics! Here are a few office policies and agreements that we would like for you to be aware of to facilitate a good relationship between you and your pediatrician:

Office Hours: Our office hours are 9:00 a.m. to 5:00 p.m. Monday through Friday

Appointments: Patients are seen by **appointment only**. Each child needing examination by the doctor should have an individual appointment.

In general, well examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. In addition, well examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the well examination, but can see your child for his/her illness during the scheduled appointment. This also applies to other conditions that require a significant amount of time for the physician to effectively manage the condition (i.e., asthma, ADHD). We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep the appointment. Absences from school will only be excused by our office if your child has been seen in the office for the illness.

Walk Ins and Late Arrivals and No Shows: Rescheduling may be necessary if you are late for your appointment. We will try to work you in if time allows. If you cannot keep your appointment we ask that you cancel 24 hours prior to appointment time.

Each well visit and or ADHD evaluation appointment missed and not cancelled prior to 24 hours before scheduled appointment time will be assessed a $25 fee to the patients account.

Financial Agreement: Fees, Insurance and Health Plans: A Parent/Guardian must notify the office of changes in address, telephone number or insurance. You must bring your insurance cards to every visit. The person who brings the child to the office will be expected to pay at the time of service. **You will be responsible for payment of charges from services rendered if we are unable to verify benefits with your insurance company. Insurance companies require collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not yet been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always question your insurance company regarding your benefits first if you have any questions about covered services or bills**.

WE ARE NOT RESPONSIBLE FOR CHECKING BENEFITS/COVERAGE OF YOUR POLICY. WE ONLY VERIFY ELIGIBILITY.

Koala Pediatrics files primary insurance only for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services and deductibles are the responsibility of the patient and payable at the time of service.
Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. **Proof of insurance is not a guarantee of payment**. Patients without insurance or covered under an insurance plan in which we are not contracted are
financially responsible for all charges incurred at the time of service. In the event that payment for a service performed is erroneously denied by the insurance carrier, it is the patient's responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier. Patients must verify plan participation with our office.

If your child(ren) has insurance that we do not participate with or if your child(ren) does not have insurance, we do offer a Private Pay discount.

Balances are due at time of appointment. Financial arrangements will be required for balances greater than 60 days outstanding and prior to appointment.

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We accept cash, checks, Visa and MasterCard. **There is a $25 fee for returned checks**.

I request release of payment information to Koala Pediatrics by third party payers when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to Koala Pediatrics and I authorize payment of those benefits directly to that provider.

Medical Records: Medical records can be faxed to another physician's office free of charge upon release of the medical record. Patient copies of the medical record can be obtained for $25. Copies of the medical record will be provided within 2 business days with a prepayment.

Medication Refills: Patients on medication for ADHD will be seen for medication check-ups every 3 months. Refills for ADHD medications will be provided only if these appointments are kept.

Vaccination Policy: As medical professionals we feel strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If your child has received any vaccinations at any place other than our office, you must provide us with proof of vaccination. ***If you should absolutely refuse to vaccinate your child despite our efforts, we will ask you to find another healthcare provider who shares your views***. Please understand that by refusing to vaccinate your child you are putting your child at an unnecessary risk for life threatening illnesses, disability and even death.

After Hours Services: After-hours contact will be the Children's Health Network.

By signing below, you acknowledge that you have read and understand the office policies and financial policies. I accept the financial terms noted above and certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility to present Koala Pediatrics with valid insurance information at each visit and inform Koala Pediatrics should any information on this form change at any time in the future.

Signature of Parent/Legal Guardian _____ Date: _____

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PATIENT DATA

- PLEASE LIST EACH CHILD IN THE FAMILY IN BIRTH ORDER BELOW (oldest to youngest):
- If information differs for each child, please use a separate form
- If you are a patient 18 or older – list ONLY yourself and your contact information

Last Name	**First Name**	**Date of Birth** (mm/dd/yy)	**Gender**	**Child Resides With**
		/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
		/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
		/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
		/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both

TELEPHONE NUMBERS

- Primary Phone (first number) is the one to be used for messages and reminder calls
- Please list phone numbers in order to be called

- -	**Cell ONLY**	☐ Mother ☐ Father ☐ Other:
- -	☐ Cell ☐ Home	☐ Mother ☐ Father ☐ Other:
- -	☐ Cell ☐ Home	☐ Mother ☐ Father ☐ Other:

BILLING ADDRESS AND FINANCIAL INFORMATION

Name of financially responsible person (bills will be mailed to) _____

Billing address: _____

City: _____ State _____ Zip _____

PARENT / GUARDIAN INFORMATION

Name:	DOB: / /
☐ Single ☐ Married ☐ Divorced ☐ Widowed	Relationship to Child: ☐ Parent ☐ Stepparent ☐ Foster/Guardian
Address: _____ (if different from above)	
Email address:	
Employer/Occupation:	

Name:	DOB: / /
☐ Single ☐ Married ☐ Divorced ☐ Widowed	Relationship to Child: ☐ Parent ☐ Stepparent ☐ Foster/Guardian
Address: _____ (if different from above)	
Email address:	
Employer/Occupation:	

Custodial parent, if applicable: Stepparent's name, if applicable: *Complete Care Authorization if needed*	_____

Printed Name _____ Date _____

Parent/Guardian/Patient Signature _____

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MISCELLANEOUS			
Pets: ☐ Yes ☐ No	Guns in home: ☐ Yes ☐ No	Daycare: ☐ Yes ☐ No	School Grade _____
Emergency contact: (other than above)		Phone:	
Preferred Pharmacy:		Phone: _____ Zip:	
Former Pediatrician: (if applicable)		Referred By:	

INSURANCE INFORMATION

☐ **No change to insurance (for existing patients only)**

Insurance Company Name

Aetna	AmeriHealth	BCBS	Cigna	Emblem	GHI	Humana	Medicaid	Meritain	Tricare	United	UMR
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other: _____

Policy Holder Name:

Relationship: ☐ Parent ☐ Stepparent ☐ Other_____ | Policy Holder DOB: / /

Address if different from Patient / Parent:

Insurance ID#:

VACCINE POLICY / CONSENT FOR PAYMENT / ASSIGNMENT OF INSURANCE BENEFITS / PRIVACY POLICY

VACCINE POLICY

Initial ☐ *I understand that Koala Pediatrics **only** accepts patients into the practice who agree to meet the minimum recommended vaccination schedule/timetable and that any child(ren) who may be behind on vaccines will be brought current as soon as possible.*

CONSENT FOR PAYMENT

Initial ☐ *I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed.*

*I understand that **Insurance/Medicaid Cards should be presented at EVERY VISIT.***

Initial ☐ *I hereby authorize direct payment of surgical/medical benefits to **Koala Pediatrics**, for service rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize **Koala Pediatrics** to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.*

Initial ☐ *Divorce has no bearing on the responsibility for medical care as it affects third parties. **WHOEVER BRINGS THE CHILD IS EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICE RENDERED THAT DAY.** Koala Pediatrics does not participate in payment disputes between parents.*

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES / COMMUNICATION CONSENT

Initial ☐ *I have received, or have been given the opportunity to receive, a copy of the **HIPAA Notice of Privacy Practices for Koala Pediatrics.***

EMAIL PERMISSION

Please use the following as my preferred email address:

_____

I understand that I may opt out at any time, that this information is NOT shared with third parties, and is for the exclusive use of Koala Pediatrics.

☐ I presently receive Koala Pediatrics e-mails
☐ I DO wish to be included in the Koala Pediatrics e-mail distribution list to receive occasional brief announcements and timely information. (**Strongly recommend in order to electronic bills, receive flu clinic dates, local epidemics / infection reports and office policy changes).**
☐ I DO NOT wish to be included in the Koala Pediatrics e-mail list.

The above information is current and correct.

Parent/Guardian/ Patient Signature _____ Date _____