BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

Patient Registration Form
(Pediatric)

Patient Information

Last Name:	First Name:	MI:
Address:		
City/State/Zip:		
Social Security Number:	Date of Birth:	Gender assigned at birth: Male Female
Employer (include address):		
Emergency Contact:	Emergency Contact Phone:	Relationship to Patient:
Primary Language: English Spanish Other (Please specify):	Hispanic / Latino: Yes No	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Pharmacy Name:		Pharmacy Phone:
Pharmacy Address:		

Parent / Guardian Information

PARENT / GUARDIAN #1 Check here if this is the patient's guarantor (person responsible for charges not covered by insurance).

Last Name:	First Name:	MI:
Address:		
City/State/Zip:	Relationship to Patient:	

Home Phone:	Cell Phone:	Work Phone:	Email Address:
Preferred Contact: Home Phone Mobile Phone Work Phone MAIL ONLY	OK to leave a message regarding your medical care on preferred phone? Yes No	Appointment Reminders: Text Voice	Social Security #: Date of Birth:

PARENT / GUARDIAN #2 Check here if this is the patient's guarantor (person responsible for charges not covered by insurance).

Last Name:	First Name:	MI:
Address:		
City/State/Zip:	Relationship to Patient:	

Home Phone:	Cell Phone:	Work Phone:	Email Address:
Preferred Contact: Home Phone Mobile Phone Work Phone MAIL ONLY	OK to leave a message regarding your medical care on preferred phone? Yes No	Appointment Reminders: Text Voice	Social Security #: Date of Birth:

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Patient Last Name:
Patient First Name:
Date of Birth:

Pediatrician Information

Pediatrician:	Phone:
Address:	

Insurance Information

Is this visit work related? Yes No	Authorization Number:

Primary Health Insurance		**Secondary Health Insurance**	
Insurance Name:		Insurance Name:	
Policy #	Group #	Policy #	Group #
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Relationship to Patient:	Policy Holder's Employer:	Relationship to Patient:

AUTHORIZATION and RELEASE OF INFORMATION

Initial:

_______ I give Brown Surgical Associates permission to ask for third party payor/Medicare payments for my medical care. I understand that third party payor/Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party payor/Medicare payment requests. I understand that the CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) is the government Medicare agency. I request that payment of authorized third party payor/Medicare benefit be made either to me or on my behalf for any services furnished me by BSA, including physician services. I authorize any holder of medical or other information about me to release to the CMS and its agents any information needed to determine these benefits or benefits for related services.

_______ I understand that Brown Surgical Associates may obtain my prescription history from my pharmacy, other healthcare exchanges as well as querying the state prescription drug monitoring program.

_______ Brown Surgical Associates patient portal is a secure, confidential, HIPAA compliant communication tool. It is an optional service and you may enroll at any time. The portal is designed to enhance patient-physician communication. Access to this secure patient portal is an optional service. I may suspend or terminate it at any time for any reason. I acknowledge and fully understand the risks associated with online communication. I acknowledge that using the portal is voluntary and will not impact the quality of care I receive. I agree to adhere to the policies set forth in this agreement. I understand this consent will expire in 12 months and I will be required to sign and update my form. I will notify the office if there is any change in my email address or if I feel my password has been breached. I agree not to hold Brown Surgical Associates liable for infractions beyond its control. By signing below, i give permission to Brown Surgical Associates to enroll me in the patient portal.

_______ I have received Brown Surgical Associates' Notice of Privacy Practices.

Patient Signature (or guarantor if under 18):	**Date:**

Permission to Disclose Medical Information

I hereby authorize Brown Surgical Associates office to speak to the following people regarding my medical condition:

Name:	Relationship:
Name:	Relationship:

I understand I may revoke this permission at any time by informing the physician's office in writing.

Patient Signature (or guarantor if under 18):	**Date:**

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PEDIATRIC HEALTH HISTORY SHEET

Welcome to our practice. To provide you with the best, most comprehensive care possible for your child, please provide us with the following in formation. All information will be held strictly confidential and is released only with your written permission

Last name	First name	Date of Birth	Gender

Reason for today's visit

Past medical problems *(check any that apply)*

Congenital heart disease		Prematurity		Sleep apnea	
Heart murmur		Seizures		Depression	
Asthma		Attention deficit		Anxiety	
Diabetes		Developmental delay		Other:	
Gallstones		Lyme disease			
Gastro-esophageal reflux		Bleeding disorder			

Surgical History *(please list operation and year if known)*

Medications (name)	**dose & frequency**	**Allergies**	**type of reaction**
		❑ Latex	

Family History (if yes, specify relation see abbreviations)
Mother(M), Father(F), Brother(B), Sister(S), Aunt(Au), uncle(Un), grandmother(GM), grandfather(GF)

❑ Coronary artery disease	❑ Arrhythmias	❑ High BP
❑ Cystic fibrosis	❑ Lung cancer	
❑ Gallstones	❑ Colon cancer	❑ IBD (Crohn's Dz, UC)
❑ Diabetes	❑ Thyroid disorder	
❑ Hemophilia	❑ Thalassemia	❑ Lymphoma, □ Leukemia
❑ Skin cancer	❑ Breast cancer	
❑ Kidney stones	❑ Anesthesia related disorder (extreme fever, prolonged effect)	

Social History

Patient lives with: □ parents □ mother □ father □ siblings (#)
□ foster parent how long? □ care center

Does patientt smoke? Y / N Is there 2nd hand exposure to smoke Y / N

Immunizations/Childhood illnesses

□ up to date □ no recent exposure to communicable diseases □ other

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of the Warren Alpert Medical School of Brown University

Patient Name: ____ **Date of Birth:** _________________________

REVIEW OF SYSTEMS					
Constitutional/general	**yes**	**no**	**Head and Neck**	**yes**	**no**
fevers /chills			diplopia (double vision)		
sweats			blurry vision / loss of vision		
weight loss/weight gain			photophobia		
fatigue/ lightheadedness			hearing loss / tinnitus		
Skin /Breast			**Neurologic**		
rashes			headache/migraine		
lumps			numbness/tingling		
new lesions/sores			ataxia/paresis/paralysis		
breast pain / nipple discharge			weakness/syncope/seizure		
Cardiovascular			**Respiratory**		
chest pain/palpitations			cough/hemotysis		
orthopnea/edema			wheezing/dyspnea		
syncope			pleuritic chest pain		
claudication			snoring		
Gastrointestinal			**Genitourinary**		
abdominal pain			frequency/urgency/flank pain		
nausea/vomiting			dysuria (pain with urination)		
hematemesis/heartburn			hematuria (blood in urine)		
constipation/diarrhea			incontinence		
hemorrhoids/rectal bleeding			nocturia (frequent nightime voiding)		
Endocrine			**Hematologic**		
heat/cold intolerance			bleeding problems		
polyuria (frequent urine voiding)			swollen glands		
polydipsia (frequent water intake)			spontaneous bleeding		
change in appetite			easy bruisability		
change in menstrual cycle					
Musculoskeletal			**Psychiatric**		
joint pain			depression		
back pain			anxiety		
muscle aches			hallucinations (visions, hearing things)		
stiffness			suicidal ideation		
swelling					

Parent/Guardian Signature: ____ **Date:** ____________________

Patient Name: ______________________________

Date of Birth: ______________________________

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Patient Financial Policy

Brown Surgical Associates participates with most insurance plans including, Aetna, Blue Cross Blue Shield of RI, Cigna, Harvard Pilgrim, Neighborhood of RI, Tufts, United Healthcare, Medicare, and Medicaid. However, some of the services we provide may be considered elective, cosmetic or uncovered by various insurance plans and therefore the financial responsibility of the patient.

Office Visits:
Many insurance plans require the patient to satisfy a deductible, co-insurance, and/or co-payment as part of coverage. If a referral and/or pre-authorization is required for the visit, but cannot be obtained, you will be responsible for payment. If you do not have your copayment or your insurance information with you at the time of your appointment, you may be rescheduled. *Please note that Brown Surgical Associates does not charge a fee for an initial post-operative visit.*

Scheduled surgeries and office procedures:
Our staff will verify coverage and obtain necessary authorizations for scheduled surgery and office procedures. We will estimate your financial responsibility after insurance based on coinsurance rates and remaining deductibles. A deposit is required prior to surgery as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment.

For patients with participating insurance:
- You are responsible for any office visit copayment at the time of service.
- We will submit the claim to your insurance, apply insurance payments and contractual adjustments.
- You will be responsible for any unpaid copayment, coinsurance and/or deductibles that your insurance has indicated.

For patients with non-participating insurance:
- As a courtesy, we will submit the claim to your insurance.
- The insurance payments will be applied and you will be balance billed for any remaining balance.

For patients without insurance:
- Payment is due at time of service for office visits and prior to scheduled surgery.
- If a payment plan is required for a scheduled surgery, arrangements will be required prior to surgery.
- If you were approved for a reduced financial responsibility, such as Community Free Service, through Patient Financials Services at Women and Infants Hospital or a Lifespan Hospital, Brown Surgical Associates will honor the approved reduction for all services rendered during the approved time period. Please contact the Billing Office for further information.

Overdue Balances:
We will provide two (2) statements for any balance due after insurance payment. If payment is not received within 90 days, your account may be sent to an outside collection agency. If your account is turned over for collections, you will be responsible for the full balance plus any collection, interest or legal expenses incurred as a result of the collection process. Patients with overdue and/or collection balances may be expected to pay in full or set up a payment plan before returning to the office for continued service.

For the convenience of our patients, we accept Visa, MasterCard, Discover and American Express. If you have any questions regarding insurance or billing, please contact our Billing Office at 401-453-9625.

My signature below confirms that I have read this policy and I understand and agree to my financial obligation with Brown Surgical Associates, Inc.

______________________________ ______________________________

Patient or Guarantor Signature Date

Revised 9/26/2019

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