Patient Registration Form

PATIENT INFORMATION

Legal First Name: _____ **MI:** ___ **Legal Last Name:** _____

First Name Used: _____ **Assigned Sex at Birth:** ☐ Male ☐ Female ☐ Choose not to disclose

Date of Birth: _____ **Primary Language:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone Number: _____ **Home Phone Number:** _____

Email: _____ **Preferred Method of Contact:** ☐ Cell Phone ☐ Home Phone ☐ Email

May we text you to confirm an appointment (circle one)? Yes No

May we email you to confirm an appointment (circle one)? Yes No

How did you hear about us? (Please share the name of the applicable individual/organization below.)

☐ Current patient ☐ Hospital ☐ Insurance company ☐ Primary Care Physician ☐ Specialist Physician ☐ Therapist

☐ Website/social media ☐ Word of Mouth ☐ Other (please specify below)

Name of individual/organization who told you about the Cope Center for Autism: _____

FAMILY INFORMATION

Mother/Guardian Information:

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Best Contact Phone Number: _____ **Email:** _____

Father/Guardian Information:

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Best Contact Phone Number: _____ **Email:** _____

EMERGENCY CONTACT

Contact Name: _____ Relationship to Patient: _____

Contact Best Phone Number: _____ Contact Best Email: _____

PEDIATRICIAN INFORMATION

Name: _____ Phone Number: _____

Fax Number: _____ Address: _____

PATIENT INSURANCE

Primary Insurance Company: _____

Member #: _____ Group #: _____

Policy Holder's Name: _____ Relationship: _____ Date of Birth: _____

Secondary Insurance Company: _____

Member #: _____ Group #: _____

Policy Holder's Name: _____ Relationship: _____ Date of Birth: _____

PHARMACY INFORMATION

Name: _____ Phone Number: _____

Address: _____

Patient or Guardian Signature: _____ Date: _____

General Consent for Treatment

1. CONSENT TO CARE: I authorize Jennifer Cope Pediatric Neurology, LLC (collectively with its affiliates, including Cope Center for Autism, a NJ Non-Profit Corporation, "Cope Center for Autism") to provide treatment to my child.

2. REFERENCE LABORATORY SERVICES: I understand that the Cope Center for Autism utilizes the services of an outside lab to perform some of the lab tests requested by its physicians and other health care providers. I further understand that the reference laboratory will bill separately for its services. I consent to the Cope Center for Autism and to provide demographic information as necessary for billing purposes.

3. DISCLOSURE OF PROTECTED HEALTH INFORMATION: I understand and agree that the Cope Center for Autism may receive, have access to, use and disclose my medical and billing information as described in this Consent and the Cope Center for Autism Notice of Privacy Practices. This includes, as applicable, my diagnosis, prognosis, treatment received, diagnostic tests, images and procedures performed, medication history and other information about my medical care (my "medical information") which may be maintained now or in the future.

I understand that my medical information, which may be shared under this Consent, may also include sensitive information regarding my past, present and future behavioral and mental health, HIV/AIDS related information, sexually transmitted diseases, tuberculosis, genetic information, including genetic test results, drug or alcohol related illness, or emancipated care I may receive as a minor, unless a separate written consent from this form would be required by applicable law. I understand and agree that this information may be accessed, used and disclosed to carry out treatment, payment or health care operations, and other purposes permitted or required by law, including coordination of care. Cope Center for Autism may release my information to or receive my information for these purposes from my former, current or future health care providers, my insurance companies/payors, including Medicare or Medicaid, or any other person or entity that may be responsible for coordinating my care or paying for payment on any portion of my bill for services. I acknowledge that this Consent serves as notice to me of the recipients who may have access to, use and disclose my medical information.

4. ELECTRONIC COMMUNICATIONS: Following my visit, the Cope Center for Autism, or its designated vendor, may contact me by telephone, text message, email, mobile application, or US mail to request feedback on my experience and/or to communicate with me regarding my personal, or my dependents, outstanding invoice(s). I confirm my understanding and agree to be contacted in this manner in connection with today's visit and any future visits. In the future, I may opt-out of receiving text messages by notifying the Cope Center for Autism in writing. This includes responding via text message. Standard telephone/text charges may apply if the Cope Center for Autism contacts me. I further agree that, based on my feedback, the Cope Center for Autism may utilize my statements or comments, on an anonymous basis, on its website to provide reviews of its care that might help prospective patients choose its services.

5. FINANCIAL AGREEMENT: I understand and agree that I am financially responsible to pay for any services I receive in accordance with the regular rates and terms of the Cope Center for Autism. I agree to make prompt payment to the Cope Center for Autism for any and all charges not paid for by my health insurer or payor, to the fullest extent permitted by law. I understand that my health insurer or payor may require that I obtain pre-certification and/or pre-authorization for the services provided to me, and that I am responsible for any charges for health care services that are not pre-certified and/or pre-authorized. I acknowledge that it is my responsibility to understand my insurance coverage requirements, benefits and limitations.

6. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I acknowledge receipt of the Cope Center for Autism Notice of Privacy Practices and was given the opportunity to ask questions and voice concerns. I hereby consent to the uses and disclosures set forth in the Cope Center for Autism Notice of Privacy Practices. I also understand that this consent is revocable at any time by writing to the Cope Center for Autism as indicated in the Cope Center for Autism Notice of Privacy Practices, except to the extent that action has already been taken in reliance on my consent. This consent will remain in effect for a reasonable time in order to accomplish the purpose for which it has been given.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT FOR TREATMENT AND THAT ANY QUESTIONS THAT I HAD ABOUT IT HAVE BEEN ANSWERED TO MY SATISFACTION BY THE STAFF OF THIS FACILITY.

Patient Name: _____ **Date:** _____

Patient or Authorized Representative Signature: _____

Name of Person Signing: _____ **Relationship:** _____

Authorization to Discuss Health Information with Others and/or Leave Telephone Messages

The purpose of this document is to inform us if we have your permission to:

- Relay information to other people regarding your care and treatment.
- Leave information about your care and treatment on your telephone answering machine.
- Call you at work, and/or on your cell phone or other telephone number.

When our physicians, practitioners or office staff need to speak with you about your healthcare, we generally place a telephone call and ask to speak with you, our patient, first. Some examples of when we may need to call you are: to schedule/change/cancel an appointment; to see how you are feeling after a visit with us; with follow-up instructions after a visit; and/or to provide laboratory, radiology or other diagnostic test results, etc.

PREFERRED METHOD FOR OUR FOLLOW-UP COMMUNICATIONS WITH YOU:

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Work Phone _____

If you are unavailable when we telephone you:

- May we leave a detailed message about your care and treatment on your answering machine?
  ☐ Yes ☐ No
- Are there one or more individuals that we have permission to speak with regarding your healthcare? If "Yes," please specify who:

Name	Relationship	Phone #	Type of Information
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions

Jennifer Cope Pediatric Neurology, LLC and its affiliates, including Cope Center for Autism, a NJ Non-Profit Corporation, will abide by the guidelines given in this document unless you instruct us differently.

Patient Name: _____ **Date:** _____

Patient or Authorized Representative Signature: _____

Name of Person Signing: _____ **Relationship:** _____

Patient Insurance/Financial Responsibilities and Statement of Understanding

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a patient of Jennifer Cope Pediatric Neurology, LLC (collectively with its affiliates, including Cope Center for Autism, a NJ Non-Profit Corporation, "Cope Center for Autism").

INSURANCE COVERAGE

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- If your claim is processed incorrectly by your insurer, you give the Cope Center for Autism permission to appeal the claim on your behalf by your signature below.

FINANCIAL OBLIGATIONS

1. Co-payments are due at the time of service.
2. The Cope Center for Autism will bill participating insurance companies after verifying coverage. If claims are not paid, Cope Center for Autism will bill you for services rendered.
3. Payment for non-covered services, deductibles and co-insurance payment amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of the Cope Center for Autism, the payment must be forwarded to us. You may issue a personal check to the Cope Center for Autism. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance that the Cope Center for Autism participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.
8. Payment is due with respect to a child patient regardless of who brings the child in for the service. This includes step-parents, grandparents, caregivers, etc. It is the parent/guardian's responsibility to notify the office of any address, phone or insurance changes. **Please have your insurance card with you at every visit.** You are responsible to pay for services and cost of collection in the event of a default. A payment plan can be made to avoid your account being turned over to a collection agency. If the account is turned

over to collections, a fee will be assessed in addition to the total balance of the account payable by the guarantor. **If your account is in collections, your child cannot be seen until the balance is paid in full.**

9. For families in which parents are separated or divorced, the parent bringing the child to the office is authorizing treatment and is, therefore, the parent responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request to assist in the collection of fees from the other parent. It is the responsibility of the authorizing parent to convey to the other what was discussed at the appointment. If there are further questions or clarification is needed, please call our office to discuss further. Our office cannot call to update a parent at every visit.
10. Insurance must be provided and active in order to utilize your benefits. If no insurance is active for the visit, the patient will be charged the discounted self-pay rate which is due prior to leaving your appointment. Once insurance is corrected or reinstated, we will process your claim through insurance. Once payment is received from insurance, we will then process a refund for the payment made at the time of service.

NO SHOW OR CANCELLATION FEES: A $50 fee applies to all physician or nurse practitioner visits cancelled less than 24 hours prior to the appointment time and no-shows to any scheduled appointments.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBILITIES AS STATED ABOVE. I hereby authorize the release of medical records to my insurance company, as may be necessary for the purpose of reimbursement. I realize that I am ultimately responsible for any and all services rendered to me (my child) regardless of any insurance determinations.

Patient Name: _____ **Date:** _____

Patient or Authorized Representative Signature: _____

Name of Person Signing: _____ **Relationship:** _____

Witness to Signature: _____

A copy of this form is available upon request.

E-Prescribing/Medication History Consent Form

E-prescribing is defined as a physician or authorized practitioner's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 lists standards that have to be included in an e-prescribe program. These include:

- Formulary and benefit transactions—gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions—provides the physician or authorized practitioner with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification—allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that Jennifer Cope Pediatric Neurology, LLC (collectively with its affiliates, including Cope Center for Autism, a NJ Non-Profit Corporation, "Cope Center for Autism") can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Cope Center for Autism to enroll me in the e-prescribe program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name: _____ **Date:** _____

Patient or Authorized Representative Signature: _____

Name of Person Signing: _____ **Relationship:** _____

Witness to Signature: _____

Consent for Parent Support Services

1. CONSENT FOR SERVICES: I, *(insert parent name)*_____ (hereinafter "Parent") authorize Cope Center for Autism, a NJ Non-Profit Corporation (collectively with its affiliates, including Jennifer Cope Pediatric Neurology, LLC, "Cope Center for Autism") to provide parent support services with respect to my child.

2. SERVICES: This Consent is for the purpose of providing parent support services to Parent in making informed decisions concerning the support and educational needs of the child. The Cope Center for Autism will use its best efforts to provide Parent with research-based information to advise and support Parent with respect to, as applicable, outside service providers and educational, therapeutic and/or transitional matters regarding the child.

3. DISCLAIMERS: This Consent does not bind Parent to solely use the Cope Center for Autism's non-attorney/non-medical parent support services. It is expressly understood that the services are not to be construed as legal advice or services or medical advice or services. In signing this Consent, Parent understands that there are no guarantees and hold the Cope Center for Autism harmless with regard to the services of unaffiliated providers, the outcome of financial government decisions and post-secondary outcomes.

4. LIABILITY: The Cope Center for Autism's entire liability under this Consent, if any, for damages relating to this Consent and/or its performance pursuant to this Consent, whether based on contract or negligence, shall be limited to the amount paid to the Cope Center for Autism pursuant to this Consent relative to the period of occurrence of events which are the basis of such claims. In no event will the Cope Center for Autism be liable for any consequential damages arising from or in any way related to this Consent or the Cope Center for Autism's performance pursuant to this Consent.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT FOR PARENT SUPPORT SERVICES.

Patient Name: _____ **Date:** _____

Patient or Authorized Representative Signature: _____

Name of Person Signing: _____ **Relationship:** _____