Cornerstone Patient Packet Form Checklist

Complete and Return the following forms to our office to schedule an appointment.

- ☑ Cornerstone Patient Packet Checklist (this page)
- ☐ Signed “Cornerstone Fit Checklist”
- ☐ Patient Registration completed
- ☐ Portal Registration Completed
- ☐ Medical Records Release

*This form is to be completed and sent to your current pediatrician (if applicable) so that we may get your child’s vaccine records and past medical records. PLEASE complete the name/address/phone/fax for your past provider (if applicable)

- ☐ Authorization for Medical Treatment
- ☐ Initial Health History Questionnaire
- ☐ No-Show/Late Arrival Policy Signed
- ☐ Copy of Insurance Card (front and back please)
- ☐ Insurance Agreement
- ☐ Card on File (except Medicaid)

For office only:	Staff initial/date
☐ Packet completed	_____
☐ Copy F/B Ins. Card	_____
☐ Registered	_____
☐ Eligibility checked	_____
☐ MRR faxed	_____
☐ Doc Approved	_____
☐ MRR/vaccines rec’d	_____
☐ Packet in Athena	_____
☐ Vac/MR in Athena	_____
☐ Scheduled	_____

Name of Patient:_____
Date of Birth: _____

Choosing Cornerstone Pediatrics
Pages 1-4: Important information for you to keep with your files

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Are We a Good Fit for You ?

It is crucial when choosing a pediatric practice for your children that you have given serious consideration to the fit between the practice philosophies and your own. **Excellent care happens when the physician and office staff are aligned with your family priorities and philosophies regarding care. We strive to share decision-making based on mutual respect.**

Please read the following over carefully to be sure Dianne McNeill, MD and Cornerstone Pediatrics is a good fit for you and your children. **We look forward to meeting you and forming a mutually rewarding relationship.**

Benefits of a Solo Practitioner

In this practice, **every** appointment is made with Dr. Dianne allowing a **personal relationship to be built between the patient, the family, and the pediatrician.** As your child grows, they are followed by their same pediatrician who knows their history as well as their personality. Also, every phone message, portal message, referral, specialist note and test is reviewed by Dr. McNeill.

As a solo practitioner, Dr McNeill is dedicated to improving and maintaining your child's health through preventive and integrative pediatric care. **Dr. McNeill's mission for Cornerstone Pediatrics is to provide you with exceptional personalized quality care in a warm and friendly environment.**

Prenatal:

Prenatal visits can be done by telemedicine from the comfort of your home! These meetings are a great way to get to know your potential pediatrician and to get comfortable with our office and ask questions. But if you would prefer to visit the office, we can schedule an in person prenatal visit as well! Prenatal visits are not required, and there is no charge for these visits.

Dr. McNeill does not see newborns in the hospital. Instead, the experienced newborn hospitalists will determine the care your baby will receive there. As soon as you know when you are being discharged from the hospital, please call our office to schedule the baby's first visit. We will arrange for the first visit within 2-3 days of discharge. Please be sure to let us know when you call if there are any concerning medical problems in the hospital, such as prematurity, jaundice or weight loss.

Vaccines

Our vaccine policy follows the schedule outlined by the AAP (American Academy of Pediatrics) and the CDC (Centers for Disease Control and Prevention). **We believe the single most important preventative medical intervention is vaccines.** We are happy at your child's well

care visit to discuss vaccines, the science behind vaccines, your questions, concerns and our recommendations. **Our goal is to work *with* you, *not* against you**.

We recognize that the choice to vaccinate may be an emotional choice for some parents, but as we feel so strongly about this issue- **we do not accept patients whose parents refuse all vaccines.** As a result, if your immunization philosophy differs from our view, we would ask that you choose another medical office for your child that aligns with your preferences and shares your medical philosophy.

Scheduling Appointments

Please call our office number **757-410-9600** to schedule appointments. We do our best to accommodate **same day sick appointments** for our patients, but recommend that consults, chronic medical condition appointments be made in advance to best accommodate your child and Dr. McNeill's schedule.

Sometimes an appointment may not be needed. For questions and concerns you may have about your child's health, development and/or behavior, you can call our office during business hours and our nurse or our experienced medical assistants can triage your concerns. **Well child visits may be scheduled up to 3-6 months in advance. Please call during routine office hours to schedule these appointments or send us a message on the patient portal.**

Office Hours

We make every effort to meet the needs of our patients, we schedule both routine well visits and sick visit appointments during traditional business hours on Monday, Tuesday and Thursday. We highly recommend you call ahead to schedule an appointment. **We see same day sick visits on Mondays, Tuesdays, Thursdays and Friday mornings**.

Please familiarize yourself with our office hours to see if they work for your family

After hours

If your child is a patient of Cornerstone and you have concerns about your child being sick outside of regular business hours, you can call the office phone number at 757-410-9600. This phone number will be answered by the answering service who will contact our Anytime Pediatrics on call service. There is always a doctor on call 24/7 and you should never feel your child's care is uncovered. Many insurance plans also offer a On-Call service as noted on your insurance card. If it is a non urgent question that can wait until the next business day, please wait for normal business hours or send a message to our patient portal.

Insurance

Please be sure we participate with your insurance plan. With the myriad of insurance plans available to our families, it is **your responsibility** to know the limits and coverage of your particular health insurance policy. We will do our best to assist you with your insurance plan; however, if you have questions about your coverage, it is your responsibility to check with your specific insurance company.

Name of Patient:_____
Date of Birth: _____

We will ask you to bring your insurance card and ID at each visit, and please be prepared to pay any co-pays, deductibles and balances at the time of service. Our office does not want you to be surprised by a bill, but we must always bill your health plan based on federal guidelines and the actual services provided. IF AT TIME OF APPT, YOU ARE INELIGIBLE OR YOUR INSURANCE IS NOT CORRECT, WE HAVE THE RIGHT TO CANCEL YOUR APPOINTMENT AND RESCHEDULE WHEN YOUR INSURANCE HAS BEEN VERIFIED. For annual physicals, many insurance companies will not cover 2 physicals within a one year period. Please contact YOUR insurance company to verify coverage for physicals if you have questions.

Billing and Fees

Insurance co-pays, deductibles and balances are expected to be paid at the time of service. If you are unable to comply, you must work with our office prior to the visit to set up a payment plan.

Credit Card on File

Cornerstone Pediatrics is committed to making our billing process as simple and easy as possible. **For this reason, we require that ALL non-Medicaid patients provide a credit card on file with our office.** We will scan your card with a card reader that will store your card number in a ***secure*** location in your electronic medical record. **For security reasons, only the last four digits will be visible to our staff**. Credit cards on file may be used to pay co-pays, coinsurance and when you are seen in our office, and will be used for any deductibles and/or account balances after your insurance processes your claim. You will receive an email notifying you prior to the CARD on file being charged.

Timeliness & Missed Appointments

We gladly reserve appointment times for you and appreciate that you have chosen Dr. Dianne and Cornerstone Pediatrics for your care. As a courtesy, we will remind you of your appointment by calling you prior to your scheduled date and time. If we cannot speak directly to you, we will leave a message. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment.

We respect our patients' valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. **We reserve the right to charge a no-show fee of $50 for regular appointments canceled or broken without advance notice of 24 hours. After three (3) "no shows" we reserve the right to discharge your family from our practice.**

We understand sometimes things happen beyond your control that may cause you to be late. However, we reserve the right to ask you to reschedule if you arrive late for your appointment.We look forward to meeting you and your child and providing the quality, comprehensive medical care.

Name of Patient:_____
Date of Birth: _____

Forms

The following forms to be filled out by Dr. McNeill require the child to have had a well child check up in the last twelve months**:**

- School/Daycare Physical Forms
- Sports Physical Forms
- Administration of Medication Forms
- WIC Forms

Often form completion may require an Office Visit, these include completion of FMLA Forms, DMAS-7, EFMP, etc.

In order to provide excellent and efficient care to our families, we ask that you please bring any physical, sports, medication forms, etc that you need to be completed to your visit with YOUR PORTION already completed. We will do our very best to complete forms that are brought in **at time of visit** so that you leave with everything you need. If you bring in the form at a later time, we will gladly complete it for you at no charge, but we ask that you please allow us 3-5 business days to have the forms completed, reviewed and signed by Dr. McNeill.

For URGENT form completion (needed within 24 hour turnaround time), there is a $10 charge.

Ongoing Consults for Chronic Conditions

Because Dr. McNeill is a solo practitioner, we try to be respectful of set appointment times. Wellness visits are a time to discuss growth, development and simple concerns you and your child may have. Dr. McNeill won't be able to address chronic issues that require medications and follow-up at your child's wellness visit. Dr. McNeill wants to make sure all of your child's needs are addressed and that is why chronic issues are best addressed in a separate appointment. If your child has a chronic condition that requires ongoing medication, additional appointments are necessary to manage care in accordance with the American Academy of Pediatrics standards of practice.

Regular interval monitoring for treatment tolerability and response is recommended for:

- Asthma/Allergies/Eczema (every 3 months)
- Chronic Constipation
- Acne, treated with prescription medication (every 3 months)
- ADHD: see specific protocol (every 3 months)
- For other prescribed medication management

Name of Patient:_____
Date of Birth: _____

Please give the following pages (5-17) to the Cornerstone Staff:

Cornerstone Fit Checklist

If it appears that we ARE a good fit (hooray!), please initial to assure us that you have reviewed the following:

_____ Cornerstone Pediatrics does not accept patients whose parents *refuse all* vaccines.

_____ Cornerstone reserves the right to charge a no-show fee of $50 for regular appointments canceled or broken without advance notice of 24 hours. After three (3) "no shows" we reserve the right to discharge your family from our practice and send to our collections agency that will accrue more fees due.

_____ If your child has a chronic condition that requires ongoing medication, separate appointments will be completed at a different time. This is required to provide excellent care in accordance with the American Academy of Pediatrics standards of practice

_____The following forms to be filled out by Dr. McNeill require the child to have had a well child check up in the last twelve months: School/Daycare Physical Forms, Sports Physical Forms, Administration of Medication Forms, WIC Forms. The following require an office visit to properly complete the paperwork for FMLA, DMAS-7, EFMP, etc.

_____ Forms to be filled out should accompany your child at their wellness visit if possible. If you need a form completed at a later time, we will gladly complete it for you, free of charge, but we ask that you please allow us 3-5 business days to have the forms completed, reviewed and signed by Dr. McNeill.

_____For urgent form completion (24 hr turnaround time), there will be a $15 fee.

Name of Patient:_____
Date of Birth: _____

Cornerstone Pediatrics Patient Registration

Prospective Patient Legal Name:

Last_____First:_____Middle(full)::_____

DOB_____Legal Sex:_____First Name Used/Nickname:_____

Home Address:_____ Best email:_____

_____Alt email: _____

1. **Parent/Guardian Contact: Relationship:_____**

   Name:_____Cell #_____home #:_____dob:_____

   Address if different from patient:_____

   Occupation_____ Employer_____Employer #_____

2. **Parent/Guardian Contact: Relationship:_____**

   Name:_____Cell #_____home #:_____dob:_____

   Address if different from patient:_____

   Occupation_____ Employer_____Employer #_____

3. **Emergency Contact (other than parents):**

   Name_____Relationship:_____

   Phone:_____ Alt phone #_____

4. **Next of Kin (Closest Living Relative)**

   Name:_____Relationship:_____

   Phone:_____ Alt phone #_____

5. **Guarantor (name to whom statements are sent):**

   Last Name:_____First Name:_____DOB:_____

   Mailing address if different from patient: _____

   _____

Name of Patient:_____
Date of Birth: _____

Other:

First Language:_____ Ethnicity:_____

How did you hear about us? _____

Marital Status of parents? _____

Who is living in the home?_____

Dentist:_____Last Dental Exam:_____

High risk (diet/family hx) of hx of cavities: (circle) Yes No

Last Wellness Exam:_____

INSURANCE INFORMATION:

Primary Insurance Name:_____

Policy Holder:_____DOB:_____

Patient's Relation:_____

Group #_____ID/Cert #_____

Issued:_____

Do you have secondary insurance? (circle) Yes No

If yes, please list Insurance/Policy Holder/DOB/Group #

_____

_____

PLEASE INCLUDE A PHOTO/COPY OF YOUR INSURANCE ID(S) FRONT AND BACK

Reminder: Please be sure we participate with your insurance plan. With the myriad of insurance plans available to our families, it is your responsibility to know the limits and coverage of your particular health insurance policy. We will do our best to assist you with your insurance plan; however, if you have questions about your coverage, it is your responsibility to check with your specific insurance company.

We must have a copy of insurance to schedule an appointment.

We will ask you to bring your insurance card and ID at each visit

Please be prepared to pay any co-pays at the time of service. **Our office does not want you to be surprised by a bill, but we must always bill your health plan based on federal guidelines and the actual services provided.**

Name of Patient:_____
Date of Birth: _____

CORNERSTONE
PEDIATRICS

Authorization for Medical Treatment of Child

Child's Name :	**Child's Date of Birth:**
Drug or Serious Allergies	
Medications	
Known health conditions	
Other information the doctor should have about your child	

Person(s) who may bring child for care:		
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Authorized Care:	
☐ YES ☐ NO	Diagnosis & treatment of illness/problem
☐ YES ☐ NO	Diagnostic tests (e.g. X-ray, blood draw, etc.) recommended by the doctor
☐ YES ☐ NO	Preventive care ("well check-up")
☐ YES ☐ NO	Screening tests as recommended by the doctor
☐ YES ☐ NO	Immunizations appropriate for age and history as recommended by the AAP and the ACIP

Please read each section below and initial indicating your understanding:	
Initial here	This authorization is only effective for care at Cornerstone Pediatrics and does not need to be notarized. You may wish to provide your child's caretaker with a separate, notarized authorization for care elsewhere.
Initial here	This authorization will remain in your child's record and is effective from the date signed until the child is 21 and able to authorize his/her own care. If you wish this authorization to be effective only for certain dates, cross out the previous sentence and write effective dates here: Beginning on _____ and ending on _____.
Initial here	The person to whom you are delegating authority must provide photo ID at EVERY visit to our office.
Initial here	You agree that we will bill your insurance plan <u>if we have current insurance information & can verify coverage</u>, and that you will be responsible for any amounts not covered by insurance. Insurance plans differ, and some tests, treatments and immunizations may not be covered under your plan. The person to whom you are delegating authority will be responsible to pay for any copay or fees due at the time of service unless you contact our office to make financial arrangements in advance.
Initial here	If immunizations have been authorized above and are administered, the current applicable Vaccine Information Statements will be given to the named adult accompanying the child.

Parent/Guardian Name:	**Date of Birth:**
By signing here and initialing the sections above, I/we give permission for any of the persons listed above to authorize any and all medical treatments for the child named at the top of the form at Cornerstone Pediatrics.	
Mom/Guardian Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____	Dad/Guardian Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____
Parent/Guardian Signature:	**Today's Date:**

Name of Patient:_____
Date of Birth: _____

Dr. Dianne McNeill, MD, PLLC dba Cornerstone Pediatrics

Initial History Questionnaire

Child's Full Name_____ Date of Birth_____Ethnicity_____

Reason for today's visit:_____

Who may we thank for referring you to our practice?_____

Reason(s) for choosing/changing to our practice:_____

_____

Prior Pediatrician (Name/City/State)_____

Preferred Pharmacy:_____

Allergies/Adverse Reactions	*Yes*	*No*	*IF YES, Please list medication & reaction*
Is your child allergic to any medications?			
Medications	*Yes*	*No*	*IF YES, Please list*
Is your child on any medications? (prescription & over the counter)			
Is your child on any supplements/vitamins?			
Specialty Care Providers	*Yes*	*No*	*IF YES, Please list*
Does your child see any specialists/receive services such as PT/OT/ST, etc.?			

Prenatal/Birth History	Name of Hospital:		
Delivery (circle)	*Vaginal*	*Cesarean*	*C/S reason:*
Gestational Age:	*Term*	*Early:_____wk*	*Late :_____wk*
Birth Weight		Birth Length	
Discharge Weight			

	Yes	*No*	*If Yes, Please Comment*
Any prenatal complications for mom?			
Any maternal infections? GBS?			
Maternal Medications/Antibiotics?			
Maternal Drugs/Alcohol?			
Any prenatal complications?			
Any birth complications/meds for baby?			
Any problems after birth for mom or baby?			
Breastfeed/Pumping/Formula/Both? (circle)			Name of Formula (if any):

Name of Patient:_____
Date of Birth: _____

Past Medical History	Yes	No	IF YES, Please comment
Has your child ever been hospitalized (other than birth)?			
Has your child had any serious injuries or accidents?			
Does your child have any serious medical conditions or chronic issues?			
ADD/ADHD			
Allergies			
Anemia			
Anxiety			
Asthma/Reactive Airway/Wheeze (Circle)			
Bladder/Kidney Problems			
Blood Diseases/Bleeding Disorders			
Cancer			
Concussion			
Congenital Anomalies/Genetic Disorders			
Constipation			
Depression			
Developmental/Behavioral Disorders			
Diabetes			
Ear or Hearing Problems			
Eczema/Atopic Dermatitis/Skin Problems			
Endocrine/Thyroid Problems			
Gastrointestinal Disorders/GERD			
Headache/Migraine			
Heart Problems/Heart Murmur			
Immunizations: Is your child behind?			
Muscle/Joint/Bone Problems or Fractures			
Seizures/Epilepsy			
Vision/Eye Problems/Glasses or Contacts?			
Other:			
Surgical History Has your child ever had surgery?	Yes	No	IF YES, Please list Procedure/ Approx Date/ Physician or Hospital

Developmental History	Yes	No	Please comment
Has your child met developmental milestones on time so far?			
Do you have any developmental concerns?			
Do you have any behavioral concerns?			

Name of Patient:_____
Date of Birth: _____

Family History (Biological parents, siblings, grandparents, aunts or uncles) *M (Mother), F (Father), S (Sister), B (Brother), MGM (Maternal GrandMother), MGF (Maternal GrandFather), PGM (Paternal GrandMother), PGF (Paternal GrandFather), MA (Maternal Aunt), PA (Paternal Aunt), MU (Maternal Uncle), PU (Paternal Uncle)*				
Condition	Yes	No	Relationships*	List or Comments
ADD/ADHD				
Allergies				
Anemia				
Anxiety				
Asthma/RAD/Wheeze/Chronic Bronchitis				
Bladder/Kidney Problems				
Blood Diseases/Bleeding Disorders				
Cancer				
Congenital Anomalies/Genetic Disorders				
Depression				
Developmental/Behavioral Disorders				
Diabetes				
Ear Problems/Frequent Ear Infections				
Eczema/Atopic Dermatitis				
Gastrointestinal Disorders/GERD				
-Constipation				
-Gerd/Reflux				
-Irritable Bowel Syndrome				
-Inflammatory Bowel Syndrome (CD/UC)				
Immune problems/Immunodeficiency				
Hearing Problems/Hearing Aid				
Heart Problems/Murmur				
-Heart Attack/Disease				
-High Blood Pressure				
-High Cholesterol				
Hypo/Hyperthyroid/Thyroid				
Muscle/Joint/Bone Problems				
Seizures/Epilepsy				
Serious Illness or Injury				
Skin Problems				
Vision/Eye Problems				
Other:				

Name of Patient:_____
Date of Birth: _____

Social History

To help us get to know you, please give us a list everyone who your child lives with:

Mom/Guardian:_____Employer:_____Job Title:_____
Phone:_____Email:_____Social Security#:_____
Dad/Guardian:_____Employer:_____Job Title:_____
Phone:_____Email:_____Social Security#:_____
Parents Relationship: Married/Divorced/Separated/Unmarried/It's Complicated :_____
Siblings/Stepsiblings:Names/DOB:_____
_____
Relatives:_____
Other Parents:_____Employer:_____Job Title_____
Phone:_____Email:_____Social Security#:_____
Languages spoken in the home(s):

	Yes	*No*	*IF YES, Please Comment*
Does your child go to daycare/babysitter?			Where?
Does your child go to school?			Grade:_____Name of School:
Any concerns about school performance?			504 or IEP?
Does child participate in sports?			
Does your child participate in other organized activities?			
How many hours per day does child spend on media screen time?			(include all screens … TV/computer/videogames)
Does your child have TV/computer/gaming station in their room?			
Does your child have a Phone?			Phone location at night? Any restrictions on use?
Does anyone smoke/vape around child?			In home? Outside? In car?
Does your family have any pets?			Type:
Do you have smoke alarms in your home?			Carbon Monoxide alarms?
Does your family wear seatbelts?			
Does your child use CarSeat/BoosterSeat?			Rear Facing Car Seat?
Does your child use helmet for bike/scooter?			
Does your child use sunscreen?			
Does your child use insect repellant?			
Does anyone have gun in home?			Gun locked?

List any other current concerns:

_____

Form completed by:

_____ _____ _____ _____

Name (Printed) Name (signature) Relationship to patient Date

Name of Patient:_____
Date of Birth: _____

Cornerstone Pediatrics
No-Show Policy

PURPOSE:
No-Show Policy has been implemented to improve scheduling opportunities and encourage patients to keep their scheduled appointments or call and reschedule or cancel their appointments in a reasonable amount of time (at least 48 hrs). As a courtesy to you, we provide reminder calls, emails and/or text messages 2-3 days prior to your child's scheduled appointment. If you fail to keep the appointment or give adequate notice of at least 48 hrs, it prevents another patient who may need the appointment and may keep them from being seen in a timely manner, leading us to need to implement this policy. This will maximize the time Dr. McNeill and our staff has to spend with your child to be able to continue to provide excellent care for your family.

No- Show Policy:
We have implemented this "No-Show" policy which will affect all patients who do not keep their scheduled appointment or cancel an appointment with less than a 24 hour notice.

1st No Show- Parent/guardian will receive a phone call or letter advising of our policy.

2nd No Show- Parent/guardian will receive a letter and charged a $50 No-Show fee for each child.

3rd and Subsequent No Shows- Parent/guardian will receive a letter and charged another $50 No-Show for each child fee and all family members may be dismissed from the practice.

No-Show for Double Appointment- Parent/guardian who schedule 2 or more children and no-show will be restricted from scheduling double appointments in the future. Parent/guardian will be responsible for appropriate missed appointment No-Show fee of $50 per patient.

No-Show for **New Patient** 1st Appointment- Parent/guardian will receive a phone call or letter advising of our policy. Family must then "Pre-Pay" for the estimated cost of the visit with their card on file. A 2nd New Patient No-Show will result in no further appointments being scheduled for the patient and the family will be dismissed and the "Pre-Pay" will be put toward the cost of the lost visit.

Please note that the No-Show fee is not covered by insurance and is the patient/guardian's responsibility. We also understand that emergencies may occur, and should that be the case, please contact the office as soon as possible to let us know your situation and we will take that into consideration as we assist you in rescheduling your child's appointment.

_____

Parent/Guardian Name (printed) Signature Date

Name of Patient:_____
Date of Birth: _____

Cornerstone Pediatrics
Late Arrival Policy

PURPOSE:
We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient and their family deserves. Late arrivals take away our ability to provide that personalized care in a timely manner and can diminish the full experience of receiving the exceptional care in a a non-rushed manner and also impact all the other families who are scheduled that day.

Late Arrival Policy:
Patients arriving more than 10 minutes late for a scheduled well visit, ADHD or consultation will most likely need to be rescheduled to another day, unless there is available time left in the schedule to work them back into that day's schedule.

Patients arriving more that 10 minutes late for a sick appointment will be worked back into the schedule and seen as soon as the schedule allows.

Patients who arrive early or on time will be seen before those who arrive late if we are working them back into the schedule.

We also understand that unexpected obstacles or emergencies may occur, and should that be the case, please contact the office as soon as possible with your anticipated arrival time to let us know your situation and we will take this into consideration as we assist you in rescheduling your child's appointment.

_____

Parent/Guardian Name (printed) Signature Date

Name of Patient:_____
Date of Birth: _____

Cornerstone Pediatrics Insurance/Payment Agreement

Please read carefully and initial each line and sign and date the bottom. Once everything is completed, the staff will contact you and schedule your child, if applicable.

_____1. Current insurance card(s) MUST be provided at every visit to be scanned and help ensure the correct insurance plan is selected.

_____2. Cornerstone is NOT responsible to know the limits and coverage of your particular health insurance policy. It is *your* responsibility to check with your specific insurance company. IF YOUR INSURANCE IS NOT VALID OR ELIGIBLE AT THE TIME OF YOUR APPOINTMENT, WE RESERVE THE RIGHT TO RESCHEDULE.

_____3. Insurance co-pays and prior visit coinsurance are expected to be *paid in full at the time of service*. If you are unable to comply, you must work with our office prior to the visit to set up a payment plan.

_____4. Deductible responsibilities must be paid in full prior to being seen for visit.

_____5. Office MUST be notified of any changes in insurance as SOON as possible, but no later than **24 hrs prior to appointment** to be sure we are in network and accept the insurance, or there is a risk of the appointment being rescheduled.

_____ 6. Pt MUST disclose any other insurances, otherwise they will be responsible for any denied claims due to incorrect insurance information.

_____7. Pt must have Dr. McNeill listed as their PCP with their insurance company. Pt must do COB (coordination of benefits) to both insurances to be sure the insurances know of the other and to be sure that they know who is the primary insurance. Primary insurance is based on the parent who has the earliest birth MONTH (ie: January parent is primary and December parent is secondary)

_____8. To cover any charges not covered by your insurance, we require that all parents provide a credit card on file (securely) with our office, unless the child is covered by a Medicaid plan. You will be notified at least 3 days in advance of charges, so if you need to, you can change your card on file. Additionally, the card will be used to refund anything due to the family in a more timely manner than by check being mailed to your address on file.

_____

Parent/Guardian Name (printed) Signature Date

Name of Patient:_____
Date of Birth: _____

CORNERSTONE
PEDIATRICS

Patient Name/ DOB:

Dianne McNeill, M.D., FAAP

Authorization to Use or Disclose Protected Health Information

Medical Records Release

At my request, I authorize:

PRIOR Practice/Physician name: _____
Address: _____
Phone:_____
Fax: _____

To Disclose/Transfer the Following Information:

_____All Records
_____Immunization/Vaccine Records (_____please fax to 410-9640 ASAP)
_____Other (Specify)_____

To Disclose/Transfer records to:

Dianne McNeill, M.D., FAAP
Cornerstone Pediatrics
308 Cedar Lakes Drive, Suite 103
Chesapeake, VA 23322
Phone 757-410-9600
Fax 757-410-9640

Purpose of Disclosure:

_X_ At the request of the patient/legal guardian

*I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that this authorization expires 1 year from the date signed.
*I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.
*I understand that photocopy or facsimile of this authorization is as valid as the original.
*I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individuals protected health information.

Signature of Patient/Legal Guardian Relationship to Patient Date