HATCH!
PEDIATRICS

Patient Registration

Tell us about your child

Last Name:_____ First Name:_____ MI:_____

Nickname:_____ Age:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Gender: OMale OFemale Language Preference: OEnglish OSpanish OOther_____

Race: OCaucasian OAfrican American ONative American OOther

Ethnicity: OCaucasian OAfrican American ONative American OOther

Tell us about your family (Please fill out completely)

Parent/Guardian Last Name:_____ First Name:_____ MI:_____

O Responsible Parent (where statements will be sent)

Address (if different from patient):_____ **DOB:** _____

City:_____ State:_____ Zip:_____

Phone (Home):_____ (Cell):_____ (Work):_____

Occupation:_____ Employer:_____ **SSN:**_____

Email Address: _____

Parent/Guardian Last Name:_____ First Name:_____ MI:_____

Address (if different from patient):_____ **DOB:**_____

City:_____ State:_____ Zip:_____

Phone (Home):_____ (Cell):_____ (Work):_____

Occupation:_____ Employer:_____ **SSN:**_____

Siblings:

Name_____ Date of Birth:_____

Name_____ Date of Birth:_____

Name_____ Date of Birth:_____

Name_____ Date of Birth:_____

Are there any custody issues pertaining to this child?

O No.
O Yes. Please submit a copy of the parenting plan to the receptionists

Who should we call in case of emergency? (Someone other than Parent/Guardian)

Last Name:_____First Name:_____MI:_____

Phone (Home):_____(Cell):_____(Work):_____

Relationship to Patient:_____

Will insurance be used for today's visit?

O No. The visit will be paid for today.
O Yes. Please provide the receptionist with your insurance card. If you are covered by multiple insurance companies, indicate which is primary, secondary, etc.

Hatch Pediatrics accepts most major insurance plans. Check with the receptionist for more information.

Privacy Policy (Please mark all that apply)

O I acknowledge that I have received the Hatch Pediatrics Notice of Privacy Policy.
O I authorize Hatch Pediatrics to contact me regarding my child's appointment, health information, lab results, billing problems or any other situation relating to my child's healthcare.
O I authorize Hatch Pediatrics to leave a detailed message regarding my child's healthcare. Mark all that apply:
OVoicemail OWith the following individual(s):_____Phone:_____

Authorization to Treat in Absence of Parent or Guardian (optional)

O I authorize my child to be brought to Hatch Pediatrics by _____. I consent for my child to be treated, and I agree to be responsible for the cost of such care.

Agreement to Pay

O I authorize the release of my child's medical records to my health plan, insurance company, or Medicaid, as applicable, for payment. **I request that my health plan, insurance company, or Medicaid, as applicable, make payment for services I receive at Hatch Pediatrics directly to Hatch Pediatrics, LLC.** I understand that I am responsible for payment for any services that are not covered by any health plan, insurance company, or Medicaid, including co-payments and deductibles. I understand **co-payments are due prior to my child being seen**. I understand that if my child does not have health insurance, or if I do not mark this circle, I will be responsible for payment which is due at the end of each visit. For any balance that remains unpaid 60 days after the date of service, I agree to pay 1.5% monthly interest charges (18% APR). Should any balance be referred to a collection agency due to default on payment, all costs of collections up to 50% of the balance, including attorney/court costs, will be added to the balance of my account

By signing below, I am confirming that I understand and consent to the assignment of benefits, payment responsibility, treatment(s), and disclosures above.

Patient Name:_____Date:_____

Signature:_____

Relationship to patient: OParent OGuardian OOther:_____

Thank you for choosing our practice for the care of your child. How did you hear about us? Please check one:

- Hatch! website
- Referred by another health care provider, if so which provider _____
- Referred by friend/family, if so please list name _____
- Other _____

HATCH!
PEDIATRICS

Patient Medical History

Patient Name:_____ Date of Birth:_____

Birth History

Birth weight:_____

Where was your child born?_____

Was your child born prematurely (before 37 weeks gestation)? OYes ONo

If yes, how many weeks gestation when born?_____

Did your child develop jaundice? OYes ONo

If yes, was treatment with lights required? OYes ONo

Did your child pass the infant hearing test (older children will not have had this test)? OYes ONo

Was blood collected for the Newborn Screening Test? OYes ONo

Describe any other problems during the newborn period:_____

_____

_____

_____

Medications

Please list any prescription or over-the-counter / herbal medications taken by your child.

_____ _____

_____ _____

_____ _____

Preferred Pharmacy _____

Allergies

Mark all that apply to this patient:

- O NONE
- O Penicillin (including Amoxicillin and Augmentin)
- O Cephalosporin (including Keflex/Omnicef/Rocephin)
- O Latex
- O Bee Stings
- O Pollen
- O Dust / dust mites
- O Mold
- O Peanuts
- O Other nuts
- O Shellfish
- O Eggs
- O Dairy
- O Wheat
- O Cats
- O Dogs

Other allergies? Please list:_____

Past Medical Problems

Mark all that apply to this patient:

- O NONE
- O Autism
- O Developmental Delay or Intellectual Disability
- O Ear Infections
- O Speech or Language Delay
- O Constipation
- O Headaches
- O Depression
- O Urinary Tract Infection
- O Asthma
- O ADD/ADHD
- O Gastroesophageal Reflux Disease (GERD)
- O Pneumonia
- O Seizure With fever only? OYes ONo
- O Chronic Abdominal Pain
  - O Anxiety
  - O Sleep Problems
- O Other?_____

Past Surgery

Mark all that apply to this patient:

- O NONE
- O Tonsillectomy
- O Ear tubes
- O Hernia Repair
- O Appendectomy
- O Circumcision
- O Adenoidectomy
- O Tear Duct Repair
- O Hypospadias Repair
- O Other?_____

Family History

Mark all that apply to the **family members of this patient**:

Problem	Mother	Father	Brother	Sister	Grandmother Maternal/Paternal?	Grandfather Maternal/Paternal?
Asthma						
Allergies						
Specify:						
Eczema						
Autism						
ADD/ADHD						
Developmental Delay						
Intellectual Disability						
Celiac Disease						
Inflammatory Bowel Disease						
Heart Defect						
Specify:						
Heart Disease						
Diabetes						
High Blood Pressure						
Kidney Disease						
Thyroid Disease						
Anxiety						
Depression						
Alcoholism						
Seizures						
Migraine						
Cancer						
Specify:						
Stroke						

Other?_____

Social History

Tobacco use at home? OYes ONo If yes, Ocigarettes Osnuff
Violence Exposure at home? OYes ONo
School Concerns? OYes ONo
Travel Outside the U.S.? OYes ONo
Guns at home? OYes ONo If yes, stored locked? OYes ONo
Pets at home? OYes ONo
Day Care? OYes ONo

Hatch Pediatrics Financial Policy

The charges at Hatch Pediatrics are usual and customary for our specialty. The clinic strictly follows billing guidelines set by the federal government for the care we provide. We are bound by our agreements with insurance companies to precisely follow these rules. Each doctor is trained in the rules and carefully considers billing prior to submission.

Your insurance is a contract between your family and your insurance company. It is your responsibility to know your plan's coverage, restrictions and requirements. You will be billed for any applicable co-payments, deductibles and exclusions of your insurance contract.

Note that Hatch Pediatrics is a Preferred Provider Organization (PPO). Care at Hatch will not be covered if your insurance is a part of a Health Maintenance Organization (HMO). It is your responsibility to know if your policy is in network with Hatch Pediatrics.

We currently accept Medicaid/HMK, TRICARE, CHAMPVA and all commercial, PPO-based insurance (BCBS, Cigna, Aetna, UHC, EBMS, Pacific Source, MT Health COOP, Multiplan, Allegiance, Health Info Net). Accepted insurance is subject to change. We DO NOT accept reimbursement from health share programs.

Self-pay visits will be collected at time of service and charges will be discounted 20%.

Applicable co-payments will be collected at time of service.

We accept cash, check, Mastercard/Visa and Care Credit.

Partial payments will not be accepted unless otherwise negotiated. Balances that remain unpaid after 60 days may incur a 1.5% (18% APR) monthly interest charge.

NSF Checks are assessed a $30 return check fee.

If a balance remains unpaid after the insurance claim is processed and no attempt is made to make payment arrangements after 60 days in arrears, your account will be referred to a collection agency. All costs of collection up to 50% of the balance, including attorney/court fees will be added to balance due.

Here is a sampling of our fees:

New Patient – Well Child Check	$230 - $282
New Patient – E/M (illness) Visit	$156 - $397
Established Patient – Well Child Check	$210 - $254
Established Patient – E/M (illness) visit	$105 - $320
Procedures (wart removal, sutures, foreign body removal, etc)	$108-$485

If your child is seen for a well child check-up (WCC) and there is an additional medical diagnosis, your doctor will bill for both the WCC and the additional diagnosis. Although the diagnostic care is provided on the same day as the WCC, each is considered distinct and acceptable by your insurance company. You may be charged a co-pay and/or deductible on the visit for the medical diagnosis portion.

If your child has to return to the office at a later date for an immunization, either because they are unwell at the time of their well child check-up, or because you defer getting immunizations on that day for another reason, they will be seen by a doctor for the follow-up visit. This means that immunization follow-up visits will incur a physician charge and may require co-pay or deductible.

By signing this document, you indicate that you have read and understand the above policy and had all your questions answered.

Child's name (print): _____

_____ _____

Parent Signature Date

Org Date: 09/02/2022

HATCH!
PEDIATRICS

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We understand the confidential nature of the information you provide to Hatch Pediatrics. We want you to understand how Hatch Pediatrics may use and disclose certain information you provide us, and what rights you have concerning that information.

What Information is Protected?
Information protected by this privacy policy includes information Hatch Pediatrics receives or creates that identifies you and concerns:
1) Your past, present or future medical health or condition
2) Medical care that is provided to you
3) The past, present or future payment for medical care provided to you.

How May We Use Protected Information?
Hatch Pediatrics may use or disclose your protected information to provide you treatment, obtain payment for your treatment, or perform health care operations. Some examples are:
Treatment: We may communicate with other health care providers, including doctors, nurses or pharmacists, to provide health care to you and manage your health care.
Payment: We may use or disclose your protected information to determine the amount of your co-payment responsibility and to obtain payment for your treatment from your insurer.

Health Care Operations We may use or disclose your protected information to review the performance of our staff, to prevent fraud and to develop compliance programs in order to offer you more effective and comprehensive treatment.

We may hire third parties to help us with these matters. We may disclose your protected information to these third parties so they can perform the services we request. We require these third parties to agree that they will use your protected information only to provide the services we have requested.

Hatch Pediatrics may use or disclose your protected information for other reasons. Examples are listed below. The examples are for illustration only and are not intended to be all-inclusive.

Communications with You We may use your protected information to contact you (to provide appointment reminders, or treatment advice and instructions, or other health-related information that may be beneficial to you).
Health Oversight Agencies: We may disclose your protected information to agencies authorized by law to perform audits, investigations, inspections or other activities for the oversight of the health care system, government benefit programs, government regulatory programs or civil rights laws.

Individuals Involved in Your Care We may disclose your protected information to family members that are involved in your health care. For example, if a family member or friend is present with you when we provide treatment to you or discuss your treatment with you, we may use our professional judgment in disclosing your protected information to that person.

Public Health Purposes We may disclose your protected information to authorities to prevent or control the spread of disease, to report abuse or neglect, to report adverse events or to enable product recalls.

As Required By Law We may disclose your protected information as may be required to report victims of abuse or neglect, in response to requests from law enforcement, or in response to court order, administrative order, subpoena, warrant, or other lawful process.

Special Circumstances We may use or disclose your protected information in certain special circumstances, including disclosure to agencies authorized by law to collect information for national security and intelligence activities, for specialized government functions in the event you are a veteran or in the military, for providing assistance in identifying you or locating you in the event of a disaster, for investigation of a death or identification of a deceased person, for research purposes, to avert a threat to health or safety of an individual or the public, to comply with requirements for worker's compensation programs, or to facilitate organ, eye or tissue donation or transplantation. Hatch Pediatrics never markets or sells personal information.

Hatch Pediatrics will obtain written authorization before using or disclosing your protected information for any reason other than those included in this notice. You may revoke your authorization in writing at any time. Upon receipt of your written revocation, we will stop using or disclosing your protected information, except to the extent that we have already taken action in reliance of the authorization.

Your Rights
You have certain rights concerning your protected information and this Notice, including:
Notice: You may request a copy of the Notice at any time. To request a paper copy, visit Hatch Pediatrics.

Inspection and Copies You have a right to inspect and receive a copy of the protected information we maintain about you. To do so, contact Hatch Pediatrics and request a copy. We may charge you for the costs of copying and mailing your protected information.

Amendments If you feel that the protected information we maintain about you is incomplete or incorrect, you may request that we amend it. The request must include the reason you are requesting the amendment. In certain cases, we may deny your request for amendment. If we deny your request, you may send us a written statement disagreeing with our denial.

Accounting of Disclosures You have the right to receive an accounting of the disclosures we have made of your protected information. The accounting will not include disclosures made for treatment, payment, or health care operations, or disclosures made directly to you, your family or friend involved in your care, or disclosures authorized by you. The right to receive an accounting of disclosures is subject to certain other exceptions, restrictions and limitations. You may submit your request in writing to Hatch Pediatrics. The first accounting you request within a 12-month period will be free of charge, but you may be charged for the cost of additional accountings.

Alternative Communication You may request that we contact you about your protected information only in a certain manner (such as in writing or by phone) or only at a certain location (such as your home or place of work). We will accommodate reasonable requests submitted in writing.

For More Information or to Report a Problem
If you have questions or would like additional information about the Hatch Pediatrics privacy policy, you may contact Hatch Pediatrics at (406) 587-5870. If you believe that your privacy rights have been violated, you may file a complaint with Hatch Pediatrics or the Department of Health and Human Services. To file a complaint with Hatch Pediatrics, send your complaint in writing to Hatch Pediatrics, 280 West Kagy Blvd, Suite G, Bozeman, MT 59715. There will be no retaliation against you for filing a complaint.

Revisions to Notice
Hatch Pediatrics may revise the terms of this Notice and make the new Notice effective for all of you protected information. If material changes are made to this Notice, a copy of this notice will be posted at Hatch Pediatrics, and will be available upon request.
Effective Date
This notice is effective as of January 9, 2017. Hatch Pediatrics is required by law to maintain the privacy of your protected information and to provide you with this Notice. Hatch Pediatrics is required to comply with the terms of this Notice for so long as it is in effect. Hatch Pediatrics is required to disclose any breaches promptly if it could compromise your information.

Child imMTrax Permission Form

Please Print

Childs Name:_____ Sex: M☐ F☐ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Client/Parent/
Guardian Signature:_____ Date:_____

Primary Health Care Provider: _____

HATCH!
PEDIATRICS

280 W Kagy Blvd, Suite G • Bozeman, MT 59715
Phone: 406-587-5870 • Fax: 406-522-1536

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Records (Circle One) REQUESTED FROM or SENT TO

_____
Medical Practice Name

_____
Address

_____
City State Zip

Phone#_____ Fax#_____

Purpose of Release:

- ➢ Transfer primary care due to:
  - ☐ New primary care clinic
  - ☐ Out of town move
  - ☐ Insurance change
  - ☐ Consultation/Second Opinion

Dates of Service:

- ☐ All Dates of Service
- ☐ For the date ranges: _____ to _____
- ☐ For the following dates of services_____

Specific Information Requested:

- ☐ Entire Medical Record
- ☐ Vaccine Records
- ☐ Clinic visit notes, lab and x-ray results
- ☐ Other, specific information only (please explain)_____

By signing this authorization I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information. I understand that Hatch Pediatrics will not condition the provision of treatment or payment on the provision of this authorization. Per the Notice of Privacy Policy, I understand I have the right to revoke this authorization is writing at any time. I understand that this authorization is in effect for one year from the date signed.

_____
SIGNATURE **DATE**

_____
Printed Name **Relationship to Patient**