WELCOME TO AGUILAR PEDIATRICS

In order to serve you better at your first appointment, we ask you to complete the following before we can make your first appointment.

1. If your child has any health issues, please request a copy of the records from the previous pediatrician and any specialist he/she is seeing so that Dr. Aguilar can review them to decide if our office, will be the best option for your child. The front desk has a release form. ***Please note that it is your responsibility to get the Medical Records & Immunization Records.***
2. Please provide a copy of the shot record from the previous Doctor's office. If you need to send a request, ask the front desk for a release form. However, please note it is your responsibility to get the shot record from your previous Doctor's office.
3. Please fill out all of the attached paperwork and give to the office.
4. ***Call and change PCP*** (Primary Care Physician) to Dr. Edwin F Aguilar.
5. We only accept patients who accept the American Academy of Pediatrics vaccine schedule.

I understand and accept the American Academy of Pediatrics Vaccine Schedule.

Parent Signature/ Firma De Padres:______________________ Today's Date/ Fecha De Hoy:__________

We look forward to working with your family!

Dr. Edwin F. Aguilar, Nurse Practitioners: Nathalie Shelor, Evi Hoy and Amir Alghali and April Taylor.

Patient Registration Form

Patient Information			
First Name:	Last Name:	MI:	Date Of Birth:
Gender: Male Female	Primary phone number:	Cell:	Email Address:
Address:	City:	State:	Zip Code:

Patient Insurance

Insurance Name:	Insured Name:	Relationship:	Date of Birth:
Insurance ID:	Medicaid Number:	Copay:	Preferred Pharmacy Include Address:

Responsible Party (Guarantor)

First Name:	Last Name:	D.O.B:
Address:	Email:	Phone Number:

Patient's Authorization

I authorize **EDWIN F. AGUILAR, M.D.** to apply for benefits on my behalf for services rendered **by EDWIN F. AGUILAR, M.D.**. I request payment from the insurance company be made directly to **EDWIN F. AGUILAR, M.D.** I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

____

Signature Date

Dr. Edwin Aguilar

6830 Hospital Drive, Suite 206

Rosedale, MD 21237

410-238-5390

Parents with newborn babies:

For the 1st visit our office needs to have the BABY'S Medicaid number or for private insurance the baby NEEDS TO APPEAR ON YOUR POLICY. If we not have this or if the baby does not appear on your policy, the visit will have to be a self-pay visit and then you can submit to your insurance carrier for reimbursement.

There are no exceptions.

____

Parent name

____

Parent signature

1. Please call Maryland Health Connection to report the baby's birth immediately. DO NOT WAIT UNTIL THE 1ST APPOINMENT.

   Maryland Health Connection

   1-855-642-8572

2. Call your insurance company/Managed Care Organization immediately to report the baby's birth.

3. Before the first visit call below number to get baby's Medicad # and card. FOR THE 1st VISIT, OUR OFFICE NEEDS TO HAVE THE BABY'S MEDICAID NUMBER OR CARD.

   State of Maryland Medicaid Provider Line

   410-767-5503 Option 0

4. If a Mom with a new born doesn't have baby's Medicaid ID #, Mom can call the number below. They speak Spanish.

   Maryland Children's Health Eligibility Unit

   410-887-2957

For any other problems with Medicaid, the parents can call:

Administration Care Coordination Unit

410-887-8741

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:		Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: ____________

Illnesses during pregnancy?	No ☐	Yes ☐
Medications during pregnancy?	No ☐	Yes ☐
Alcohol/Drug Abuse?	No ☐	Yes ☐
Problems at birth?	No ☐	Yes ☐

Describe: ____________

Type of delivery? ☐ Vaginal ☐ C-section

Birth Weight____________Discharge Weight_____

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B Immunization:____________

Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?____________

____

How many?_____

☐ Rent? ☐ Own? ☐ Shelter?

Who cares for child?____________

Date of Birth? Mother____________

Father____________

Are parents working? Mother No ☐ Yes ☐

Father No ☐ Yes ☐

Foster Care? ________Dates:________

Other Languages?____________

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) ____________	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: ____________

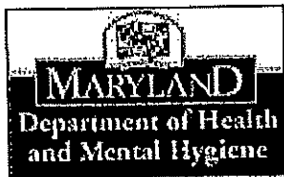
MEDICAL HISTORY

Has your child ever had:

Allergies (List) ____________	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: ____________	No ☐	Yes ☐

Current Medication(s): (*List*) ____________

Reviewed by:	Date of Review:



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Maryland
Vaccines for Children (VFC) Program

Patient Eligibility Screening Record

Date: ____________________

Child: ____
Last Name First Name MI

Date of Birth: ____

Parent/Guardian/
Individual of Record: ____
Last Name First Name MI

Health Care Provider: ____

The provider's office must keep this form for each child (birth through 18 of age) who receives immunizations through the VFC Program in Maryland in the patient's permanent medical record for six years. The health care provider or the parent, guardian, or individual of record may complete this form, and should complete a new form if the child's status changes. The provider may use this record for all subsequent visits as long as there is no change in the child's eligibility status.

This child qualifies for vaccination through the Maryland VFC Program because he/she (please check only one box, verification of response is NOT required):

(a) Is covered by or enrolled in Medical Assistance ☐

OR

(b) Does not have health Insurance ☐

OR

(c) Is Native American (American Indian) or Alaskan Native ☐

OR

(d) Has health insurance that does not cover (pay for) vaccines (VFC vaccine available only at a FQHC or Local Health Department) ☐

PLEASE NOTE IF YOU HAVE PRIVATE INSURANCE:

- A physical exam will only address preventative health concerns.

- A physical exam is not meant to diagnose or treat problems.

- If the Nurse Practitioner/Doctor has to address any other issue, you may incur additional charges.

EDWIN F. AGUILAR, MD
6830 HOSPITAL DRIVE, SUITE 206
ROSEDALE, MARYLAND 21237
410-238-5390

Thank you for scheduling your annual physical exam today. Prior to your visit, please be advised that an "annual physical" is considered a preventative or wellness visit. **This exam will address preventative health care only and is not meant to diagnose or treat problems.**

If your health care provider addresses and/or treats other health issues at this visit that are new or chronic in nature rather than having you return for a separate follow-up or sick visit, you may incur additional charges for those services.

Although most insurance companies reimburse for one preventative health exam each calendar year, some do not. If you have any doubts, please check with your insurance carrier or your employer's benefits department.

If you need further explanation about incurring additional fees for services provided during your visit, please discuss your concerns with your nurse practitioner and/or doctor.

I acknowledge that I have read this statement and understand, depending on the issues addressed at my visit, additional charges may apply.

Parent Signature ____

Date: ____

Aguilar Pediatrics

No Show Policies and Procedures

The goal of Aguilar Pediatrics is to provide quality care to our patients. Missing appointments is a detriment to the patient's health and the practice's ability to operate in an effective manner. Therefore, please note the following policies and procedures for "No Show" appointment are hereby effective August 1, 2019.

What is a "No Show"?

• A patient missing a scheduled appointment without, at a minimum, a twenty-four (24) hour cancellation or rescheduling notice.

• Any appointment that is scheduled on the same date of service that is not cancelled within 1- hour prior to appointment time.

• Any late arrival of 15 minutes or more and the patient is consequently unable to be seen.

What is the impact of a "No Show"?

• Missing the appointment may jeopardize the health of the patient.

• Missing the appointment denies care to other patients who need to be seen by a provider.

• Missing the appointment disrupts patient flow and affects other families.

What happens if I have too many "No Shows"?

We understand that circumstances may sometimes prevent families from being able to extend advance notice when cancelling appointments. However, we believe that these instances should be few and far between.

• After your first "No-Show" appointment, you should expect a phone call or text message from our practice notifying you of the "No-Show".

• If there are two "No-Shows" in a rolling 6 month period for any member of the same family, you can expect to receive a caution letter in the mail and each account will be charged a $25 no show fee. Double Header Appointments (multiple patients scheduled) will be subject to multiple no-show fees.

• If there are three "No-Shows" in a rolling 6 month period for any member of the same family, this may result in discharge of the family from the practice.

Families who "No-Show" for double header appointments (2 or more patients scheduled at the same time) may be restricted from scheduling double headers in the future. New patients who "No-Show" for their initial visit will receive a letter explaining that new patients who "No Show" 2 times for their initial visit will not be allowed to establish care at Aguilar Pediatrics. Aguilar Pediatrics will attempt to contact our patients by phone, email or text messages two business days prior to your scheduled appointment. **Please remember that confirmation calls are a courtesy. It is the Parent/Patient's responsibility to keep up with your scheduled appointment date and time and notify the office in advance when there is a need to cancel or rescheduled. Signature ______________________________

Patient's Name/ Nombre Del Paciente:______________________ Today's Date/Fecha De Hoy:____________

Aguilar Pediatrics/Payment Policy

Thank you for choosing us as your child's primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read carefully and ask us any questions you may have. A copy will be provided upon request once you sign the blank space at the bottom of this form.

- Insurance: We participate in most insurance plans including Medicaid. If you are not insured by a plan we do business with then full payment is expected before the visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions regarding your coverage.
- Co-Payments and Deductibles: All Co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- Non-covered Services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by insurance companies. You must pay for these services in full for the portion not paid by the Insurance company .
- Proof of Insurance: All patients must complete our patient information form before being seen by the doctor or nurse practitioner. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely matter, you may be responsible for the balance on the claim.
- Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company ; **We are not party to your contract.**
- Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- Non-Payment: You will receive statements from PMB "Physicians Medical Billing Company" after you have received 3 statements by mai;l, a payment in full will be required before your child/children can be seen. The 4th and 5th statement will be sent and then the nonpayment will be referred to a collection agency. Partial payments are not accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency along with you and your immediate family members may be discharged from this practice. If this occurs you will be notified by regular and certified that you have 30 days to find alternative medical care. During the 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

By signing below, I have read and understood the payment policy and agree to its terms and guidelines:

Parent Signature/Firma De Padre:______________________ Today's Date/Fecha De Hoy:____________

Consent Form/Formularios De Consentimiento

Edwin Aguilar M.D

6830 Hospital DR Ste 206

Rosedale MD, 21237

P-410-238-5390, F-410-238-5396

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations such as quality reviews.

- I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic

- I understand that I have the right to request a restriction of how my protected health information is used. You may request this in writing at any time by sending a written notification to 6830 Hospital Drive, suite 206, Rosedale, MD 21237 to Edwin Aguilar M.D.

- I also understand that I may revoke this consent at any time by making a request in writing ,except for information already used or disclosed

Patient Name/Nombre De Paciente:______________________________

Date Of Birth/Fecha De Naciemiento:__________________________

Parents Name/Nombre De Padre:_______________________________

Parents Signature/Firma De Padre:____________________ Today's Date/Fecha De Hoy:__________

Relationship To Patient/Relacion Con El Paciente:________________

Dr. Edwin Aguilar

Nathalie Brahver, CPNP

6830 Hospital Drive, Suite 206
Rosedale, MD 21237
Phone: 410-238-5390
Fax: 410-238-5396

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

I request and authorize ____ to
release healthcare information of the patient named above to:

Dr. Edwin Aguilar
6830 Hospital Drive, Suite 206
Rosedale, MD 21237
Fax: 410-238-5396

This request and authorization applies to:

Immunization Record ____________ Most Recent Physical ____________

Laboratory Results ____________ Entire Record ____________

Healthcare information relating to the following treatment, condition, or dates: ____________________

Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.