PEDIATRIC ASSOCIATES OF FARMINGTON, LLC. 200 MOUNTAIN ROAD, FARMINGTON, CT 06032.
TEL. (860) 676-9000. FAX: (860) 676-1541

Child's Name: _____ M F Birth date: _____ Student Status: FT PT N/A
(First) (Last)
Child's Social Security #: _____ Who does the child live with? _____

Primary Care Physician: **if not in this office**. _____Tel. No.: _____ Fax. No.: _____

SIBLINGS:
Name: _____ SocSec#: _____ M F Birthdate: _____

Name: _____ SocSec#: _____ M F Birthdate: _____

Name: _____ SocSec#: _____ M F Birthdate: _____

Name: _____ SocSec#: _____ M F Birthdate: _____

Pharmacy Name & Tel. No.: _____ Who referred you to this practice? _____

PARENT / GUARDIAN INFORMATION: Single Married Divorced Separated Widowed Partnered with **(Please circle)**

Father/Parent/ Guardian's name: _____
(First) (Last)
Address: _____

City: _____ State: _____ Zip: _____

SocSec#: _____ Birthdate: _____

Phone: Home:_____ Work: _____

Cell: _____ Fax: _____

Email address: _____

Profession/Employer: _____

Mother/Parent/Guardian's name: _____
(First) (Last)
Address: _____

City: _____ State: _____ Zip: _____

SocSec#: _____ Birthdate: _____

Phone: Home:_____ Work: _____

Cell: _____ Fax: _____

Email address: _____

Profession/Employer: _____

Insurance Information **(Please present your insurance cards to the receptionist at every visit)**

First Insurance:

Name of Insurance Co: _____

ID#: _____

Group #: _____

Name of Insured: _____

Soc Sec #: _____ Birthdate: _____

Employer: _____

Relationship to Insured: Child Stepchild Other _____

Second Insurance: I do not have a secondary insurance: _____
Initial

Name of Insurance Co: _____

ID#: _____

Group #: _____

Name of Insured: _____

Soc Sec #: _____ Birthdate: _____

Employer: _____

Relationship to Insured: Child Stepchild Other _____

ASSIGNMENT AND RELEASE AND AUTHORIZATION FOR CARE OF MINOR

I, the undersigned, assign directly to Pediatric Associates of Farmington, L.L.C. all medical benefits, if any, otherwise payable to me for services rendered to my child(ren). I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I give permission for the staff of Pediatric Associates of Farmington, L.L.C. / Dr. Deepa Limaye / Lisa Petricca, PA-C and their staff, to provide any necessary medical care to my minor charge(s) listed above.

Signature of parent or guardian: _____ Date: _____

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PLEASE PRINT

PERMISSION

Please consider this a request for me to exercise my rights under Federal and State laws by requesting only the following people to communicate in every way any confidential communication about my child's protected health information (PHI) with the provider and / or staff when the legal guardian(s) are not present. I understand that the providers and staff will need to treat the child as if I was present and the PHI may be disclosed during these appointments. I will be contacted as necessary. This form remains in effect as long as I do not make any changes.

Name: _____ Relationship to child: _____ Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____ Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____ Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____ Signature of parent/guardian _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PRIVACY PEDIATRIC ASSOCIATES OF FARMINGTON, LLC

Names of all children that apply to these restrictions: ☐ All the children listed on the first page.

Patient Name _____ Patient Name _____

Patient Name _____ Patient Name _____

_____

RESTRICTIONS QUESTIONNAIRE

May we send statements and reminder cards to the address in the Registration sheet?	Yes	No
If no, what address should be used ?_____		
May we contact you at work?	Yes	No
May we contact you at home or on the cell phone?	Yes	No
If not to both of the above, which number should we call? _____		
May we leave messages (including laboratory results) on your answering machine?	Yes	No
May we send you a fax? If yes, Fax No. _____	Yes	No
May we contact you via email? If yes, Email address _____	Yes	No

_____ _____ _____
Name of Patient or Legal Representative Signature Date

FOR THE STAFF ONLY : TO BE COMPLETED ONLY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT:

On _____, Pediatric Associates of Farmington, LLC attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-name patient. We were unable to obtain this acknowledgement because:

Patient declined to sign this written acknowledgement. ☐Patient did not understand the request to sign the written acknowledgement
Other (please specify) _____

_____ _____
Signature & Date of Employee Signature & Date of Witness

_____
For restrictions to your protected health information (PHI) other than noted above, please submit your request to the Compliance/Privacy Officer utilizing our "Restriction of Use or Disclosure of Protected Health Information (PHI) Form."

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To make it easier for the providers to concentrate on the care of your child we ask you to review these policies and cooperate with us in ensuring the best care for your child.

Thank you for understanding and please let us know if you have any questions

1. **AT EVERY VISIT**: Please bring the patient's insurance card, your photo-ID and any payment/co-pay applicable at each visit. **Federal trade commission identity theft: 'RED FLAGS RULE': We have to check photo identification at every office visit to comply with this rule.**

2. **APPOINTMENTS:** please make your next physical exam or follow up appointment before you leave.

3. **FLU VACCINE**: Please call us in September to schedule your flu vaccine.

4. **CALL REMINDERS:** A courtesy call is given prior to the appointment but we expect the caregivers to make note of their appointments.

5. **FAILURE TO KEEP APPOINTMENTS**:
a. A fee of $100 will be charged for any missed appointments or for failure to cancel the appointment 24 hours prior to the appointment.
b. We shall be unable to schedule any more appointments if either the initial appointment or more than three appointments are missed.

6. **CO-PAYS:** All payments are expected at the time of the visit. We will be charging an administrative fee of $5.00 if asked to bill.

7. **RETURNED CHECKS**: A fee of $25.00 will be charged for every returned check.

8. **PRESCRIPTION REFILLS AND FORMS**: Please give us 24-48 hours. Forms not requested at the annual physical exam will be charged an administrative fee of $5.00 each.

9. **QUESTIONS AT THE VISIT**: If you are here for a specific visit such as a vaccine, please understand that any concern expressed and addressed has to be documented as an office visit. Please let us know earlier if you have any other concerns besides the vaccine administration.

10. **ACCOMPANYING CHILDREN:** Please let us know when you come, if the accompanying child(ren) also need(s) to be seen so we can inform you if it is possible without inconveniencing the next patient.

11. **ELECTRONIC DEVICES**: Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

The policies written above have been reviewed and understood.

Date: _____ Signature and name of legal guardian of the child(ren) listed on registration sheet: _____

_____

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DEVELOPMENTAL EVALUATION APPLICATION FORM

Child's Name: _____ _____ M / F Birth date: _____ Age: _____
Last First Name (Any Other Name)

Why do you want this child evaluated? Please list all the concerns.

_____

_____

_____

_____

When were these problems first noted and by whom? _____

_____

What has prompted you to seek evaluation at this time? _____

_____

Please Circle all terms that describe your child.

Hyperactive, fidgety	Short attention span	Poor concentration	Academic difficulties	Delayed milestones
Hearing problems	Vision problems	Sleep problems	Delays in speech/language	Loss of skills
Eating problems	Temper tantrums	Conduct problems	Loner, few friends	Poor self esteem
Bedwetting				

Is this child: Biological / Adopted / In Foster Care / _____.
Check all those involved in raising this child: Mother / father /Grandparent / Housekeeper/Babysitter / Daycare worker / other (specify)_____

List all languages spoken by the child_____ List all languages spoken at home _____

School: _____ Address: _____ Tel: _____

Current Grade:_____ No. of years in this school _____ Has this child repeated a grade ? Y / N Grade: _____

List all schools previously attended:

School	City/state	Grade	Years

List all members living in the same home as the child.

Name	Sex	Age	Occupation/Grade	Relationship

List all immediate family members not living in the same home as the child

Name	Sex	Age	Occupation/Grade	Relationship

List all previous evaluations done

Type of evaluation	Date	Evaluation Site /Person/ address
Psychological	_____	_____
Educational	_____	_____
Speech/Language	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurology	_____	_____
Psychiatry	_____	_____
Other	_____	_____

Please list all previous diagnosis or educational classifications made: _____

Please list all services received or currently receiving:

Services	Dates	Times per week	Provider/Therapist
Counseling/Psychotherapy	_____	_____	_____
Resource Room	_____	_____	_____
Self-contained class	_____	_____	_____
Tutoring	_____	_____	_____
Physical therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech/Language Therapy	_____	_____	_____
Medication (stimulants)	_____	_____	_____
Other _____	_____	_____	_____

Please fill this if different from the registration sheet.

Legal guardian / Parent information: Single Married Divorced Separated Widowed Partnered with **(Please circle)**

Father/Parent/ Guardian's name: _____ (First) (Last)
Address: _____
City: _____ State: _____ Zip: _____
SocSec#: _____ Birthdate: _____
Phone: Cell:_____ Work: _____
Home: _____ Fax: _____
Email address: _____
Profession/Employer: _____

Mother/Parent/Guardian's name: _____ (First) (Last)
Address: _____
City: _____ State: _____ Zip: _____-_
SocSec#: _____ Birthdate: _____
Phone: Cell:_____ Work: _____
Home: _____ Fax: _____
Email address: _____
Profession/Employer: _____

DEVELOPMENTAL BEHAVIORAL EVALUATIONS: All evaluations to be scheduled in one or two sessions. Please bring all contributory records such as school reports or previous evaluations.

Informational sheet to review:

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11. **ELECTRONIC DEVICES:** Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

Thank you for understanding and please let us know if you have any questions.

Our providers:
Deepa Limaye, MD is Board Certified by the American Board of Pediatrics in both General Pediatrics and Neurodevelopmental Disabilities. She is the Developmental consultant for the Craniofacial division at the CT Children's Medical Center.
Lisa Petricca, PA-C is Board Certified by the National Commission on Certification of Physician Assistants (NCCPA) and a fellow member of the American Academy of Physician Assistants.

This is the only location of our office.
Office Hours: **Mon / Tue / Fri – 8.30 to 12 & 12.30-4.00 pm Wed / Thu - 8.30 to 12 & 12.30- 5.00 pm**

Guidelines followed:
We follow the guidelines of the American academy of pediatrics.
We are strong advocates of immunization and preventive care. We like our patients to read and ask us questions so we can always have an open discussion about the care of your child.

Calls during office hours:
Every call is answered as fast as possible. If the call is deemed urgent, the staff will get the provider out of the room. If it is a routine call, you can expect an answer either at lunch time or before the end of the day.