CORAZON PANES SANCHEZ., M.D., L.L.C.

CECIL COUNTY
4863 PULASKI HWY., STE. 120
PERRYVILLE, MD 21903
PHONE #: 410-642-9172
FAX #: 410-642-9176

111 Ryan Drive
Rising sun, MD 21911
Phone # 410-658-1300
Fax # 410-658-1311

BALTIMORE COUNTY
815 EASTERN BLVD.
BALTIMORE, MD 21221
PHONE #: 410-687-4114
FAX: #: 410-687-0182

PATIENT REGISTRATION

NAME:________________________________ DOB:_________________ SEX: ( ) MALE ( ) FEMALE

SOCIAL SECURITY #:______-_____-_____ ADDRESS:_____________________________________

CITY/STATE:___________________________ ZIP:___________ TELEPHONE #:________________

MOTHER'S NAME:__________________________ FATHER'S NAME:__________________________

MOTHER'S S.S. #: ________-_______-________ FATHER'S S.S. #:________-________-________

SCHOOL:__________________________________ GRADE:_____________________________________

EMERGENCY CONTACT NAME:_________________RELATION TO THE PATIENT:__________

HOME TELEPHONE #:________________ CELL PHONE : _______________ BEEPER:____________

REFERRED BY: FAMILY( )ADVERTISEMENT( )YELLOW PAGES( )INSURANCE( )OTHERS( )

MOTHER'S EMPLOYER:____

WORK TELEPHONE #:_______________ CELL PHONE:________________ BEEPER:___________

E-MAIL ADDRESS: ____

FATHER'S EMPLOYER:____

WORK TELEPHONE #:_______________ CELL PHONE:________________BEEPER:_____________

E-MAIL ADDRESS:____

INSURANCE INFORMATION:

COMPANY:______________________________________ GROUP #:____________________________

POLICY HOLDER NAME:___________________________ DOB:_______________________________

MEMBER #:____________________ EFFECTIVE:_______________ EXPIRATION: ______________

"I verify the accuracy of the above information and authorize the release of any medical information necessary to process any claims."

PATIENT OR AUTHORIZEDSIGNATURE

X____ DATE: _________________________

(PARENT OR LEGAL GUARDIAN)

"I request payment for this claim and if payer accepts assignment, I authorize payment directly to the physician or supplier for the described."

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As a parent/ guardian of ___________________________, DOB ___________________,

I give permission to CORAZON PANES SANCHEZ, M. D., L.L.C. to perform health assessments, physical examinations, routine screening, evaluation and treatment of any suspected or diagnosed medical conditions.

____
Parent/ Legal Guardian Signature

____
Address

____
City/State/Zip Code

____
Telephone Number

____
Signature of Witness

____
Date

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CONSENT THE IMMUNIZATION OF A MINOR

I, ____, AM
PRINT NAME

__________ A GRANDPARENT
__________ AN ADULT BROTHER OR SISTER
__________ AN ADULT AUNT OR UNCLE
__________ A STEPPARENT
__________ ANOTHER ADULT WHO HAS CARE AND CONTROL
__________ AN ADULT WHO HAS CARE AND CONTROL OF THE MINOR NAMED BELOW UNDER AN ORDER OF A COURT TO THE CARE OF AN AGENCY OF THE STATE OR COUNTY AND REASONABLY BELIEVE THE MINOR NEEDS IMMUNIZATION.

OF ____, A MINOR WHOSE (CHECK ONE)
NAME OF MINOR
____ NATURAL OR ADOPTIVE PARENT, _____ GUARDIAN, _____ PERSON WHO, UNDER

COURT ORDER, IS AUTHORIZED TO GIVE CONSENT TO THE MINOR IS ___________________
(NAME OF PARENT)
AND FOR WHO I AM GIVING CONSENT FOR MINOR IMMUNIZATION.

THE FOLLOWING DESCRIBES THE SITUATION OF ALTERNATE CONSENT:

__________ * THE PARENT HAS VERBALY DELEGATED THE AUTHORITY TO ME TO CONSENT FOR IMMUNIZATION OF THE ABOVE-NAMED MINOR AND I HAVE SUFFICIENT INFORMATION ABOUT THE MINOR AND THE MINOR'S FAMILY TO ENABLE ME TO CONSENT.

__________ * THE PARENT IS NOT REASONBLY AVAILBLE BECAUSE:

________ THE LOCATION OF THE PERSON IS UNKNOWN.

________ I HAVE MADE A REASONABLE EFFORT WITHIN THE PAST 90 DAYS TO LOCATE AND COMMUNICATE WITH THE PARENT FOR THE PURPOSE OF OBTAINING CONSENT AND THE ATTEMPT HAS FAILED.

________ I HAVE CONTACTED THE PARENT AND REQUESTED THAT THE PARENT CONSENT TO THE IMMUNIZATION AND NO ACTION HAS BEEN TAKEN ON THE REQUEST BUT I HAVE NOT BEEN EXPRESSLY DENIED THE AUTHORITY TO CONSENT TO THE IMMUNIZATION OF THE ABOVED NAMED MINOR.

____ ____
SIGNATURE OF PERSON GIVING CONSENT WITNESS

____ ____
DATE DATE

*PARENT IS DEFINED AS THE NATURAL OR ADOPTIVE PARENT, THE GUARDIAN, OR PERSON WHO, UNDER COURT ORDER, IS AUTHORIZED TO GIVE CONSENT FOR THE MINOR.

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****

PROMISORY NOTE

DATE: _______________

ACCOUNT: ___________________

CORAZON PANES SANCHEZ, M.D., L.L.C. has agreed to bill my insurance company for today's visit on the account above. In the event that my insurance thus not cover this office visit, whether it's in full or partial payments, I understand that I will be liable for the account balance. At such time, I will contact the billing office and make payment arrangements.

_______________________________ _______________________________

(Parent/Legal Guardian – Print) **(Authorized personnel – Print)**

_______________________________ _______________________________

(Signature) **(Signature)**

****NOTE****

All parties consider this to be a binding contract between CORAZON PANES SANCHEZ, M.D., L.L.C. and the above Parent/Legal Guardian

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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	**PSYCHOSOCIAL HISTORY**
Name of Hospital:	Who lives in household?
Illnesses during pregnancy? NO YES	Rent? Own? Shelter?
Medications during pregnancy? NO YES	Who cares for the child?
Alcohol/Drug Abuse? NO YES	Date of Birth: Mother:
Problems at birth? NO YES	Father:
Describe:	Are Parents Working? Mother: Father:
Type of Delivery? VAGINAL C-SECTION	Foster Care?
Birth Weight: Discharge Weight:	Dates:
Did baby receive Hepatitis B immunization: NO YES	
Newborn Hearing Screen? NO YES	Other Languages?

FAMILY HISTORY

Has anyone in your family (parents, grandparents, aunts/uncles, sisters/brothers) had:

1. Allergies/Asthma	NO	YES	WHO:
2. TB/Lung Disease	NO	YES	WHO:
3. HIV/AIDS	NO	YES	WHO:
4. Suicide Attempts	NO	YES	WHO:
5. Heart Disease	NO	YES	WHO:
6. High Blood Pressure/Stroke	NO	YES	WHO:
7. High Cholesterol	NO	YES	WHO:
8. Blood Disorders/Sickle Cell	NO	YES	WHO:
9. Diabetes	NO	YES	WHO:
10. Seizures	NO	YES	WHO:
11. Mental Illness	NO	YES	WHO:
12. Cancer	NO	YES	WHO:
13. Birth Defects	NO	YES	WHO:
14. Hearing/Speech Problems	NO	YES	WHO:
15. Kidney Disease	NO	YES	WHO:
16. Alcohol/Drug Abuse	NO	YES	WHO:
17. Hepatitis/Liver Disease	NO	YES	WHO:

18. Thyroid Disease	NO	YES	WHO:
19. Learning Problems/ Attention Deficit Disorder	NO	YES	WHO:
20. Family Violence	NO	YES	WHO:

MEDICAL HISTORY

Has your child ever had:

1. Chicken Pox	NO	YES	If yes, when?
2. Frequent Ear Infections	NO	YES	If yes, when?
3. Vision/Hearing Problems	NO	YES	If yes, when?
4. Skin Problems/Eczema	NO	YES	If yes, when?
5. Asthma/Allergies	NO	YES	If yes, when?
6. TB/Lung Disease	NO	YES	If yes, when?
7. Seizures/Epilepsy	NO	YES	If yes, when?
8. High Blood Pressure	NO	YES	If yes, when?
9. Heart Defects/Disease	NO	YES	If yes, when?
10. Liver Disease/Hepatitis	NO	YES	If yes, when?
11. Diabetes	NO	YES	If yes, when?
12. Kidney Disease/Bladder Infections	NO	YES	If yes, when?
13. Physical/Learning Disabilities	NO	YES	If yes, when?
14. Bleeding Disorders/Hemophilia	NO	YES	If yes, when?
15. Sexually Transmitted Diseases	NO	YES	If yes, when?
16. Emotional/Behavioral Problems	NO	YES	If yes, when?
17. Depression/Suicidal Thoughts	NO	YES	If yes, when?
18. Hospitalizations/Surgeries	NO	YES	If yes, when?
19. Physical/Emotional/Sexual Abuse	NO	YES	If yes, when?
20. Bone/Joint Injuries	NO	YES	If yes, when?
21. Obesity/Eating Disorders	NO	YES	If yes, when?
22. Other (please specify):	NO	YES	If yes, when?

CHILD'S CURRENT MEDICATION LIST

REVIEWED BY: ____________________________________ **DATE:** _________

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OFFICE POLICIES

Effective April 5, 2008; the following moderate fees will be charged and policies will be implemented that will enable us to continue to serve you and the health care needs of your children with the same level of care and attention that you have been accustomed.

1. The parent or guardian is responsible for the Medicaid eligibility at the time of the visit. If services are given, and the patient is not eligible, the parent or guardian will be liable for the fee. Also, the patient must be under the correct Primary Care Physician (PCP), or no payment will be paid by the insurance company.
2. Also, commercial insurance patients, the parent or guardian, the policy holder is responsible for all the charges not covered by the insurance, including all copays, coinsurances, deductibles.
3. If there is any legal issues (e.g. custody concerns or problems), notify the staff to have an appointment with Dr. Sanchez.
4. All co-pays are to be paid at the time of the visit, or cannot be seen unless it is a sick emergency visit.
5. All prescriptions, referrals, forms, notes, etc. need to be picked up. These items cannot be faxed unless it is an undo hardship for that day necessity.
6. Unless seen with the last two weeks, filling out forms for immunizations, school papers, daycare papers, etc., an appointment has to be made.
7. Unless an unforeseen emergency, like an injury, referrals have to be requested by the parent or guardian 10 days prior to the appointment.
8. When you make a appointment, please keep the appointment at the time scheduled.
9. Call at least 24 hours ahead of time to cancel the appointment. You will be notified if you miss an appointment the first time. Then if this persist you will be charged $25.00 for a missed appointment with no notification.
10. If you have an appointment for a child and another child in the family is sick, please call and tell us the circumstances for another child to be seen; we need to schedule and have the chart prepared. Please realize that we would like all sick children to be accommodated for their problem.
11. Rebilling charges for balances on statements over 60 days without any confirmation payment plan or correspondence with the office, an extra $10.00 per statement for office work, stationery, and postage.
12. A bounced check fee $25.00

Thank you for your cooperation and for your understanding the necessity of the implementation of the above policies

____________________________ ____________________________

Corazon Panes Sanchez, M.D. **Signature of parent/guardian**

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As per our office police, after one missed appointment we will try and notify you of your missed appointment. This means that you have to keep your home phone number, cell number, and home address current. After the second missed appointment you will be responsible for a missed appointment charge.

$25.00 FEE FOR MISSED APPOINTMENT

Please adhere to the following:

1. **When you make a appointment, please keep the appointment at the time scheduled.**
2. **Call at least 24 hours ahead of time to cancel an appointment. (We do understand unforeseen circumstances.)**
3. **If you have an appointment for a child and another child in the family is sick, please call and tell us the circumstances for another child to be seen, we need to schedule and have the chart prepared.**

KEEPING CHILDREN HEALTHY AND WELL IS OUR GOAL! LET US ALL WORK TOGETHER!

____
(Parent/Guardian Signature)

____
Corazon Panes Sanchez, M.D.
And Staff

CORAZON PANES SANCHEZ., M.D., L.L.C.

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RELEASE OF RECORD(S)

Date ____________

To: ______________________________________

____

____

____

I here authorized the release of my medical records to the following:

CORAZON PANES SANCHEZ, M.D., L.L.C

CECIL COUNTY		**BALTIMORE COUNTY**
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I would like to have any and all information including the diagnosis and records of any treatment rendered to me during the following dates:

________________________________ to ________________________________

________________________________ ________________________________

(Print Patient Name) (Patient Date of Birth)

________________________________ ________________________________

(Parent or Legal Guardian) (Witness)

NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Corazon Panes Sanchez has implemented the following policies and procedures so that the confidentiality of your personal and/or medical information remains confidential.

Your physician and all other employees working in the practice will keep any information related to you (medical and/or non-medical) in a confidential manner. However, so that we may provide you with appropriate medical advice for general practice operations and or/ for the purpose of obtaining payment, we will, at our discretion, provide information pertaining to the treatment you receive in this practice, the charges for this treatment and related information to other healthcare related entities. This information will be submitted through the following mechanisms; U.S. Postal Service, facsimile, Internet, voice mail, and/or personal communications. The following is a list of the most common types of entities to whom we would most typically provide personal health-related information. This list is not all-inclusive. Other entities may be added in the future.

- Physicians and non-physician providers who work outside of this practice
- Medical facilities (i.e. hospital, surgery centers, health department)
- Laboratories for the purpose of running medical tests
- Other healthcare providers, such as pharmacies, ambulance services, clinical research organization, school health departments, and day care providers
- Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management, tracking immunizations and updating health care
- States or federal agencies that require the submission of specific health-related information

We may mail the following to you: new patient forms, appointment correspondence, recall cards, account statements, newsletters, brochures, etc. In addition, we may need to contact you by phone to discuss office appointments, test results, treatments, referrals, account balances and/or to return your phone calls. We will first attempt to contact you (the parent or guardian) at home or cell phone. If you want another family member contacted, please inform the office for your file. However if you are not available and you provide us with your work number, we will attempt to call you at work. If you do not want this please advise the office. If you are not available, we will leave a message for you to either call the office or remind you of your appointment times.

Please advise the office of any particular rules for billing or calling when there is family separation, divorce or other legal custody manners.

In the event you do not pay all of your charges in full at the time of your visit, we will mail a statement to your home. Depending on your specific situation, we may mail recall cards to your home noting that you need to contact the office to schedule an appointment for a check-up for the child. We will use your home address you provided us at the time you registered with the practice.

We may contact your insurance company to determine coverage, eligibility, deducible status an/or co-insurance and co-pay requirements.

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NOTICE TO PATIENTS

Consent to Use and Disclose Protected Health Information

Corazon Panes Sanchez, M.D. LLC will use your health-related information for the purposes of providing you with medical treatment, obtaining payment for services rendered and/or for general health care operations. Your health related information will be submitted through the following mechanisms: U.S. Postal Service, fax submissions, Internet submission, voicemail, and/or professional communications. The most common entities that will receive this information are other providers, facilities, insurance companies and pharmacies. More specific information pertaining to our practice policies is provided for you in our “Notice of Privacy Practices” statement. You have the right to review this statement prior to receiving health care and prior to signing this consent. The terms of our Notice of Privacy Practice may change, at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment and /or health care operations. We are not required to agree with your requested restrictions. If we do not agree with your request, we will discontinue treatment. We have chosen to participate in the Chesapeake Regional Information System for our patients, Inc. (crisp), a state wide health information exchange. As permitted by law, your health information will be shared with this in exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

I have received a copy of the practice’s Notice of Privacy Practices. _________ (Initials)
I understand that I may revoke, at any time, this consent. This revocation will not affect previous actions, prior to revocation._______ (Initials)
I consent the above noted terms related to the use and disclosure of the individually identifiable health information for the purpose of treatment, payment and/or health care operation. I understand that this consent will remain in effect until I revoke it, in writing.
Patient’s Name (Print):_________________________________ Date: ________________
Parent’s Signature (or Patient’s Legal Guardian): ______________________________________
Witness: ____