Northport Pediatric & Adolescent Medicine
205 East Main Street, Suite 2-6,
Huntington, NY 11743
Tel (631) 757-5604 Fax (631) 266-2190

Dr. Susan Gunduz, M.D., F.A.A.P.
Dr. Linda Moerck, D.O., F.A.A.P.

Thank you for choosing Northport Pediatric and Adolescent Medicine.

Well visits for your child are scheduled yearly. Insurance plans usually cover a well visit 365 days after your child's last well visit or one well visit per calendar year.

Please check with your insurance plan's well visit coverage policy, so that we can help you schedule your appointments.

Insurance will cover the well visits for 12 months and later, these visits include:
a 12 month well visit, a 15 month well visit, an 18 month well visit, a 2nd year well visit, a 2 1/2 year well visit (please note that not every plan covers the 2 1/2 year old well visit; check with your plan before scheduling), and a 3rd year well visit, and yearly visits thereafter.

There may also be situations where your child may be ill for their well visit, or have other concerns, noted during the visit, which may require more diagnostic time. Those visits will require a copayment, or deductible, as well.

Thank you for growing with Northport Pediatrics!

Northport Pediatric & Adolescent Medicine

Patient Name: _____ Nickname: _____ Birthdate: _____ Sex:

DEMOGRAPHIC INFORMATION:

Ethnicity (choose one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefers not to answer

Preferred Language: _____

Race (Choose one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefers not to answer

SIBLINGS:

Other Children's' Names	Birthdate	Sex	Demographics (same as above?)	If different, please specify
1.		M F	Yes No	
2.		M F	Yes No	
3.		M F	Yes No	
4.		M F	Yes No	

ACCOUNT INFORMATION:

Custodian (patient lives with):

Name: _____
DOB: _____ SSN: _____
Address: _____
_____
Primary Phone: _____
Secondary Phone: _____
Email: _____

Guarantor (bills sent to):

Name: _____
DOB: _____ SSN: _____
Address: _____
_____
Primary Phone: _____
Secondary Phone: _____
Email: _____

Mother's Maiden Name: _____

Emergency Contact:

Name:	Relationship:	Phone:

If you would like to receive appointment reminders via text message, please enter a phone number we can text: _____

Would you like to sign up for **My Kid's Chart**, our patient portal, so you can securely view and print your child's medical record online? We will e-mail you the link so you can sign up. [ ] Yes [ ] No

If yes, please provide e-mail and write legibly: _____

INSURANCE INFORMATION: Please provide a copy of your current insurance card(s)

Insurance holder's name: _____ Date of Birth: ____/____/____

Employer: _____ Phone: _____

If for any reason the insurance company should refuse payment of the bill, I am legally responsible at the office rate. I hereby authorize payment of medical benefits to Susan Gunduz, M.D.

Signature _____ Date _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:	Date of Birth:
Patient's Name:	Date of Birth:
Patient's Name:	Date of Birth:
Patient's Name:	Date of Birth:

I authorize and request **(previous office name)** _____

at phone number_____ and fax number_____

to release healthcare information of the patient(s) named above to:

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This request and authorization applies to:

- ❑ All healthcare information
  or
- ❑ Between the Dates: _____

Parent/Guardian
Signature: _____ Date Signed: _____

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Thank you for choosing Northport Pediatric and Adolescent Medicine!

Your newborn will need at least 7 well visits in the first year of life. Some insurance plans will cover the costs of these visits, however, we recommend that you check with your insurance plan about your baby's coverage.

Accordingly, please check your insurance plan's well visit coverage policy so that we can help you plan for the future and schedule all necessary well visits.

Well visits required during the first year are as follows:

• 2 week	• 4 month
• 4 week	• 6 month
• 2 month	• 9 month
• 3 month	

We also suggest a 5 month visit; most insurance carriers do not cover this visit.

Insurance will cover additional well visits for 12 months to the third year of life, as follows:

• 12 month; visit MUST be scheduled for after the baby's first birthday.	• 2 year
• 15 month; we recommend coming in 2 weeks before the baby is 15 months.	• 2.5 year; most insurance carriers do not cover this visit.
• 18 month	• 3 year

In addition to these well check-ups, newborns usually require a few visits to check for weight gain, jaundice, rashes, illness, development concerns, vaccine separation, etc. **These are not considered well visits.** A copayment, or deductible payment will be required for these visits.

There may also be situations where your newborn may be ill for their well visit, or other concerns are noted during the visit, which may require more diagnostic time. Those visits will require a copayment, or deductible, as well.

Please let us answer any questions you may have. We want to offer a calming, healing environment at every encounter.
Welcome and we are excited you chose to grow with Northport Pediatrics!

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We at Northport Pediatrics are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our office policies. Your clear understanding of the office policy agreement is important in our professional relationship.

Appointments

1) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate advanced notice.
2) If you know you are running late, please call the front desk and let them know. We will be more than happy to accommodate you.
3) If you are 15 minutes late to your appointment and have not called the front desk to give notice that you will be late, we reserve the right to cancel your appointment.
4) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
5) The front desk is told to book well visits at least 365 days apart from the last one. Well visits are also valid for 365 days. If you would like one sooner than 365 days from the last well visit, please call your insurance company and double check to see if it can be sooner. Otherwise, you may be billed out of pocket.

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.
5) We reserve the right to ask you for a copy of your insurance card at any visit. Please provide it when asked by the front desk. Otherwise, you may be billed directly if we do not have your updated policy.
6) If you need a referral to a specialist to be sent through your insurance, there must be a record of a visit discussing with the doctors the specialist type as well as a 48 hour notice.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.
3) Co-payments are due at the time of service.
4) Self-pay patients are expected to pay for services in full at the time of the visit.

5) Many insurance plans have large deductibles. Charges that pass to patient responsibility are the rates we have contracted with the insurance companies. It is not allowable for us to lower these fees.
6) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.
7) For scheduled appointments, prior balances should be paid prior to the visit.
8) We accept cash, checks, Visa, American Express, and MasterCard credit and debit.
9) A $50 fee will be charged for any checks returned for insufficient funds.
10) Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. Satisfactory arrangements can almost always be made. We believe financial considerations should never prevent children from receiving the care they need at the time they need it.
11) All new patients are required to keep a credit card on file.
12) All patients are highly encouraged to keep a credit card on file.

Forms
1) There is no charge for a school and camp form given at the time of your child's visit. This is considered part of the visit.
   a) There may be occasions where your camp form is very in depth and we will need more time to fill out the form and will discuss it with you at your visit.
2) If you need forms filled outside of your well visit, we will do our best to have them back to you the same day but expect them to take 3-5 business days. There is no additional charge for forms to be filled.

Transfer of Records
1) If you transfer to another physician, we will provide a copy of your immunization record right then and there as a courtesy to you. We require at least 5 business days to get all of your records ready to be sent.
2) We can not send any information to your new doctor without a signed record release. This release form can be found on our website, in the office, or if needed we can email you a blank form.

Prescription Refills
1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.
2) Some prescriptions will require an office visit for it to be renewed.

Harassment
1) This is a private practice where we strive to create a pleasant environment for all patients and staff. We understand that there are times when patients may be frustrated and we will make every attempt to assist you. However, this practice will not tolerate physical abuse, verbal abuse, or harassment of any kind, under any circumstance. **Abuse or harassment in any form is grounds for immediate discharge of the entire family from the practice**

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____

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Credit Card Policy

Please be advised that we require all patients to keep their credit card information on file with our office.

Your information will be kept safe and secure and secure and your card will not be charged without your consent. Only Dr. Susan Gunduz, the practice owner, and our office manager, Brian Keifer, will have access to your credit card information.

If you have any questions or concerns, please contact Brian directly, or via text at 631-875-1478.

We appreciate your understanding regarding our credit card policy.

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Dear Guarantor:

We respectfully request a copy of your credit card/ debit card, or health savings card to be kept on file with our office. Any credit, debit, or health savings card information provided to this office will be kept confidential, and may only be accessed by Dr. Susan Gunduz personally.

After we receive an explanation of benefits from your insurance company, we will charge your credit card for the amount due. We will also charge your credit card for any past due balance.

If you wish to receive a receipt detailing your charges please initial here. X_____

If you **have a deductible plan** with your insurance company, and choose not to keep your card on file, we will collect from you an amount equal to 30 percent of total charges generated at the time of your visit. After we receive an explanation of benefits statement from your insurer, we will charge you for the remaining balance due, if applicable, or refund you any credit balance.

I, _____ (Parent or Guarantor), understand the office policy regarding credit and debit cards, deductible plans, and any outstanding balances which may be due.

Accordingly, I hereby authorize Dr. Susan Gunduz, MD, to charge my credit or debit card referenced below for the medical treatment of _____.
(Patient name/names)

Credit or Debit Card Number: _____ V-code _____

Expiration Date (MM/YR): _____ Zip code _____

X _____
(Signature of Parent or Guardian)

X _____
(Date)