Dante P. Gabriel, MD - Faye Montes, MD - Alma Guzman, MD - Marson Teñoso, MD
15 Tower Ct. Suite 150, Gurnee, Il. 60031
Phone: (847) 623-4464 – Fax: (847) 623-9984
Visit our website at www.drgabrielpediatrics.com

Welcome to Our Practice!!

We are pleased you have chosen our practice for your child's care and we are looking forward to meeting you and your family. We will strive to make your experience a pleasant one

New Patients
Remember to bring your registration papers and previous medical records with you. Please note we are unable to give any immunizations without previous immunization records. A parent or legal guardian **MUST** accompany a minor to the first visit and any visit when your child will be receiving any immunizations.

Hours
Our office is closed for lunch daily 12:30-1:30pm. Our phones are answered starting at 9:00am Monday through Saturday. If you have an emergency after hours, please call 847-623-4464 and our answering service will page the doctor on call. If the matter is life threatening, please call 911 for immediate assistance.
For any non-urgent matter (medication refills, canceling appointments, etc) please call during normal business hours as our answering service will send our office the messages via fax and will not be answered until the following business day.
Office hours are as follows:
Monday 9:00 am – 6:00 pm • Tuesday 9:00 am – 4:30 pm • Wednesday 9:00 am – 12:00 pm
Thursday 9:00 am – 6:00 pm • Friday 9:00 am – 4:30 pm • Saturday 8:45 am – 12:00 pm

Appointments
We work by appointments only. Sick visits are made the same day. (This appointment must be kept. We have a 24hr. cancellation and late cancellation policy that also pertains to sick visits). Routine appointments are made within 1-2 weeks. If your child is scheduled for a routine appointment and another illness related condition is treated your child's appointment will be switched to a sick visit and a copay will apply. Remember a parent **MUST** accompany a minor to their doctor's appointments! If a parent cannot attend, then written consent must be given to the adult accompanying the patient and must be made available at the time of visit.
We must receive a call 24 hours in advance when canceling an appointment. A fee will be charged if proper notice is not given.

Insurance
You must bring your child's current insurance card at the time of any visit. If you have a change in insurance, please notify the receptionist. Co-payments will be collected at the front desk. We accept checks, money orders and cash. A cash station is located in the pharmacy next door for your convenience**.**

Medication Refills
Please call the pharmacy and request a refill. They will contact us if a new prescription is needed. Antibiotics are not refillable, you must call for an appointment. Refills on controlled substances will not be given without patient being seen by a doctor.

Policy forms
It is important that you read and understand out policy forms before signing. If you do not agree with our policies and wish to decline signing the forms, you will be required to transfer to a new physician. Your records may be requested in person, by fax or mail with a signed consent to release medical records and paid fee.

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2018 Patient Demographic Form (Please Print)

Patient Name: _____ Date of Birth: _____ Gender: F / M
Mother's Name: _____ Father's Name: _____

Home Address: _____ Apt #: ___ City: _____ State: _____ Zip: _____
Home Phone #: (_____)_____--_____ Cell #: (_____)_____--_____

Secondary #: (_____)_____--_____ Work #: (_____)_____--_____

Email Address: _____@gmail.com/@yahoo.com/@hotmail.com/@_____

Emergency Contact (DO NOT LEAVE BLANK!!)

Contact Name: _____ Relationship to patient: _____ Phone #: _____
OPTIONAL
Ethnicity: _____ Race: _____ Language preference: _____

Please Select Your Local Pharmacy of Choice: **Walgreens / CVS / Osco / Target / Walmart / Other: _____**
Pharmacy Address/Location: _____ City: _____

Do you give our office permission to download your child's prescription history today and for all future appointments? Y / N

Please list the name of siblings along with date of birth

_____ _____

_____ _____

Name of Insurance Policy Holder: _____ Date of Birth: ___/____/____ SS#: _____
Billing Address: **Same as Above / Other**: _____
Employers Name: _____ Address: _____
Please Check Insurance Carrier and Type: __ PPO __ HMO __ HFS (Medicaid) __ POS
Aetna / United Health Care / Blue Cross Blue Shield(not to be confused with Medicaid plans) / Cigna / Humana / Tricare-Standard / □Medicaid Blue Cross Community □Medicaid / CoreSource / Cash Account / Allied / Other: _____

PLEASE NOTE Our office does not get involved with custodial or financial disputes involving separated or divorced parents. The parent who brings in the patient will be responsible for any balances or payments due at the time of the visit and assumes responsibility for services rendered! Please initial: _____

By signing below, I acknowledge that I have read and fully understand all the information listed on this form and have provided all the information to the best of my knowledge. I have read and agree to the missed appointment / late cancellation policy.
I agree to the assignment of medical benefits to Dante P. Gabriel, MD, SC for services rendered. I assume all responsibilities for charges not covered by my insurance or if I have failed to have my child assigned to a plan within a network for this office in a timely manner.

Parent Signature: _____ Print Name: _____ Date: _____

Is all the information on this form correct? If yes, please sign and date below:

_____ _____ _____ _____

BE SURE TO COMPLETE ENTIRE FORM!! THANK YOU!

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Agreement to Comply with Office Policies

The policies and rules set forth on this form are for the benefit of our office/ staff as well as our patients. Please be advised that failure to comply with these policies may result in violation of our practice policies and rules which may lead to ending our patient-provider relationship.

Appointment policies and "No-Show" or "Late-Cancel" fees are as follows:
Appointments made the same day for sick patients must be kept, if you are unable to keep your appointment a late cancellation fee of $35.00 will be assessed to your account. **Our office reserves the right to dismiss patients from our office for chronic missed appointments and/or non-compliance of medical recommendations for appointments in office or referrals to another office.**

Well-Child appointments are asked to be made in advance; as much as we strive to accommodate all of our patients as often as possible there are times we may not be able to get you in right away, to avoid this we ask that you make your appointments in a timely manner to better suit your needs. A 24-hour notice for cancellations is required; there is a $35.00 late cancellation fee or a $55 No-show fee for missed appointments.

Divorced/ Child Custody Cases: The guardian who accompanies the child is responsible to pay copays, any account balance at time of service. Our office does not get involved in custody disputes or divorce judgements.

Disruptive/ abusive behavior in the office will not be tolerated and may lead to the immediate termination of patient-provider relationship. Disruptive and abusive behaviors include but are not limited to the following:

1. Profane or disrespectful language.
2. Demeaning behavior (ex: referring to our staff as "stupid" or any derogatory names)
3. Sexual comments.
4. Throwing things or charts.
5. Outbursts of anger.
6. Criticizing office staff in front of other patients.
7. Negative comments about staff or physicians.
8. Boundary violations with staff or patients.
9. Unethical or dishonest behavior.
10. Verbal or physically threatening behavior.

By signing I acknowledge and agree to comply with the office policies and am aware of the consequences if this agreement is broken or disregarded.

Parent/legal guardian signature: _____ Date: _____

Patient Name: _____ DOB: _____

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HIPAA Agreement

Patient Name: _____ DOB: _____

I give my consent to the doctor's named above, to use or disclose all information contained in my child's medical record for the purpose of carrying out treatment, payment and/or continuity of my child's healthcare.

Please provide the names of any person/s who you wish to have authorization to obtain this child's private medical records or health information. You must also provide either a social security # or date of birth for the persons being listed below for security and verification purposes:

Name: _____ SS#/DOB: _____ Relation: _____
Name: _____ SS#/DOB: _____ Relation: _____

I understand that I may revoke this consent at any time by giving written notice to the office upon my desire.
I acknowledge receipt of the Physician's Notice of Privacy Practices.
Parent/ Guardian signature: _____ Date: _____

Please note that our office charges the following fees:

Returned check = $35.00	Copies of Immunizations = $2.00
No Show sick visit = $35.00	Sports/School/Camp Physical forms = $15.00
No Show routine exam = $55.00	FMLA Papers/ forms = $25.00
Misc letters from this office $5.00	Social Sec & Immigration forms = $5.00
Late Cancellations = $35.00	Medical records release = $15.00

It is your responsibility to pay the above stated fees when requesting any forms to be filled out or letters are written out for your personal use. Any time there is an appointment broken or cancelled late a charge will be added to your child's account, it is your responsibility to pay any fees that are charged for missed appointments or late cancellations.

Parent/Guardian signature: _____ Date: _____

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Vaccine Policy Statement

We at Dante Gabriel, MD, SC, Pediatrics are dedicated in providing the best care possible to all our patients. To do this effectively, we must enter into partnership based on mutual trust with our patients/parents to achieve this goal TOGETHER. Our physicians follow the American Academy of Pediatrics recommendations and CDC guidelines on immunizations. We believe that immunizations are one of the most important health interventions a parent can do on behalf of their children, and we want all our patients to benefit from this modern lifesaving resource.

While we recognize and respect the parents' role as the ultimate decision maker for their child's healthcare, we believe strongly that we are obligated to deliver the best and safest healthcare possible for our patients and our community. Dante Gabriel's Pediatrics adhere to the recommendations set forth by the AAP and CDC.
The following is a policy our office has set for all patients:

- ✓ Gabriel Pediatrics **will not** accept NEW patients or NEW babies whose parents refused to immunize. Established patients who decide to stop and/or refuse further immunizations will be transferred out of our care.
- ✓ Gabriel Pediatrics will accept New patients who wish to follow an altered vaccine schedule so long as the parents agree to complete vaccine schedule by time the patient is 18 months of age. This must include one dose of MMR. We are not recommending any alternative schedules; Gabriel Pediatrics continues to adhere to the guidelines set forth by the AAP.
- ✓ Gabriel Pediatrics will document any refusal for vaccination that was recommended at your time of visit and must be signed by parent/legal guardian.
- ✓ If parents refuse vaccines for a new baby in the family, we will not accept such newborns as patients of our practice per our policy.
- ✓ If parents absolutely refuse to vaccinate their child/ren despite all our efforts, we will require you to find another provider who shares your same beliefs. We do not keep a list of such providers, nor would we recommend any of them.
- ✓ For patients who are not adequately vaccinated but who have already been established in our office, we will follow the guidelines listed above and additionally but not limited to the items below:
  - We will continue to educate parents about the benefits of vaccinations to their children. We will also explain all risks of not vaccinating against several childhood diseases and infections. This counseling will be done at all your child's appointments and is considered a billable service.
  - Parents of such children need to remind providers in our office and other providers about the vaccination status of their child whenever medical care is sought for them.
  - Parents of these children must wait in a designated area with their children until called into a patient exam room when visiting our office.
  - If established patient was already on an alternate vaccine schedule before this policy was set, your child's alternate vaccine schedule must be readdressed and reviewed with your physician to ensure compliance with this policy. All documentation will be kept in the patient's chart.

Dr. Gabriel Pediatrics feels it is best for all children to be vaccinated. It is in the best interest of your child. Please take the time to adhere to the recommendations of The American Academy of Pediatrics and The Center for Disease Control.

Patient Name: _____ Patient DOB: _____

By signing below, you confirm and acknowledge that you have read the above policy in its entirety and understand said policy.
Parent Signature: _____Printed name: _____ Date: _____

For Office Use:

Reviewed by: _____ Date: _____