Gabriel Pediatrics, S.C.

Dr. Dante Gabriel, FAAP **Dr. Faye Montes, FAAP**
Dr. Alma Guzmán, FAAP **Dr. Marson Teñoso, FAAP**
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 custodial 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 office hours vary Monday through Saturday, please see our office hours below. If you have a non-life-threatening emergency after hours and wish to speak with the on-call doctor, please call our office and have a doctor paged. Our answering service is available outside of our normal office hours 24/7 year-round. If the matter is life threatening, please call 911 for immediate assistance!
For any non-urgent matters (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 – 5:00 pm • Wednesday 9:00 am – 12:00 pm
Thursday 9:00 am – 6:00 pm • Friday 9:00 am – 5:00 pm • Saturday 9:00 am – 12:00 pm

Appointments
Our office is operated by appointment only. Appointments for acute illness are available for same day daily. Appointments must not be broken. Our office has a strict attendance policy which requires a 24hr. notice for cancellations. Our office charges a $35 late cancellation fee or a $55 fee for No-Show. 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.

Insurance
You must bring your child's current insurance card at the time of all appointments. 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.

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.

BE SURE TO COMPLETE FORM OUT IN ITS ENTIRITY

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2019 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: _____

Primary Phone #: (_____)_____--_____ Secondary #: (_____)_____--_____

Patient Phone #: (_____)_____--_____ Work #: (_____)_____--_____

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

Emergency Contact (DO NOT LEAVE BLANK!!) Name: _____ Relation: _____ Ph #: _____

OPTIONAL → **Ethnicity: _____ Race: _____ Language preference: _____**

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

Pharmacy Address/Location: _____ City: _____ IL / WI

Do you give our office permission to download your child's prescription history today and for all future appointments? Y / N
Do you give us permission to leave a message containing personal health information on your phone or email listed? Y / N
Ph # _____ Email: _____ OK to leave message with emergency contact listed? 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 / Type: __ PPO __ HMO __ HFS (Medicaid) □ **HMO LCPA** □ **HMO Advocate**
Aetna / United Health Care / Blue Cross Blue Shield/ Cigna / Humana / Tricare-Standard /
□Medicaid Blue Cross Community □Medicaid □Meridian / 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: _____

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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 our patients as often as possible. There may be a time that 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. It is also required that a child be accompanied by their parent or legal guardian any time they are due for immunizations. If your child will be accompanied by another adult, the parent or legal guardian must provide our office with written consent to treat their child while under the supervision of whoever will be bringing them in, this does not apply to children receiving immunizations. We are required to have the actual signature of the legal guardian or parent in order to administer immunizations unless the child is 18y or older.

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 and/or disrespectful language.
2. Demeaning behavior, referring to staff as derogatory names.
3. Sexual comments/harassment.
4. Throwing things or threatening behavior of staff.
5. Outbursts of anger.
6. Negative comments about other patients, staff or physicians.
7. Criticizing staff or policies in a non-compliant manner.
8. Discriminatory/ abusive behavior toward persons in office.
9. Unethical or dishonest behavior.
10. Non-Compliance of office policies or rules.

These rules and policies are setforth by Gabriel Pediatrics', S.C. to safeguard its employees and clients. By signing I acknowledge and agree to comply with the said office policies and am aware of the consequences if this agreement is broken or disregarded at any time.

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.

I give consent for the doctors' and office staff to leave message containing PHI as I have designated on my registration form.

Please provide the names of any person/s who you wish to have authorization to obtain the patient'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 that I can obtain a copy of the Physician's Notice of Privacy Practices upon my request. The PNPP is posted in the office receptionist area and available on our website.

Parent/ Guardian signature: _____ Date: _____

Please note that our office charges the following fees:

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