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MICHELLE MYERS, M.D.

NEW PATIENT CHECK LIST

WE CANNOT BOOK AN APPOINTMENT IF WE DO NOT HAVE THE FOLLOWING INFORMATION:

1. FILL OUT PATIENT REGISTRATION PACKET COMPLETELY (SEE ATTACHED)

2. FILL OUT MEDICAL RECORDS RELEASE FORM (SEE ATTACHED)

3. BRING IN COPY OF INSURANCE CARD

4. CALL YOUR INSURANCE COMPANY FOR FOLLOWING INFORMATION:

A. DATE OF CHILD'S LAST WELL VISIT: _____

B. ASK THEM, "WHAT DATE AM I ELIGIBLE TO HAVE A NEW PATIENT WELL CHILD VISIT."

DATE ELIGIBLE:_____

C. ASK THEM TO LIST US AS THE PRIMARY CARE PROVIDER

(SEE ABOVE FOR A LIST OF OUR PROVIDERS)

D. ASK FOR THE REFERENCE NUMBER OF THE CALL: _____

(REFERENCE NUMBER)

E. NAME OF INSURANCE REPRESENTATIVE YOU SPOKE WITH: _____

(NAME OF REPRESENTATIVE)

F. DATE CALLED: _____

(DATE CALLED)

VACCINE POLICY

Wheatfield Pediatrics requires patients to be vaccinated and thus all new patients must provide an immunization record to establish care. Religious exemptions are not accepted. Non-compliance with this policy will prohibit your child from being accepted as a patient at our practice.

I understand the vaccine policy and my child is vaccinated or we have intentions to vaccinate.

Parent/Guardian _____

(PARENT/GUARDIAN SIGNATURE)

After everything is completed, please return paperwork along with this check list so we can fax your release and get records from your former primary care provider. We will call you as soon as possible to book a new patient appointment.

SHERIDAN PEDIATRICS PATIENT REGISTRATION

PATIENT NAME_____ BIRTHDATE_____ ☐ MALE ☐ FEMALE

PATIENT ADDRESS:_____ PHONE #_____

CITY_____ STATE_____ ZIP CODE_____

MOTHER'S NAME:_____ MOTHER'S BIRTHDATE_____

FIRST NAME LAST

MOTHER'S MAIDEN NAME:_____ MOTHER'S SOCIAL SECURITY #:_____

MOTHER'S ADDRESS (If Different From Patient) _____

MOTHER'S HOME # (If Different From Patient) _____ MOTHER'S CELL # _____

MOTHER'S EMAIL ADDRESS _____

MOTHER'S EMPLOYER:_____ PHONE # OF EMPLOYER:_____

FATHER'S NAME:_____ FATHER'S BIRTHDATE_____

FIRST NAME LAST

FATHER'S SOCIAL SECURITY #:_____ FATHER'S EMAIL ADDRESS:_____

FATHER'S ADDRESS (If Different From Patient) _____

FATHER'S HOME # (If Different From Patient) _____ FATHER'S CELL# _____

FATHER'S EMPLOYER:_____ PHONE # OF EMPLOYER_____

****

CUSTODIAN'S NAME:_____

(IF CHILD NOT LIVING WITH PARENT) LAST NAME FIRST MIDDLE

STREET ADDRESS OF PARENT/CUSTODIAN: _____

STREET ADDRESS CITY/STATE/ZIP

HOME PH ( )_____ CELL PH ( )_____ EMAIL_____

EMERGENCY CONTACT (OTHER THAN PARENT)

_____

NAME RELATIONSHIP PHONE NUMBER

NAME OF INSURANCE COMPANY:_____ NAME OF PRIMARY INSURANCE HOLDER_____

ID #:_____ GROUP #:_____ EFF. DATE:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? NAME OF INSURANCE CO:_____

ID #:_____ GROUP #:_____ EFF. DATE:_____

NAME OF POLICYHOLDER: _____

I hereby authorize payment of insurance benefits directly to Sheridan Pediatrics. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted provider of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I authorize the performance of whatever procedures necessary in executing the treatment of the above name patient (s).

_____ _____

Signature of Parent/Guardian Date

Financial Policy Acknowledgment

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

Sheridan Pediatrics has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company. Any financial portion that is the "member's responsibility" such as a co-pay, deductible or a non-covered percentage will be collected **at the time of service _____(initial)** . If, for any reason, it is not collected at the time of service, a billing fee will be added to your outstanding balance for each statement that is mailed_____**(initial).** Remember, your insurance coverage is a contract between you and your insurance company. Sheridan Pediatrics is not responsible for services denied by your insurance company _____**(initial).**

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We still estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you for any balance.

HMO INSURANCE PLANS: All co-pays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

NON-CONTRACTED INSURANCE PLANS: If we are not contracted with your insurance company, you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources department) to send to your insurance company to request that payment be sent to you.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you for any balance.

MEDICAID: We accept Medicaid for newborn hospital follow-up exams only. If you do not have the baby's Medicaid information available at the time of the exam, we will pend the charge for up to 30 days to allow time for the Medicaid number to be assigned. If you do not provide us with the Medicaid billing information within 30 days, we will change the account to "Self Pay-No Insurance". At that point you are required to make payment within 30 days or you will be subject to rebilling fees and collection efforts.

DIVORCE DECREE: We are NOT a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, Mastercard, and personal checks (with photo id only). Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement may be assessed a $5 rebilling fee. If you experience circumstances beyond your control, please call our office and we will be happy to make payment arrangements. All balances reaching 120 days may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $15 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hours notice in order for another child to be scheduled. If you do not cancel by the deadline, a $50 missed appointment fee may be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. Patients with Medicaid plans for which we cannot charge no show fees will be dismissed after the 3rd no show.

I authorize medical care and accept the financial responsibility for my child, my step child, and/or the child that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.
I authorize the release of any medical information necessary to process any claims.

I have read and fully understand the financial policies of Sheridan Pediatrics, and agree to the terms. I also understand that the terms of these financial policies may be amended by Sheridan Pediatrics at any time without prior notification.

_____ _____

Parent/Guardian/Personal Representative Date

Authorization For Medical Treatment of Minors

I,_____, parent or legal guardian of:

_____

Do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my child to medical appointments. **Please list anyone other than the childs' biological mother or biological father who may be accompanying the child to appointments.** This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc…
I understand that only my child's biological mother and father and those listed below will have the authority to authorize treatment. Authorized individuals include (please print name and relationship):

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Please inform the above listed individuals to bring photo identification to appointments
Unlisted individuals may obtain treatment for your child in the case of an emergency. In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing.

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Sheridan Pediatrics of any changes in my health status, my child's health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____
Signature Date

Privacy Statement Acknowledgment
I acknowledge Sheridan Pediatrics has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy. (See date on posted copies)

_____ _____
Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative

Date:_____

Authorization to Leave Messages on Voice Mail/Machines
I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

Yes, please leave me a message_____ Date_____

No, don't leave any specific message _____ Date_____

Acknowledgement of "Abuse Free Zone"
At Sheridan Pediatrics we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. **Outbursts against our staff will not be tolerated and may result in your discharge from the practice.**

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

_____ _____
Signature Date

FOR FAMILIES NEW TO OUR PRACTICE
How did you find out about our office/doctors? Name of Friend/Relative_____

Hospital_____ Internet search_____ Other_____

Patient's Name_____

In accordance with Federal categories and definitions, the Insurance Companies have recently adopted a policy that requires the collection and recording of the ethnic identity of all patients. We need your help to accomplish this task. Please review the racial/ethnic definitions on this page and place a check in the box for the category that best describes your child. Sheridan Pediatrics understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal privacy laws and regulations.

Is the child Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture of origin, regardless of race.

- ❑ **YES**, Hispanic
- ❑ **NO**, not Hispanic

Check all groups that apply to your child; choose <u>at least ONE</u> box.

- ❑ **AMERICAN INDIAN OR ALASKA NATIVE**
- ❑ **ASIAN**
- ❑ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**
- ❑ **BLACK OR AFRICAN AMERICAN**
- ❑ **WHITE**

Language ❑ English ❑ Russian ❑ Spanish ❑ Chinese ❑ Thai ❑ Other_____

SHERIDAN PEDIATRICS
605 Grover Cleveland Highway, Amherst, NY 14226

Wheatfield Pediatrics Vaccine Policy – Parent Agreement

Dear Parent or Guardian,

At Wheatfield Pediatrics, we are deeply committed to the health and well-being of your child. We believe that immunizations are one of the safest and most effective tools in modern medicine to protect children from serious, potentially life-threatening diseases.

If you do not feel confident that your pediatrician wants what is best for your child, or if you do not wish for your child to receive full protection against preventable illnesses, our practice may not be the right fit for your family.

Why We Strongly Recommend Vaccination

- Vaccines prevent serious illnesses such as meningitis, measles, polio, whooping cough, and more.
- All vaccines used in our practice are safe, preservative-free, and follow rigorous safety standards.
- Side effects are generally mild (e.g., minor pain or fever); serious side effects are extremely rare.

Choosing NOT to Vaccinate: Possible Consequences

- Many pediatric practices may refuse to provide care to your child.
- Your child is at increased risk of serious illness, hospitalization, disability, or death.
- Your child may be excluded from school, daycare, or other group activities.
- Your child may require additional testing or medical interventions when sick.
- Others in the community—especially infants, pregnant individuals, and the elderly—may be put at risk.
- Valuable time during office visits may be diverted from other important health concerns.
- Alternative vaccine schedules may increase the chance of errors or gaps in protection.

Choosing to Vaccinate: The Benefits

- Giving your child the best defense against preventable diseases.
- Providing lifelong protection with less than ½ ounce of injectable vaccine over 18 years.
- Making a responsible decision based on science and medical expertise.
- Helping to protect vulnerable members of the community through herd immunity.
- Partnering with your pediatrician to give your child the healthiest possible start.

Office Vaccine Requirements

As of 2025, the following vaccines are required at Wheatfield Pediatrics (per NY State guidelines):

- DTaP (Diphtheria, Tetanus, Pertussis)
- IPV (Polio)
- MMR (Measles, Mumps, Rubella)
- Hepatitis B
- Varicella (Chickenpox)
- Hib (Haemophilus influenzae type B)
- Pneumococcal

SHERIDAN PEDIATRICS
605 Grover Cleveland Highway, Amherst, NY 14226

- Meningococcal A

The following vaccines are strongly recommended (and may be required for travel, college, or work):

- Rotavirus
- Hepatitis A
- HPV (Human Papillomavirus)
- Meningococcal B
- Annual Influenza (Flu shot)

Practice Policy on Vaccine Refusal

Families refusing any required vaccines will be asked to leave the practice.
If you are an existing patient and begin to refuse required vaccines, we will request that you find care elsewhere.
If you have unvaccinated older children in our practice and plan not to vaccinate a new child, we will ask you to take the new baby to another provider. (Older children may remain with us as a courtesy.)

New Patient Policy

- All new patients must agree to comply with our vaccination policy.
- Limited alternate schedules may be considered if they do not delay overall vaccine coverage. (e.g., spacing vaccines over 2–3 visits, but completing them on time).
- Only medical exemptions will be accepted.
- We do not recognize religious, philosophical, or personal objections as valid reasons to refuse vaccination.
- All new patients must sign this policy before joining the practice.
- Families who are not compliant with this policy will be dismissed from the practice.

Acknowledgment and Agreement

I have read and understand the Wheatfield Pediatrics vaccine policy. I agree to comply with the stated requirements and timelines for immunizations.

Patient Name: _____

Responsible Party Name: _____

Relationship to Patient: _____

Responsible Party Signature: _____

Date: _____

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

SHERIDAN PEDIATRICS

INFORMATION TO BE RELEASED FROM	INFORMATION TO BE RELEASED TO
Name of Organization	Sheridan Pediatrics Name of Organization
Street Address	603 Grover Cleveland Hwy. Street Address
City State Zip	Amherst NY 14226 City State Zip
Phone Fax	716-836-3300 716332 Phone Fax 1891
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER

TRANSFERRING IN [ ] TRANFERRING OUT [ ] RECIPROCAL COMMUNICATION [ ]

PLEASE SEND ONLY THE FOLLOWING RECORDS ALONG WITH ANY PERTINENT MEDICAL INFORMATION

- -PROBLEM LIST
- -VACCINE RECORDS
- -DX HISTORY
- -VITALS
- -GROWTH CHARTS
- -LAST WELL CHILD VISIT

DATES OF SERVICE BEING REQUESTED

A. [ ] LAST 2 YEARS OF MEDICAL RECORDS
B. [ ] Medical Records for Specific Dates Only: Beginning _____/_____/_____ Thru _____/_____/_____
C. [ ] All Medical Records

Personal information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I Understand That:

Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form to assure treatment or payment. I can cancel this authorization at any time by writing to the Health Information Services Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release of distribution by the recipient that may not be protected by confidentiality laws (Note: If the disclosure is to an employer or financial institution, this authorization will expire 90 days from the date signed by you.)

Sensitive records may require specific patient authorization. Please check the applicable box below to request the following records:
[ ] Mental Health Treatment [ ] Sexually Transmitted Diseases [ ] AIDS/HIV Treatment [ ] Alcohol/Drug Abuse Treatment (including pain medication)

I understand that I may cancel this authorization at any time by submitting a Revocation of Authorization form, my cancellation of this authorization will not affect any action Sheridan Pediatrics took before it received my request. I understand that this authorization is valid for a period of no greater than 24 months. I understand that if Sheridan Pediatrics discloses my personal information at my request, and the party receiving this information shares it with others, some state and federal laws may no longer protect it.

Signature of Patient or Legally Responsible Party: _____ Date: _____/_____/_____

Relationship to patient, if not signed by patient: _____

Signature of a minor patient required for the following records:
A minor patient's signature is required to release the following information: 1) Information related to reproductive care such a birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

Signature of Minor Patient: _____ Date: _____/_____/_____

This authorization will remain in effect until: _____/_____/_____
In no event will an authorization remain valid for more than 24 months. WAC284-04-515 (e)(2).

A copy of this form is to be kept by: a) the individual signing the form, b) Sheridan Pediatrics, c) and a third copy should accompany any disclosed personal information.

ALL FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID
PLEASE DO NOT FAX OVER 20 PAGES

PRINT CHILD'S FULL NAME: _____ **DOB:** _____/_____/_____

PARENT/GUARDIAN NAME: _____ **PHONE:** _____