

**GROWING HEARTS PEDIATRIC CARDIOLOGY INC**

New Patient

Existing/Update

**Patient Information PEDIATRIC PATIENT REGISTRATION**

Child's Name: First Name – MI – Last Name	Nick Name	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
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**Mother**  Birth  Step  Married  Unmarried  Divorced  Widowed. *If divorced, does child reside with Mother?*  Yes  No

Mother's Full Name (First M. Last)		Date of Birth	
Home Address		City	State Zip
Mother's Employer Name & Address		Work Phone Number	
Home Phone Number	Cell Phone Number	Mother's E-mail	

**Father**  Birth  Step  Married  Unmarried  Divorced  Widowed. *If divorced, does child reside with Father?*  Yes  No

Father's Full Name (First M. Last)		Date of Birth	
Home Address		City	State Zip
Father's Employer Name & Address		Work Phone Number (      )	
Home Phone Number	Cell Phone Number	Father's Home E-mail	

**Referring Physician – (Primary Care Physician)**

**Pharmacy**

Physician Name:	
Reason for Today's Visit:	

**Primary Insurance Information**

Policy Holder's Name (As it appears on card)		Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name	Sex of Policy Holder <input type="checkbox"/> M <input type="checkbox"/> F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer	Employer Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Identification/Policy Number	
Insurance Address		Insurance Network	Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification (      )

**Secondary Insurance Information**

Policy Holder's Name (As it appears on card)		Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name	Sex of Policy Holder <input type="checkbox"/> M <input type="checkbox"/> F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer	Employer Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Identification/Policy Number	
Insurance Address		Insurance Network	Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification (      )

I certify that the information I have reported above is correct and that as the Parent/Guardian/Guarantor I have read, understand and fully accept the Patient's Financial Payment Policy conditions of Registration.

\_\_\_\_\_  
Signature of Parent/Guardian/Guarantor

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

PATIENT HISTORY INTAKE – CARDIOLOGY / CARDIOVASCULAR

FEEDING HISTORY - (For Babies / Infants Only)

1) If on formula, how many ounces at each feeding?
2) How long does it take the baby to finish one feeding?
3) If breast feeding, how many minutes on each breast?
4) Does the baby suck strongly during a feeding? <input type="radio"/> Yes <input type="radio"/> No
5) Does the baby get tired easily during feeding? <input type="radio"/> Yes <input type="radio"/> No
6) Does the baby sweat or have labored breathing during feeding? <input type="radio"/> Yes <input type="radio"/> No

**SOCIAL HISTORY**

Does the child live with both parents? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mother Age?	Father Age?	Mother Job?	Father Job?
How many siblings does the child have?		Age/Sex of Sibling Each?	
Do any siblings also have Congenital or other heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No – If Yes, please detail:			
At what grade in school?		Any problems at school?	
What hobbies/activities does the child enjoy/play?		What kind of sport does the child participate in?	
Any major stress at home, or school?			

**GROWTH AND DEVELOPMENT**

Does child appear to be growing similar to family pattern? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does child have any difficulty keeping up with age group? <input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, please describe below
Is the child up to expectations at school? Any learning or attention problems? <input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, please describe.

**PAST MEDICAL AND SURGICAL HISTORY**

<i>Prescription &amp; OTC Drugs - Name / Dosage / Frequency</i>	<i>Any Drug or Food Allergies?</i> <input type="checkbox"/> None known
	<i>LIST</i>
<i>Operations / Hospitalizations – Reason</i>	<i>Date</i>

**PATIENT'S PAST MEDICAL AND FAMILY HISTORY**

PLEASE INDICATE IF YOU OR A RELATIVE - (M) =MOTHER (F) =FATHER (S) =SIBLING (GP) =GRAND PARENT – IS AFFECTED BY ANY CONDITION

<i>Condition</i>	<i>You</i>	<i>Relatives</i>	<i>Condition</i>	<i>You</i>	<i>Relatives</i>
Anemia			High Cholesterol or Triglycerides		
Blood Clot or Bleeding Disorder			Thyroid Problems		
Congenital Heart Disease (Born With)			Diabetes - <input type="checkbox"/> Type I <input type="checkbox"/> Type II		
Deaf from Birth (Neuronal)			Other Cardio-Vascular Disease		
Heart Attack / MI			Stroke or Mini-strokes (TIA)		
High Blood Pressure			Unexplained death in young		

Patient Name:	Date of Service:	Page 1
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REVIEW OF SYSTEMS HISTORY - DOES YOUR CHILD HAVE ANY OF THE FOLLOWING SIGNS AND/OR SYMPTOMS?

	PLEASE MARK ( X ) IF ANY OF THE FOLLOWING APPLY TO YOU <u>CURRENTLY</u> , IN THE <u>PAST</u> OR <u>NEVER</u>			
GENERAL HEALTH	CURRENTLY	PAST	NEVER	List Other Signs or Related-Symptoms
Healthy Appetite				
Weight loss or gain				
Fever				
Fever last over 5 days				
Lethargy				
Excessive Fatigue				
EYES				
Vision changes				
EARS, NOSE, THROAT & MOUTH				
Ringing in ears				
Sinus problems or Sore throat				
CARDIO / PERIPHERAL VASCULAR				
Chest Pain or discomfort				
Irregular heart rhythms				
Palpitations				
Color changes in Lips or Tongue				
Swelling around eyes, hands or Feet				
RESPIRATORY				
Shortness of breath				
Coughing or Wheezing				
Difficult breathing on exertion				
Painful breathing				
Rapid breathing				
GASTROINTESTINAL Abdominal Pains				
Nausea or Vomiting				
Black or Bloody stool				
Heartburn or Acid reflux				
URINARY				
Blood in urine				
Painful urination				
MUSCULOSKELETAL				
Muscle aches / pains / weakness				
Bone aches / pains / weakness				
Swelling of legs				
Pain in extremities				
SKIN / BREAST				
Masses / Lumps or Rash / Ulcers				
NEUROLOGICAL Dizziness				
Fainting				
Forgetfulness or Confusion				
Headaches				
Numbness				
Seizures				
PSYCHIATRIC Depression				
Anxiety / Stress				
ENDOCRINE				
Excessive Sweating				
Thyroid problems				
Abnormal thirst				
HEMATOLOGIC / LYMPHATIC				
Bruises, frequent				
Enlarged lymph nodes				
Thyroid problems				

Nurse Note:

Patient Name:

Date of Service:

Page 2

# GROWING HEARTS PEDIATRIC CARDIOLOGY INC

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## “NOTICES OF PRIVACY ACT”

Effective April 1, 2026

1. Growing Hearts Pediatric Cardiology Inc (GHPC) may use and disclose protected health information for treatment, payment, health care operations and voluntary research operations. Examples of these include, but are not limited to, referrals to home health agencies and other providers for treatment. Payment examples include but are not limited to collection agencies, insurance companies for claims and pre-authorization, including coordination of benefits with other insurers. Health care operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. GHPC is permitted or required to disclose protected health information without the individual’s written consent in certain circumstances. Two examples of such are for public health requirements or court orders.
3. GHPC will not make any other use or disclosure of a patient’s protected health information without the individual’s written authorization, which may be revoked at any time in writing.
4. GHPC will abide by the terms of this notice currently in effect at the time of the disclosure.
5. GHPC reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Any revisions will be posted and copies may be obtained at any time at our office.
6. Any patient, guardian, or personal representative has the right to inspect and obtain copies of their medical records. A fee will be assessed for copies.
7. Any patient, guardian, or personal representative has the right to request amendments to be made to their medical record.
8. Any patient, guardian, or personal representative has the right to request a six-year accounting of all disclosures of their medical records from April 2026 henceforth. The history will be provided within 60 days of the request and a reasonable charge may be assessed.
9. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to the restriction requested in a 12 month period.
10. Any person or patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy has been violated. To file a complaint with the practice, please contact the privacy officer at GHPC. It is the policy of this practice that no retaliatory action will be made against any individual that submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
11. A detailed copy of this Notice of Privacy Act is available upon request.

NAME OF PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF PATIENT OR GUARDIAN: \_\_\_\_\_

[www.growinghearts.net](http://www.growinghearts.net)

443-895-0794

GROWING HEARTS PEDIATRIC CARDIOLOGY INC: Practice Financial Policies

1. Patient Information/Proof of Insurance: At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for payment of services rendered.
2. Insurance: We participate in most insurance plans. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.
3. Your insurance may require a referral from your primary care physician prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full and a missed appointment fee may apply.
4. Copayments and deductibles: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Deductibles are due at the time of notification by your insurance company.
5. Non covered services: Not all services provided by our practice are covered by every plan. Any service determined to not be covered by your plan will be your responsibility. Please be aware that some of the services you receive may be determined to be noncovered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid. The charges for these noncovered services be your responsibility and must be paid before being scheduled for another appointment.
6. Coverage changes: If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.
7. Claims and submission: Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim
8. Nonpayment/delinquent accounts: If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full to halt collection activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and processing costs.
9. Missed appointments: Our policy is to charge for missed appointments not canceled within 48 hours of your scheduled appointment. These charges will be your responsibility and must be paid before being scheduled for another appointment. The charge for missed appointments for a Stress Test is \$100 and all other conditions it is \$50.
10. Forms Fees: Any forms such as school, camp, sports, family and medical forms are subject to a fee that is due when the forms are dropped off. Completing these forms is time consuming to our staff, and requires time away from patient care from our providers. The charge for the form is determined by the complexity of the required written or verbal communication. Fee amount may periodically change without prior notice. Payment for these forms is nonrefundable. It is our duty that these forms are accurate and consistent with the patient care plan needs. We require 15Ddays turnaround time.
11. Release of medical information: You will be provided a copy of our policies at the time of your visit and required to sign a release that authorizes us to provide a copy of your medical records if requested by your insurance carrier to process a claim. This release will expire one year from the date of your signature unless cancelled in writing prior to that date.
12. Contacting us concerning your Bill: You may call our billing director at [billing@growinghearts.net](mailto:billing@growinghearts.net) with any billing questions or concerns. Our goal is to provide and maintain a good Physician/patient relationship focused on your clinical needs while letting the experts in our billing department handle their work directly. Please address all billing concerns with those experts rather than your physician so that your clinical team can focus on your medical care
13. Termination of Services: If you do not respond to 3 notices to the address we have on file, you agree that Growing Hearts Pediatric Cardiology Inc may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual provider.  
I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) \_\_\_\_\_

Responsible Party Member's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

## This form applies to Growing Hearts Pediatric Cardiology Inc.

- General Policy: All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.
- Consent for Treatment: I, or my representative, agree to have Growing Hearts Pediatric Cardiology Inc providers evaluate and treat my condition. Absent an emergency, if the proposed treatment has significant risks, then an additional informed consent will be obtained. I understand that the practice of medicine is not an exact science, and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.
- Disclosure & Authorization to Release Information: I hereby authorize Growing Hearts Pediatric Cardiology Inc to release my final diagnosis and other medical information to third parties to determine benefits payable and process claims. I authorize Growing Hearts Pediatric Cardiology Inc to release medical information to my insurance carrier for payment purposes. I authorize Growing Hearts Pediatric Cardiology Inc and/or any physicians who render services to me to release all or part of my medical and billing records for treatment, payment, and operations and for those purposes outlined in the Growing Hearts Pediatric Cardiology Inc Notice of Privacy Practices.
- Consent to be Contacted: I agree that by providing my landline, cell phone number(s) or email address, I am giving express consent for Growing Hearts Pediatric Cardiology Inc, its staff, employees, independent contractors, assignees, successors, and agents, to contact me through email or at these numbers, or any number or email address that is later acquired for me and to leave live or pre-recorded messages, text messages or emails regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Additionally, for my convenience, emails and text messages may be sent unencrypted, which may present certain risks, including the risk of being intercepted during transmission or viewed by someone other than me. I agree to accept these risks. If I do not wish to receive text messages, I can call 443-895-0794 to opt-out. Providing an email address or telephone or cell phone number is not a condition of receiving services.
- Physicians Not Employees of any hospital: I understand that physicians may not be employees of a health system. I understand that my physician may ask other physicians to participate in my care including but not limited to other physicians, radiologists, surgeons, obstetricians/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and physician assistants. I also agree that physicians in training, students or other qualified health care personnel, under supervision of my physician, may participate in and/or observe my care unless I specifically state otherwise, either verbally or in writing.
- Electronic Prescribing: I authorize an electronic prescribing network, to release my medication refill history to my providers for the purpose of continued treatment.
- Payment for Services: I understand that Growing Hearts Pediatric Cardiology Inc may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Growing Hearts Pediatric Cardiology Inc. If I should receive the payments, I understand that I will be responsible for paying Growing Hearts Pediatric Cardiology Inc. I assign the benefits payable for health care services to the physicians and/or organizations furnishing the services. I authorize direct payment to Growing Hearts Pediatric Cardiology Inc and all other providers of service to me, of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source for the care and services rendered to me or the patient. I assign my right to appeal a denial of payment to Growing Hearts Pediatric Cardiology Inc for services rendered to me.
- I understand that Growing Hearts Pediatric Cardiology Inc may be treated as an out of network provider by my health plan for services rendered at Growing Hearts Pediatric Cardiology Inc. In such case, my copay or deductible may be greater than if services were rendered at an in network facility or lab. This means that your insurance may cover less than expected depending upon your health plan. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefits. I know that I may need to pay this before I am treated.
- I understand that rates for medical treatment in the State of Maryland are subject to change without notice during the course of my outpatient treatment.
- I understand and agree that if my plan does not pay my medical bill, I will have to do so. If my account is sent to a collection agency, I agree to pay all reasonable fees that are required to collect what is due. These fees may include court costs, attorney's fees of 15% of the billed charges and interest at the judicial rate if judgment is entered.
- ERISA: If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Growing Hearts Pediatric Cardiology Inc act on my behalf to obtain my benefits when Growing Hearts Pediatric Cardiology Inc asks to do so. I also agree that Growing Hearts Pediatric Cardiology Inc can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.
- Private Contract: I understand that Growing Hearts Pediatric Cardiology Inc will hold me responsible in any one of the following situations. I may be asked to review and sign the Private Contract form in addition to this form:
  - When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
  - When I choose not to use my health plan and agree to pay for services myself.
  - When my health plan does not participate with Growing Hearts Pediatric Cardiology Inc for the services I want or need and I agree to pay for my care myself.

- When I receive services that are not covered under my health plan.
- Assignment of Benefits: I assign to Growing Hearts Pediatric Cardiology Inc the right to submit a pre-service appeal to my health plan on my behalf.
- Mediation Agreement (applicable to Maryland only): I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at any Growing Hearts Pediatric Cardiology Inc entity located in the state of Maryland are governed by the laws of the State of Maryland. I agree that before I file any lawsuit, I will try to resolve my claim through mediation. Mediation is a process through which a neutral third person assists the parties to help settle the claim. I do not give up my right to file a lawsuit if the mediation process fails to resolve my claim. I agree that any mediation or action in court must take place in Maryland. This agreement is binding on me and anyone who makes a claim for me.
- The Growing Hearts Pediatric Cardiology Inc Notice of Privacy Practices: I received a copy of the Growing Hearts Pediatric Cardiology Inc Notice of Privacy Practices.
- Consent for the Creation and Use of Photographs, Audio and Video Recordings (PAVR): I agree to allow for the creation and use of photographs, audio and video, recordings (PAVR), and other images and recordings of me, or the patient I represent, for the purposes of internal education and quality improvement. This includes reviewing echocardiograms to assess imaging quality and conciseness or internal Education like teaching others proper EKG interpretation and understanding.  
Initial one: \_\_\_\_\_ I authorize \_\_\_\_\_ I do not authorize (initial please)
- Other Tests: In the event that a member of Growing Hearts Pediatric Cardiology Inc sustains a bodily fluid exposure during the course of my treatment, I consent to HIV testing and authorize Growing Hearts Pediatric Cardiology Inc to release the result of this said test to me, the exposed healthcare employee, and my physician. I understand that I have the right to refuse testing without penalty. \_\_\_\_\_ I authorize \_\_\_\_\_ I do not authorize
- Personal Belongings: Patients are responsible for their personal belongings and are encouraged to leave all money and valuables at home. Growing Hearts Pediatric Cardiology Inc shall not be responsible or liable for the loss of or damage to any personal property the patient brought into the facility including but not limited to money, dentures, glasses, hearing aids, personal electronic devices and documents.
- Interpreter: If interpreter used, please complete the following:      In-person Interpreter      Remote
- ID Number (if phone/video interpreter used): \_\_\_\_\_
- Printed Name of Interpreter: \_\_\_\_\_

I AGREE TO THE ITEMS STATED ABOVE AND CERTIFY THAT ALL INFORMATION PROVIDED INCLUDING INSURANCE IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. NO CHANGES TO THIS FORM WILL BE ACCEPTED.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patient signature: \_\_\_\_\_

For health care agent / guardian / surrogate / parent / spouse (circle one), I, \_\_\_\_\_ (print name), am the representative for the patient.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Representative's signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

GROWING HEARTS PEDIATRIC CARDIOLOGY INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Growing Hearts Pediatric Cardiology In Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(first) (m. initial) (last)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(street address)

\_\_\_\_\_ Medical Record #: \_\_\_\_\_  
(city) (state) (zip code) (if known)

Signature of Patient Only: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, \_\_\_\_\_, confirm that I am the representative for the patient based on the following  
(insert your name)  
relationship to the patient: \_\_\_\_\_  
(state relationship, for example – parent, spouse, guardian)

Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(street address) (city) (state) (zip)