THOMAS J. VENTO, MD
FAMILY MEDICINE

We would like to thank you for choosing us as your primary care provider. Please familiarize yourself with our office and financial policies listed below, and sign where indicated. A copy of this document will be provided to you, upon request.

Appointments – office hours are by appointment only. Patients are seen based on appointment time, not arrival time. We make every attempt to offer same day appointments for urgent matters. Please call as early in the day as possible, as same-day availability is limited. Patients that arrive late to their appointment may need to reschedule. New patients must arrive 10-15 minutes prior to their appointment time, or 25-30 minutes early if new patient paperwork has not been completed ahead of time.

Cancellations/No-Shows - If you are unable to keep your scheduled appointment, we kindly ask that you give our office at least 24 hours notice, as this allows us to provide your appointment time to another patient in need. A missed appointment without prior notice is considered a NO-SHOW. Cancelling an appointment on short notice (less than 2 hours before the scheduled appointment time) will also be considered a no-show. Patients who no-show 3 or more appointments in a 12-month period may be dismissed from our practice. New patients that no-show for their first appointment will NOT be rescheduled for any appointments at our office.

Prescription Refills – Please allow 2-3 business days for prescription refills. Do not wait until you've run out of medication before requesting a refill. Medication refills are contingent upon routine follow-up appointments; the frequency of required follow-up appointments will be determined by Dr. Vento. Prescription refills will not be authorized after office hours or on weekends. Please plan accordingly!

Referrals – Please allow 2-3 business days for insurance referrals. It is the patient's responsibility to provide all pertinent information to our office to complete a referral – the insurance information, the specialist's office information, and the reason for the visit to the specialist are all required for referral submission to your insurance company. Patients that fail to provide our office with sufficient notice for a referral may be required to reschedule their specialist appointment. Per insurance guidelines, we do NOT backdate referrals – no exceptions will be made to this policy.

Forms – Please allow 5-7 business days for the completion of forms. Depending on the complexity and nature of the form, an appointment with Dr. Vento may be required before the form can be completed.

Insurance – We verify insurance benefits at every visit. Please bring your insurance card or proof of insurance to every visit. If we are unable to verify your insurance coverage at the time of your visit, you will be considered a self-pay patient, and payment will be required at the time of service. We are contracted with most insurance plans, but it is your responsibility to verify that our office is in-network with your insurance carrier, prior to your appointment. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service. If your insurance plan requires the selection of a primary care physician (PCP), you must select Dr. Vento as your PCP **at least 24 hours prior to your appointment.** Failure to change the PCP on file with your insurance company prior to your appointment will result in cancellation of your appointment.

Self-Pay Patients - Patients without insurance coverage are expected to pay in full at the time of service. Our office can provide an estimate of charges prior to your visit; however a final cost cannot be determined until you have been seen by Dr. Vento, as charges are dependent upon the complexity and length of your visit.

Co-Payments/Past-Due Balances are due at the time of service. An office visit co-payment cannot be waived by our office, as it is a requirement placed on you by your insurance company. For your convenience we accept cash, personal checks, and credit cards (Visa, MasterCard & Discover). Failure to pay outstanding balances in a timely manner is grounds for dismissal from our practice. If you are facing a financial hardship, please contact our billing office at 410-469-4369 to discuss payment plan options.

Collections - Unpaid balances over 90 days will be referred to an outside collection agency. Patients with accounts in collections may be discharged from our practice, unless a payment plan arrangement with our billing office/collection agency is documented.

Vaccination Policy – All pediatric patients (< 18 years of age) must adhere to the vaccination schedule published by the American Academy of Pediatrics (AAP) and the U.S. Centers for Disease Control and Prevention (CDC). For the safety and well-being of all of our patients, we do not accept families that do not vaccinate their children. For new pediatric patients transferring care to our office, a copy of the vaccination record must be forwarded to our office **at least 24 hours prior to the initial appointment.** Failure to provide the vaccination records in advance of the initial appointment will result in cancellation of the appointment. Please request a copy of our vaccination policy for more information.

I acknowledge that I have received and read a copy of the office and financial policies of Thomas J. Vento, M.D.

Patient/Legal Guardian Signature Date

THOMAS J. VENTO, MD
FAMILY MEDICINE

Vaccine Policy

Vaccines have contributed to a significant reduction in many life-threatening childhood diseases. I strongly believe in the importance of vaccines and adhering to the vaccine schedule published by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the U.S. Centers for Disease Control and Prevention (CDC). I firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. For the safety and well-being of all of my patients, I have implemented the following vaccine policy:

- *My practice does not accept families that do not vaccinate their children – no exceptions!*

- *All pediatric patients (< 18 years of age) must receive all vaccines recommended by the ACIP, AAP and CDC, and adhere to the universally recommended vaccine schedule, which can be viewed online at http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf*

- *For new pediatric patients, the parents or legal guardian must provide my office with all vaccination records at least 48 hours in advance of the appointment date. Failure to provide this information will result in cancellation of the appointment.*

- *For pediatric patients that are not current with their vaccinations, the parents or legal guardian will be given a 30-day grace period, to allow sufficient time for any missing vaccinations to be administered. If after the 30-day grace period the vaccines are still not up-to-date, a discharge warning letter will be sent to the parents or legal guardian. If no action has been taken within 30 days of receipt of the warning letter, the patient will be officially discharged from my practice.*

As a physician, it is my duty to provide the safest environment possible for my patients to receive medical care. My own children receive the same vaccines that I administer to my patients. I firmly believe that vaccinating our children may be the single most important health-promoting and life-saving intervention that we can perform as parents. If you should have any questions or concerns regarding vaccines or my vaccine policy, please do not hesitate to contact my office.

Sincerely,

Thomas J. Vento, MD

1011 BALTIMORE BLVD WESTMINSTER, MD 21157 (410) 857-8536

THOMAS J. VENTO, MD
FAMILY MEDICINE

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M.I.: ___

Birth Date: _____ Sex: ( ) M ( ) F Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Preferred method of contact: ( ) Home ( ) Cell ( ) Work ( ) E-mail

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number: _____

Name & Phone # of Retail Pharmacy: _____

Name & Phone # of Mail-Order Pharmacy: _____

GUARANTOR INFORMATION: *Person responsible for bill, if other than patient*

Last Name: _____ First Name: _____ M.I.: __

Date of Birth: _____ Relationship to Patient_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Thomas Vento for all services rendered. I understand that I am financially responsible for any balances not covered by my insurance company. I also authorize Dr. Vento and my insurance company to release any medical information required to process my claims.

_____

Patient/Guardian Signature Date

1011 BALTIMORE BLVD WESTMINSTER, MD 21157 (410) 857-8536

PEDIATRIC HEALTH HISTORY FORM

Date:

Child's Name: _____ Age: _____ DOB: _____

Your Name: _____ Relationship to child: _____

Primary Care Provider: _____

Present health concerns: _____

Allergies/Reactions: _____

Medications your child takes daily: _____ Herbs/Home remedies used: _____

_____

PREGNANCY AND NEONATAL

Where was your child born: _____ Is your child: ☐ Biological ☐ Adopted ☐ Stepchild ☐ Other

Medical problems during pregnancy: ☐ No ☐ Yes (specify): _____

Delivery: ☐ Vaginal ☐ Caesarean (why): _____ Birth weight: _____ Birth length: _____

Was your child premature? ☐ No ☐ Yes, weeks: _____ Medical problems after birth: _____

Was your child breastfed? ☐ No ☐ Yes, (for how long): _____ Unusual feeding/dietary concerns? ☐ No ☐ Yes, (specify): _____

Current milk intake: ☐ Cow circle one: non-fat 1% fat 2% fat whole ☐ Soy ☐ Rice Average ounces per day (note 8 oz = 1 cup): _____

Hours of sleep per night: _____ Naps (number and length): _____

Any sleep problems: ☐ No ☐ Yes, (explain): _____

INFANCY/CHILDHOOD/ADOLESCENCE

Has your child ever been treated for or diagnosed with:

☐ Asthma _____ ☐ Seizures _____

☐ Wheezing or bronchiolitis _____ ☐ Anemia _____

☐ Seasonal allergies _____ ☐ Broken bone _____

☐ Eczema _____ ☐ Depression/anxiety _____

☐ Food allergies _____ ☐ Heart murmur _____

☐ Recurrent ear infections _____ ☐ Constipation _____

☐ Pneumonia _____ ☐ Chicken pox _____

☐ Urinary tract infection _____ ☐ Attention deficit disorder _____

Other chronic medical conditions: _____

Has your child ever been hospitalized? ☐ No ☐ Yes, (explain): _____

Previous surgeries and dates: _____

List any specialists your child has seen, dates and reason: _____

_____

DEVELOPMENT AND SCHOOL

What age did your child:

☐ Sit alone _____ ☐ Walk alone _____

☐ Say words _____ ☐ Toilet train _____

If applicable, age of first menstrual cycle: _____

Did/does your child have delayed development? ☐ No ☐ Yes

How does this child compare to others of his or her age? _____

_____

Did/does your child attend preschool? ☐ No ☐ Yes

What grade is he/she in? _____

Has he/she had any trouble in school? ☐ No ☐ Yes

Does he/she get along with other children? ☐ No ☐ Yes

Does he/she have a best friend? ☐ No ☐ Yes

Any concerns about relationships with teachers? _____

_____

DENTAL AND IMMUNIZATIONS

Please bring your child's immunization records to your appointment.

Has your child had chickenpox? ☐ No ☐ Yes Has your child been vaccinated against chickenpox? ☐ No ☐ Yes

Exposures/Habits: _____

Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ No ☐ Yes _____

Has your child been seen by a dentist? ☐ No ☐ Yes Last visit: _____ Does he/she get fluoride? ☐ No ☐ Yes

SOCIAL AND HOME

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____ ☐ Siblings (#____) ☐ Grandparents ☐ Other _____

Child's parents are: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other _____ Do any household members smoke? ☐ No ☐ Yes

Mom's occupation: _____ Dad's occupation: _____

Concerns about your child: ☐ Alcohol use ☐ Tobacco ☐ Sexual activity ☐ Aggressive behavior

Is violence at home a concern? ☐ No ☐ Yes Are there guns at home? ☐ No ☐ Yes

Childcare (if applicable): ☐ Parents ☐ Relatives ☐ Babysitter/Nanny Days per week in childcare (not with parent): _____

Pets: ☐ No ☐ Yes _____

How many hours per day does your child spend: Watching TV _____ On the computer_____ Playing video games _____

Hobbies/Extracirricular activities: _____

Sports/exercise: _____ How often: _____ How long: _____

FAMILY HISTORY

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma/Hay fever/Eczema	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Alcoholism/Drug Abuse	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Blood disorder (bleeding/clotting problems)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
Inherited/Genetic diseases	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐

REVIEW OF SYSTEMS

Please review the topics below. Check if you have a concern about your child.

☐ Fevers/chills/excessive sweating
☐ Unexplained weight loss/gain
☐ Squinting
☐ Asymmetric gaze/Crossed eyes
☐ Unusually loud voice/hard of hearing
☐ Mouth breathing/snoring
☐ Bad breath
☐ Frequent runny nose
☐ Problems with teeth/gums
☐ Coughing/wheezing
☐ Nausea/vomiting/diarrhea
☐ Constipation
☐ Blood in bowel movements
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting
☐ Bedwetting
☐ Developmental concerns
☐ Relationship with parents
☐ Self-image or self-worth
☐ Other _____

☐ Pain with urination
☐ Discharge: penis or vagina
☐ Headaches
☐ Muscle weakness
☐ Clumsiness
☐ Hay fever
☐ Itchy eyes
☐ Rashes
☐ Unusual moles
☐ Joint pain
☐ Speech problems
☐ Anxiety/stress
☐ Problems with sleep/nightmares
☐ Depression
☐ Nail biting/thumb sucking
☐ Bad temper/breath holding/jealousy
☐ Unexplained lumps
☐ Easy bruising/bleeding
☐ Depression
☐ School grades/absences