Patient Enrollment Form

Beittel-Becker PEDIATRIC ASSOCIATES

LIST THE FULL NAME AND DATE OF BIRTH OF THE CHILDREN YOU ARE ENROLLING

1. _____ **Race:** American Indian Asian Hawaiian Black White
LAST FIRST DOB **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

2. _____ **Race:** American Indian Asian Hawaiian Black White
LAST FIRST DOB **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

3. _____ **Race:** American Indian Asian Hawaiian Black White
LAST FIRST DOB **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

4. _____ **Race:** American Indian Asian Hawaiian Black White
LAST FIRST DOB **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

RESPONSIBLE PARTY INFORMATION:

Child/Children Reside with ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Father's Name: _____ **Mother's Name**: _____

Address: _____ Address: _____

_____ ZIP: _____ _____ZIP: _____

Phone: (H)_____(C)_____ Phone: (H)_____(C)_____

Father's Date of Birth: _____ **Mother's Date of Birth**_____

Social Security #: _____ Social Security #: _____

Primary Email: _____ **Secondary Email**: _____

Person to notify in case of emergency or if parents can't be reached (relative, friend, someone other than the parent)

_____

NAME Relationship Phone No.

INSURANCE INFORMATION

Please Note – We need all insurance information before your insurance can be effective with Beittel-Becker. Many insurance companies require S.S. # and DOB of parent to submit claims. Failure to provide accurate and timely information may result in you being responsible for the charges.

#1 PRIMARY INSURANCE CO. NAME: _____COPAY $: _____

Owner of Policy/Policy Holder: ☐ Father ☐ Mother ☐ Child ☐ Other: _____

ID Child #1_____ ID Child #2_____
ID Child #3_____ ID Child #4_____
Group #_____ Effective Date: _____

#2 SECONDARY INSURANCE CO. NAME: _____COPAY $: _____

Owner of Policy/Policy Holder: ☐ Father ☐ Mother ☐ Child ☐ Other: _____

ID Child #1_____ ID Child #2_____
ID Child #3_____ ID Child #4_____
Group # _____ Effective Date: _____

Authorization to Release Information – Assignment of Benefits- Receipt of Privacy Policies

I authorize release of medical information necessary to process medical claims on behalf of the above-named patient. I authorize all providers employed with Beittel-Becker Pediatric Associates to apply for benefits on behalf of the above patient(s) covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Beittel-Becker Pediatric Associates. I permit a copy of this authorization to be used in place of original. I may revoke this authorization at any time in writing. I also have had an opportunity to review a copy of the Notice of Privacy Practices. I agree with the financial policies of Beittel-Becker Pediatric Associates, and I note that I am financially responsible to make sure payment is made. I also attest that I have legal authority to make these authorizations & assignments for above- named patient.

Parent/Guardian Signature: _____

Date Signed: _____/_____/_____

For Office Use Only:

Received By: _____ Date: _____

Entered By: _____Date: _____

Make sure to enter data for all kids and parents

Beittel-Becker
PEDIATRIC ASSOCIATES

Comprehensive Patient History

The following information is very important to your child's health. Please take time to fully and completely fill out this important

Patient Information

Patient's Last Name:	First	Middle

☐ Male ☐ Female	Birth Date (mm/dd/yyyy)	Social Security Number

Patient's Home Address:

Phone # at home Address:	Other Phone:	

Child's Birth History

During Pregnancy did the mother (circle):

Have high blood pressure?	Yes	No
Have any infections?	Yes	No
Have diabetes or sugar in urine?	Yes	No
Take any medicines, drugs, alcohol?	Yes	No
Have any problems with labor?	Yes	No

Baby's weight at birth:	lbs. _____ oz._____	
Delivery was: (circle)	Vaginal	C-Section
Was baby premature?	Yes	No
Was baby overdue?	Yes	No

Number or weeks early or late: _____

List any problems the child had after birth while still in the hospital:

Family History

(check if yes)

	Father	Mother	Father's Family	Mother's Family	Childs Sibling
Asthma, Hay Fever, Eczema					
Diabetes					
Heart attack at age less than 50 years					
Hereditary disorders incl. sicke cell anemia					
Convulsions, epilepsy, neuromuscular disease					
Mental retardation or congenital malformation					
Malignancy or Leukemia					
Tuberculosis					

Child's Medical History

Has your child ever been taken to the hospital?

Month/Year	Reason

Names of any medications (over the counter/prescription) the child takes on a regular basis:

List anything to which the child is allergic:

Has your Child:

Had problems with hearing?	Yes	No
Had frequent ear infections?	Yes	No
Had problems with stomach or bowels?	Yes	No
Had broken/fractured bones or orthopedic problems?	Yes	No
Had allergies, asthma, eczema, hay fever?	Yes	No
Had allergy skin testing performed?	Yes	No
Been exposed to tuberculosis?	Yes	No
Had problems with vision or eyes?	Yes	No
Had problems with heart or rheumatic fever?	Yes	No
Had problems with urinating or kidneys?	Yes	No
Had X-rays taken?	Yes	No
Had epilepsy, convulsions, neurological disorders?	Yes	No
Been given allergy desensitization injections?	Yes	No
Taken any steroids in the past (prednisone, cortisone)?	Yes	No

Please list any additional information that could pertain to your child's health that we should know, or if you wish to make any comments regarding the "yes" items, use the space below:

Parent/Guardian Signature: _____

Date: _____

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PEDIATRIC ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____ SS #: _____

- **I authorize the use or disclosure of the above-named individual's health information as described below**
- **The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)**

The information identified below may be used by or disclosed to the following doctor, individual, or organization(s):

Release From: _____ **Release To:** _____

Address: _____ **Address:** _____

Date(s) of Service: ☐ **Include all dates** **Other:** _____

☐ ENTIRE RECORD INCLUDING VACCINATION RECORD

☐ Demographic information only including appointment time and dates
☐ H&P
☐Consults
☐ Human Immunodeficiency Virus (HIV) Information
☐ Lab Results
☐ Progress Notes
☐ Medication List
☐ Behavioral Health Information
☐ Substance Abuse Information
☐ OTHER: please specify _____

- I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will remain in effect till I revoke it, or I transfer from the practice
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient (or Patient's Legal Guardian) **Printed Name of Patient (or Patient's Legal Guardian)**

_____ _____

Relationship to Patient **Date**

2150 Noll Drive, Suite 100, Lancaster, PA 17603
Phone: (717) 299-8933 | **Fax:** (717) 299-5635 | www.beittelbecker.com

Beittel-Becker
PEDIATRIC ASSOCIATES

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Beittel-Becker Pediatric Associates.

The Notice of Privacy Practices describes how your children's protected medical information may be used and disclosed and how you can get access to this information.

The notice of Privacy Practices is posted in our office and is easily obtained on our website or by requesting a copy from our staff. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain an updated copy from our staff or you may access from our website at www.beittelbecker.com.

I acknowledge receipt of the Notice of Privacy Practices from Beittel-Becker Pediatric Associates.

Name of Patient | Date of Birth

Name of Patient's Parent/Guardian | Signature of Patient's Parent/Guardian

Beittel-Becker
PEDIATRIC ASSOCIATES

Financial Policies Acknowledgment Form

Thank you for choosing Beittel-Becker Pediatric Associates as your pediatric provider. Our primary goal is to provide our patients with health care services of the highest quality. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policies is important to our professional relationship. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you become acquainted with our financial policy.

Your Responsibilities:
It is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing what services are covered, how often (example - well visits), and how much of the cost is your responsibility.

You are responsible for:

- Your copay
- Your coinsurance
- Your deductible
- Any services that your insurance does not cover.

You must provide current, complete, and accurate insurance information at every visit. This is to protect you from receiving a bill because we did not have correct insurance information.

You must present your insurance cards at every visit. Your insurance card contains essential information that helps us process claims efficiently and without errors. Bring your insurance card to every visit.

You must pay your copay at the time of the office visit. Our agreements with insurance companies require us to collect your copay at the time of service. We accept cash, credit cards, and checks as forms of payment.

If your insurance plan requires you to choose a primary care provider, you must contact your carrier and select one of our doctors before your visit. In accordance with insurance guidelines, we cannot schedule any appointments or write any referrals until we receive notice that your child has been added to our roster.

Insurance:
We will prepare and send claims to your insurance. However, we remind you that your policy is an agreement between you and your insurance company. Please understand that you are responsible for your total obligation pertaining to your specific insurance plan. If we participate with your insurance, we have agreed to accept their fee schedule. After your insurance pays according to the specific benefits of your plan, they will send us the patient obligation, which may include amounts related to unpaid co-pays, co-insurance, or the plan deductible. We will send a statement for any remaining balance, which is payable within 30 days.

Personal Balances:
Personal balances are due immediately upon receipt of a bill. If your balance is not paid, we will resend a bill every 30 days. Failure to pay a balance after 90 days will trigger a late fee. See the “failure to pay” section below for how late balances are managed.

Payment arrangements:
We realize that financial problems may affect timely payment of your account. If you are unable to pay your responsibility in full within 30 days, please contact us promptly to discuss payment arrangements. We are able to store a credit card on-file and arrange short-term payment arrangements.

Nonpayment:
Failure to pay any balance(s) associated with your account after 90 days will incur a **$25.00** late fee which covers the additional costs incurred on our end that stem from late payments (e.g., administrative time and postage costs associated with mailing multiple bills). We will send a final notice letter notifying you of your unpaid balance. If no attempt is made to resolve the balance by the due date on the final notice letter, we will forward the unpaid balance to a collection agency. A **33.0%** charge will be added to the balance to cover the fee charged by the collection agency. Your family will be dismissed from our practice. We will still provide acute services for your children for 30 days. If you have been dismissed from our practice, and you wish to rejoin, all balances in collections must be paid, and a **$25.00** reinstatement fee per child is due prior to rejoining. A second balance sent to collections will result in permanent dismissal from our practice.

Same Day Preventative and Acute Visits:
Preventative well child visits are normally covered 100% by insurance. When your child is seen for a well child visit, there may be situations when he or she needs additional services that are not considered preventative. If a problem is found that needs to be addressed or you want a problem addressed that is not related to the preventative well child visit, the provider will need to provide services in addition to the preventative exam. These additional services will be billed to your insurance in addition to the preventative service. These services would also incur financial responsibility as well such as a copay for an office visit, which much be paid at the time of service. After your insurance processes the claims, any coinsurance or deductibles must be paid within 30 days of receipt of your bill. Examples of additional services include, but are not limited to:

- Provider's treatment of minor problems
- Medical treatments (nebulizer treatment; wart removal)
- Minor surgical procedures (removal of foreign body; splinter removal)

Evening/Saturday After Hours Charge
As a convenience to our parents, we offer appointments after our standard 8am-5pm office hours. We charge a **$25.00** after hours fee for this service. Insurance plans and parents both recognize that this fee is a cost-effective alternative to an Emergency Room/Urgent Care visit and/or leaving work to bring your child in to be seen. This fee is added to all visits that are provided:

- After 5:00 pm on weekdays
- On Saturdays

BY SIGNING THE FORM, I ACKNOWLEDGE THAT I WAS GIVEN A CHANCE TO REVIEW THE FINANCIAL POLICIES OF BEITTEL-BECKER PEDIATRIC ASSOCIATES. REFUSAL TO SIGN DOES NOT RENDER THE POLICY NULL AND VOID. THE POLICY WILL CONTINUE BEING ENFORCED IN THE SAME MANNER FOR ALL PATIENTS.

Responsible Party: _____

Print Name: _____

Patient(s) Name: _____

Relationship to Patient(s): _____

Date: _____ /_____ /_____

Beittel-Becker
PEDIATRIC ASSOCIATES

Cancellation & Broken Appointment Policy Acknowledgement Form

It is the goal of Beittel-Becker Pediatric Associates to provide our patients with health care services of the highest quality. For us to assure convenience and accessibility to all our patients, it is important that our patients arrive to their previously scheduled appointment or cancel/reschedule the appointment **24 hours** in advance. This policy allows us to use our available appointment slots most efficiently for patients in need of medical care.

Cancellation of An Appointment

You may cancel your scheduled appointment by calling the office during regular business hours. This courtesy allows our staff to schedule another patient who might be seeking immediate medical care.

Broken Appointment Policy

A "broken appointment" is an occurrence where a patient does not show up for an appointment and does not cancel or reschedule the appointment **24 hours** in advance. If you do not show for your appointment and you do not cancel or reschedule the appointment **24 hours** in advance, we will record this in the medical record as a "broken appointment." Every time you break an appointment, we will notify you by phone or by a letter in the mail.

In situations where a patient needs to cancel within **24 hours** of the scheduled appointment, we require a phone call prior to the scheduled appointment, but we will use discretion by recording this as a "late-cancelled" visit in the medical record. We do not treat a "late-cancelled" visit as a broken appointment. However, if consistent cancellations within **24 hours** of the scheduled appointment becomes a frequent occurrence, we reserve the right to begin marking them as a "broken appointment."

Fees and Termination for Broken Appointments

Failure to show up for a visit without calling to cancel or reschedule within **24 hours** of the scheduled appointment will result in a fee for a broken appointment. This fee will not be submitted to the patient's insurance; it will be charged to the patient. We understand that flexibility is important, so we will waive the fee for the first broken appointment. The missed appointment fee structure is **$25.00** for all types of appointments. A "late-cancelled" visit will not be charged a **$25.00** fee unless it becomes a consistent occurrence.

If a patient has 5 broken appointments within a calendar year, we will exercise the right to terminate the patient/provider relationship by demanding that the responsible party transfers the medical records of their child or children to another provider.

BY SIGNING THE FORM, I ACKNOWLEDGE THAT I WAS GIVEN A CHANCE TO REVIEW THE CANCELLATION & BROKEN APPOINTMENT POLICY. REFUSAL TO SIGN DOES NOT RENDER THE POLICY NULL AND VOID. THE POLICY WILL CONTINUE BEING ENFORCED IN THE SAME MANNER FOR ALL PATIENTS.

Signed By _____ Patient Name _____

Print Name_____ Relationship to Patient _____

Date _____

Beittel-Becker
PEDIATRIC ASSOCIATES

Vaccine Policy Statement

We believe in the effectiveness of vaccines to prevent serious illness and to save lives and that the protection of children from vaccine-preventable diseases is critical.

We believe that parents should follow the immunization schedule provided by the Centers for Disease Control, American Academy of Pediatrics, and the American Academy of Family Physicians.

We believe that it is **NOT** advisable to skip or delay vaccines as this will leave the child vulnerable to disease for a longer period of time and delaying and modifying the schedule to give vaccines has not been studied.

We believe that the safety of vaccines used for our children is of utmost importance as outlined by the American Academy of Pediatrics, American Medical Association, and the Institute of Medicine and that the known risks from diseases are far greater than any unknown/theoretical risk from vaccines.

We know that many vaccine preventable diseases can have dangerous consequences including seizures, brain damage, and death. Currently 20% of the patients with measles are hospitalized.

In order for vaccines to protect everyone, an estimated 85-95% of the population must be immunized.

Most parents have never seen the devastating diseases that vaccines prevent. It is our goal to make sure they never do.

*****Parents who refuse vaccines completely or want to follow a schedule other than the one recommended by the American Academy of Pediatrics will be asked to find another primary care provider who agrees with their views and opinions of vaccines*****

I acknowledge receipt of the Vaccine Policy Statement from Beittel-Becker Pediatric Associates and agree to follow the vaccine policies of the practice.

Name of Patient Date of Birth

Name of Patient's Parent/Guardian Signature of Patient's Parent/Guardian