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: _____

HIPAA NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

1. Beittel-Becker Pediatric Associates has made the Notice of Privacy Practices available to me.

2. Beittel-Becker Pediatric Associates may access, collect, use and disclose my health information to my primary care or referring physician, to consultants, and as necessary to others to process insurance claims, insurance applications and prescriptions.

3. Beittel-Becker Pediatric Associates may also disclose my health information these persons:

Name: _____ Phone: (_____) _____Relationship to the Patient: _____

Name: _____ Phone: (_____) _____ Relationship to the Patient: _____

3. Beittel-Becker Pediatric Associates **may release my complete health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, if any), **unless indicated below**:

□ Beittel-Becker Pediatric Associates **may not** release mental health records
□ Beittel-Becker Pediatric Associates **may not** release record containing communicable diseases (including HIV and AIDS)
□ Beittel-Becker Pediatric Associates **may not** release records containing alcohol/drug abuse treatment
□ Beittel-Becker Pediatric Associates **may not** release other records (please specify):

_____

4. This authorization is effective for all of my records, including past records, and remains in effect until it is revoked in writing, unless a date is specified here: _____

5. Beittel-Becker Pediatric Associates may provide me with information on activities and developments and may disclose my information to third parties who help Beittel-Becker Pediatric Associates to inform me. This authorization expires 3 years after my last appointment.

6. I may revoke this authorization, in writing, at any time. This would not be effective to the extent that anyone has already relied on it, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. My treatment, payment, enrollment, or eligibility for benefits is **not** be conditioned on this authorization.

8. I understand that my information may be disclosed by a third-party recipient and may no longer be protected by federal or state law.

SIGNATURE

I have provided all of the required information for this form and note that it is accurate and complete. I also understand and agree to adhere to the provisions as outlined.

_____ _____/_____/_____
Patient Signature Date

OR

_____ _____/_____/_____
Responsible Party Signature Date

_____
Relationship to Patient

Beittel-Becker
PEDIATRIC ASSOCIATES

Financial Policies Acknowledgment Form

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. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

You are responsible for:

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

All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless alternative arrangements have been made with our practice. 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.

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 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. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

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.

Self-Pay or Inactive Insurance:
Patients who are self-pay or have inactive insurance are required to place a credit card on file. We offer a 15% self-pay discount if the patient/caregiver authorizes us to charge the card on the same day of service. If the balance remains unpaid after 60 days, the card on file will be charged for the full undiscounted amount.

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 "nonpayment" section below for how late balances are managed.

Payment arrangements:
We realize that financial problems may affect the 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. This also applies for sports physicals, which is an additional service.

These additional services will be billed to your insurance in addition to the preventative service. These services may also incur financial responsibility as well, such as a copay for an office visit, which must 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)
- Sports physicals

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

Forms:
Our position has always been to refrain from charging excessive fees for the completion of forms. However, we do charge a $10.00 form fee for driver's permit forms if the form is not completed at the time of service. All other forms can be completed at no cost. Please allow 5-7 business days for the providers to complete the form, so plan accordingly. If you need it expedited (Next business day by 5pm) the cost is $25.00. NO SAME DAY SERVICE.

Copies and Transfer of Medical Records:
Patients requesting copies of medical records or medical records be transferred to another provider will normally not be charged a fee. Our standard practice is to copy or transfer the last several years of records. If the request is excessive, we reserve the right to charge a fee in accordance with guidelines established by the PA Department of Health (Department). The Department publishes guidelines and fees that a health care provider may charge in response to a request for production of medical charts or records. **Any unresolved balances will be sent to collections immediately upon transferring records.**

BY SIGNING THE FORM, I ACKNOWLEGE THAT I WAS GIVEN A CHANCE TO REVIEW THE FINANCIAL POLICIES OF BEITTEL-BECKER PEDIATRIC ASSOCIATES, AND THAT I AGREE TO SAME. 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 Signature: _____

Print Name: _____

Patient(s) Name: _____

Relationship to Patient(s): _____

Date: _____ /_____ /_____

Beittel-Becker
PEDIATRIC ASSOCIATES

Cancellation And Missed Appointment Policies

Beittel-Becker Pediatric Associates strives to provide exceptional care and to ensure convenience and accessibility to all of our patients. It is important that patients arrive on time for their appointments or cancel/reschedule in accordance with our appointment cancellation policy. This policy allows us to provide exceptional care to ALL of our patients which is our mission, what our patients deserve, and what they have come to expect.

Late Arrival:
Our policy is that patients must arrive by their check-in time, which is 10 minutes prior to their appointment time. This allows adequate time for the patient to complete the registration process and complete necessary paperwork. We will send text and phone reminders prior to the appointment which notifies the patient of their check-in time.

A late arrival occurs when anyone arrives more than 15 minutes after their assigned check-in time without any advanced warning and an adequate reason for running late. As a courtesy to our patients, our providers, and our staff, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after the assigned check-in time and we cannot accommodate same-day rescheduling. It will be marked as a missed appointment.

Appointment Cancellation:
We understand situations may arise in which you may need to cancel your appointment. Under these circumstances, if you need to cancel a routine visit (typically scheduled in advance of appt) such as a well-check/med review/mini-physical etc., more than 24 hours' notice is required. If you need to cancel an acute visit, more than 2 hours advance notice is required. Our text communication system is an acceptable method for canceling an appointment ONLY if made more than 24 hours in advance.

Please understand that cancellations without the required notice will be treated as a **NO SHOW** and your account will incur a fee. These fees are the sole responsibility of the patient/caregiver.

No Show/Late Cancellation:
Failure to show up for a visit without canceling the appointment or providing advanced notice according to our "Appointment Cancellation Policy" will be considered a **NO SHOW** and will result in a fee being assessed. The fee structure for missed appointments due to no show/late cancellation is **$50.00** for complex visits (20+ minutes) and **$25.00** for simple visits (10 minutes).

Patients who no-show 4 or more times in 12 months may be dismissed from the practice and will be unable to schedule future appointments. This policy applies to each child, not the family as a whole. However, if one child meets the criteria for dismissal due to no-shows, all siblings will be dismissed. If you call to cancel an appointment without sufficient notice you will be informed during the call that insufficient notice was provided which will result in a fee. **Any unresolved balances will be sent to collections immediately upon transferring records.**

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

Parent Signature: _____

Print Name: _____

Patient(s) Name: _____

Relationship to Patient(s): _____

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

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

Signature of Patient's Parent/Guardian: _____

Printed Name of Patient's Parent/Guardian: _____

Patient(s) Name: _____

Relationship to Patient(s): _____

Date: _____ /_____ /_____

Beittel-Becker
PEDIATRIC ASSOCIATES

Custody & Divorce Policy

At Beittel Becker Pediatric Associates, our primary focus is the well-being and health of our patients. We believe that custody and divorce matters should not interfere with a child's medical care. Therefore, Beittel Becker cannot be a bridge between separated or divorced parents. Our practice is to collect co-payments and account balances from the parent attending visits with the child. Subsequently, bills will be sent to the address of the responsible party and the parent who lives at that address will be responsible for payment.

Beittel Becker will not call a parent to notify of an appointment scheduled by the other. It is the parents' responsibility to communicate with each other about their child's care, office visit dates, and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each parent separately. Our providers are not responsible to call the non-attending parent following visits. "Joint Custody" means that each parent has equal access to the child's medical record and patient portal. Without a court order, we will not stop either parent from looking at their child's chart, patient portal, or obtaining their child's test results. We will not call the other parent for consent prior to treatment. We will discuss with the accompanying parent information pertinent to the child's history and/or present visit. **Please note that we encourage both parents to be available for visits whether in-person or telemedicine.**

As always, we reserve the right to charge an administrative fee for copying records should the requests become excessive. We also reserve the right to request copies of any custody/divorce agreements for documentation to help us in treating your child. In the event that issues between parents become disruptive to our practice and staff and consequently interfere with the treatment of our patients, we may have no alternative but to discharge the family and their children from our practice.