

Patient Enrollment Form



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

| | |
|------------------------|---|
| 1. _____ LAST FIRST | Race: American Indian Asian Hawaiian Black White DOB Ethnicity: Hispanic/Latino Non-Hispanic/Latino |
| 2. _____ LAST FIRST | Race: American Indian Asian Hawaiian Black White DOB Ethnicity: Hispanic/Latino Non-Hispanic/Latino |
| 3. _____ LAST FIRST | Race: American Indian Asian Hawaiian Black White DOB Ethnicity: Hispanic/Latino Non-Hispanic/Latino |
| 4. _____ LAST FIRST | Race: American Indian Asian Hawaiian Black White 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

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 |
| <input type="checkbox"/> Male <input type="checkbox"/> 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. sickle 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: _____

**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

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. 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

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: ____/____/____

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 _____

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