Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 484.245.5384

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

Name:____ Today's Date: ____
Last First M

Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

GENDER: □MALE □FEMALE

SSN: ____DOB: ____

RACE: □African American/Black □White □American Indian/Alaska Native □Asian □Native Hawaiian or Pacific Islander □ Declined

ETHNICITY: □Hispanic □Non-Hispanic □Declined

PARENT #1 INFORMATION

Name:____ SSN: _______________________________DOB: ___________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail_____________________________________

Occupation: ____Employer____

Relationship with patient______________________________ Do you live with child? □NO □YES

PARENT #2 INFORMATION

Name:____ SSN: _______________________________DOB: ___________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail_____________________________________

Occupation: _______________________________________ Employer____

Relationship with patient______________________________ Do you live with child? □NO □YES

EMERGENCY CONTACT #1

Name:____Relationship____

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

EMERGENCY CONTACT #2

Name:____Relationship____

PHONE #1(______)_______-________ □ H□C□W PHONE #2(______)_______-________ □ H□C□W

REFERRAL INFORMATION

Referring physician name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

PRIMARY CARE PHYSICIAN INFORMATION

PCP name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

INSURANCE INFORMATION

____

PRIMARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

DO YOU HAVE A SECONDARY INSURANCE? □ NO □ YES. IF SO, PROVIDE INFORMATION BELOW

____

SECONDARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER
NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

PHARMACY INFORMATION

PREFERRED PHARMACY NAME____

ADDRESS____

PHONE (__________)_________-__________ FAX NUMBER (__________) _________-___________

The information I provided is correct to the best of my knowledge.

Parent/Guardian Signature_______________________________________Date____

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CONSENT FOR TREATMENT

In presenting my child for diagnosis and treatment, I hereby voluntarily authorize Pediatric Neurology of Lehigh Valley, through its appropriate personnel, to perform or have performed upon me or my child, appropriate assessment and treatment procedures as may in the providers professional judgement be necessary. I further authorize Pediatric Neurology of Lehigh Valley, to release to appropriate agencies, any information acquired in the course of my child's examination and treatment.

I give my consent to the provider and staff of Pediatric Neurology of Lehigh Valley to perform medical services determined to be necessary or advisable for the benefit of my child's healthcare. Pediatric Neurology of Lehigh Valley is authorized to use and disclose my protected health information for treatment, payment, and operations consistent with its Notice of Privacy Practices.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

By signing below, I certify that I have read, reviewed carefully, and fully understand and accept the terms of treatment for me or my child provided by Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our treatment practices.

PATIENT NAME	DOB
GUARANTOR NAME (PRINTED)	DOB
PARENT/GUARANTOR SIGNATURE	DATE

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how PNLV may use and disclose medical information about you or your child, and how you can obtain access to this information. Please review our policy carefully. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care.!

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of PNLV. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.!

ADDITIONAL USES OF INFORMATION

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. Please review those rights below.

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

PNLV DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office.

Violations: If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below you are acknowledging that you have read, reviewed carefully, and fully understand and accept the privacy practices of Pediatric Neurology of Lehigh Valley. You understand that if you at any point have questions or concerns regarding these policies, you can refer to the Notice of Privacy Practices, or call our office.

Patient Name:____DOB: _______________

Parent Name:____DOB:_______________

Parent/Guardian Signature:____DATE:_______________

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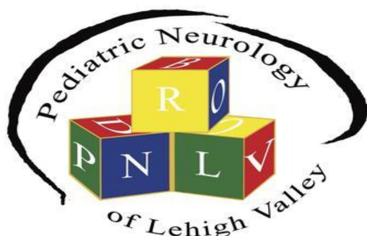
FINANCIAL POLICY

Thank you for choosing Pediatric Neurology of Lehigh Valley also known as PNLV, to care for your child's neurological health care needs. We look forward to the opportunity to provide you and your child with compassion and exceptional care. The following is a statement of our Financial Policy. Please read and initial each of the following statements. By initialing you indicate that you have read, understand, and agree with each one.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
All co-payments, co-insurance, and deductibles are due the day of service, prior to seeing the provider. Effective Monday, January 2, 2023, PNLV will require all patients keep an active credit card on file with us which will be used to collect your child's copay, coinsurance or deductible before their scheduled appointment.* The credit card on file will also be used to pay account balances after insurance adjudication and any additional fees (see Other Fees) that have been incurred past 30 days. We will scan the card in our system, and the last 4 digits of your CC will be held securely while your insurance is processing the claim to determine their paid portion and notifies us as to any additional amount owed by you for services not covered (see **Non-covered services**). At that time, you will receive a notification that the remaining balance owed will be charged to your credit card if you have not paid within 30 days' notice. Please note that there is a $35.00 fee for returned checks.
Initial ________

*** For in person visits, we accept cash, checks, Visa, Mastercard, Amex, Discover, Google Pay and Apple Pay.**

Minor Patients: Please note that the adult accompanying the minor child to the appointment and the parents **(**or guardians for the minor**)** are responsible for full payment at the time of the visit**.** We ask that minors be accompanied by a parent or guardian to each appointment**,** and that if the person accompanying the child is not the guarantor, paymentarrangements must be made in advance, prior to our provider seeing the patients. Initial ________



12/28/22 br/jb

INFORMATION REGARDING INSURANCE

Contracted Insurance Plans: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays, deductibles and coinsurance percentages are due prior to treatment. Payment for the visit is ultimately your responsibility. It is also your responsibility to ensure that you obtain an insurance referral from your primary care physician if one is needed. If you are treated without a referral, you will be responsible for the charges incurred. If we do not have the updated insurance information at the time of the appointment you will be responsible for the entire visit, and you must submit to your insurance company for reimbursement. Initial ________

Non-Contracted Insurance Plans: We are not contracted with Medicare or any form of (MA) medical assistance and **will not** bill MA or Medicare. You are responsible for payment of all services rendered whether covered by insurance or not. For non-contracted commercial insurance plans, to assist you, we will bill your commercial insurance company. If we don't have your updated insurance information on file at the time of your visit, you will be responsible to pay all costs and you must submit to your insurance company for reimbursement. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Initial ________

Non-covered services: Please be aware that some – and perhaps all – of the services or diagnoses you receive may be non-covered or not considered reasonable or necessary by your insurance company. This includes, in accordance with AMA CPT guidelines, we reserve the right to charge for Telehealth visits, after business hours/ weekend appointments and phone calls with Dr. Boo that include evaluation and management of your medical condition. We will bill your insurance for such charges, but if it is not covered by your plan, you will be responsible for the charges. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Initial ________

Assignment of Benefits: I hereby assign, transfer, and set over directly to Pediatric Neurology of Lehigh Valley (PNLV) sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize PNLV to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PNLV. I authorize PNLV to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers. Initial ________

OTHER FEES

Missed Appointments: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours/1 full business day prior to canceling your appointment. Unless canceled at least 24 hours/ 1 full business day) in advance—i.e., by Friday morning for a Monday morning appointment, our policy is to charge for missed appointments at the rate of $125.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.
Initial ________

Telehealth Appointments: Most health insurance plans cover telehealth visits, but some have limitations on what is covered. To avoid having payment for your telehealth visit denied, please contact your insurance company to verify what is covered before scheduling or completing a telehealth appointment. You will be responsible for what is not covered by your plan. Initial _______

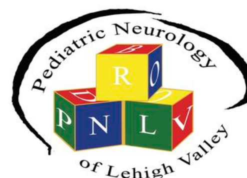
Forms: There is a minimal charge of $10.00 and up to a maximum of $50.00 for completion of any forms not completed during a scheduled office visit. You agree to allow us to run the credit card on file once the form(s) are completed. A receipt will be provided. Initial _____

RIGHT TO AMEND: You understand and agree that PNLV may amend the terms of this Financial Policy at any time without prior notification to the patient. Initial_______

Discharge from Practice: You will be dismissed from the practice if you fail to meet your financial responsibilities within 60 days and/or we must use a collection agency to bring your account up-to-date. Initial __________

****If you have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance.**

Sign the following acknowledgment and return to the staff of PNLV to keep on file. Please keep a copy for your records.



FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

By signing below, you are acknowledging that you have read, reviewed carefully, and fully understand our Financial Policy and accept your financial responsibility to Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our financial practices. You understand that you are obligated to ensure payment of the fees stated in our Financial Policy, in full and in a timely manner.

Patient
Name:____DOB:_________________

Guarantor
Name:____DOB:_________________

Parent/Guardian
Signature:____DATE:________________

12/28/22 br/jb

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Credit Card On File (CCOF) Policy

Thank you for choosing Pediatric Neurology of Lehigh Valley, PC, for your child's health needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. With the changing environment in healthcare, more responsibility of payment is being placed on the patient in the form of copays and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file in our office.

Effective Monday, January 2, 2023, Pediatric Neurology of Lehigh Valley, PC, will require all patients keep an active credit card on file with us which will be used to collect your child's copay, coinsurance, or deductible before their scheduled appointment. The credit card on file will also be used to pay account balances after insurance adjudication. After the visit, we will bill your insurance company. We will only charge your credit card when they inform us of patient responsibility. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

When I booked my appointment, the receptionist told me I must keep a credit card on file with the office. I've never heard of that before.

This is not surprising that this is new to you, as it is not yet the norm in this area. Having a CCOF is the new standard in the healthcare industry nationwide and will likely be adopted by the majority of medical practices, particularly free-standing private practices that are not linked to major institutions. We are definitely not the first to do this. Insurance reimbursements are declining, and the expectation is that health care providers find ways to become more efficient. This year with the Affordable Care Act and the Health Exchanges, we are seeing a massive increase in patient deductibles. These factors are driving many doctors' offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient instead.

I always pay my bills on time. Why do I have to do this?

The entire billing process is wasteful but the few patients that we have to bill multiple times or even send to a collection's agency do cost us a lot of time and expense. Reducing unnecessary costs is essential for us to continue to accept insurance. This new process dramatically cuts down on the administrative costs associated with billing. Nothing is changing about how much you pay. When you come into our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care. We bill your insurance company for you, and we have contracts with most insurance companies that help to get you the best possible coverage for your care. Having a CCOF will only cover your responsibility after your insurance pays its contracted share.

Credit Card on File Billing Authorization FAQ

Q: What is a deductible?
A: An annual deductible is the dollar amount you must pay out of your own pocket during your plan year for medical expenses before your insurance begins to pay. For example, if the policy has a $1,000 deductible, you must pay the first $1,000 of medical expenses before your insurance will begin to pay. Your insurance company must receive a claim to process in order to apply balances towards your deductible.

Q: Is my credit card secure?
A: Yes, we keep your credit card info securely within your HIPAA compliant Electronic Medical Record and Billing System, Medent, in addition to our encrypted payment gateway, Global Payments Merchant. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.

Q: What if I need to discuss my bill?
A: We will always work with you to resolve any issues and will refund you if we have made a billing error. If you disagree with how your insurance carrier processed the claim, you will need to contact their customer service department directly

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Credit Card On File (CCOF)

Due to the rising costs of health care and loss of revenue from unpaid balances, Pediatric Neurology of Lehigh Valley, PC will be collecting your child's copay, coinsurance or deductible before their scheduled appointment. Once the finalized EOB is received from the insurance company, you will receive one statement and, if it is not paid within 30 days, we will run your credit card on file for any additional patient responsibility. This would include non-covered services such as missed appointment fees and prolonged visits. Your credit card information will be kept confidential and secure as payments to your card are processed only for the copay, coinsurance or deductible before the appointment and then once again after the claim has been filed and processed by your insurance carrier.

***PLEASE REFER TO OUR CCOF POLICY AND FINANCIAL POLICY FOR MORE INFORMATION**

I, ___________________________________ , authorize Pediatric Neurology of Lehigh Valley, PC to retain my credit card information and to charge my credit card before my child's appointment for all copays, coinsurance and deductibles as well as any balance put into the "patient responsibility" column of all future statements. I understand and agree that this payment will be processed before the appointment and after the claim is finalized and when we receive a copy of the Explanation of Benefits (EOB) from my insurance plan. Pediatric Neurology of Lehigh Valley, PC will also provide me with a receipt as proof of payment.

I understand and agree that this form is valid until I give a 30-day written notice to cancel the authorization to Pediatric Neurology of Lehigh Valley. PC located at 961 Marcon Boulevard Suite 452. Allentown, PA 18109. If I revoke my authorization, I am also agreeing to forego all future appointments and medication refills until I agree to the credit card on file agreement.

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Card Holder's Name (as shown on card): ____

Card Type: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express Expiration date (mm/yy):______ /______

Credit Card Number: ____

CVV Code: ___________ Billing Zip Code:__________

Email Address:____

Cardholder Signature____Date:_______________________

Important Credit Card On File (CCOF) Information:

- During the time you leave a credit card on file, if it expires or otherwise becomes uncollected, we will expect you to promptly provide a new means of payment within 48 hours of the office staff making you aware of the denial or we will consider this a breach of contract.
- Credits on your account after your insurance claim has been adjusted will be returned to the credit card on file.
- Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.
- Your credit card information is kept securely within your HIPAA compliant Electronic Medical Record and Billing System, Medent, in addition to our encrypted payment gateway, Global Payments Merchant. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.

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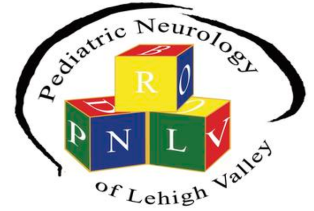

CONTROLLED SUBSTANCE POLICY AGREEMENT AND CONSENT FORM

Thank you for choosing Pediatric Neurology of Lehigh Valley, also known as PNLV, to care for your child's neurological health care needs. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care. The use of controlled substances is only one part but can be an integral aspect of the treatment for various neurological conditions such as ADHD, Headaches, Anxiety, Tics, and Seizures. It is our policy at PNLV, that patients (or their guardians) receiving prescriptions for controlled substances be required to sign a **Controlled Substance Agreement** verifying understanding of, and agreement with, our **Controlled Substance Policy** as stated below. If you have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance.

___________/__________/_____________
TODAY' S DATE

____/__________/_____________
PATIENT NAME DATE OF BIRTH

Please read carefully and initial each line to indicate agreement with each statement below

Dr. Boosara Ratanawongsa also known as **Dr. Boo** will be my/my child's only designated provider for his controlled substance medication that pertains to the diagnosis Dr. Boo has given. As the patient/ patient's parent or legal guardian, by signing this agreement, I am indicating that I understand, I am responsible for and voluntarily agree with the following:

______I agree to take the medication ONLY as prescribed, and I will not change the dose without getting approval from Dr. Boo.
______The above prescription(s) will be filled by Dr. Boo **only**. I agree not to seek ADHD medicine from any other source, including other physicians, emergency departments, or clinics. I understand that if I/I or my child do so, the treatment will be stopped, and I/ I and my child may be discharged from the practice.
______I will make sure the patient has an appointment for refills.
______The patient will keep, and be on time for, all their scheduled appointments with Dr. Boo.
______I understand that after initiation of treatment, a follow up visit is **required** within 30 days, and then every 3 months after that. If there is a **change in dosage** needed, then you will be asked to come back within 30 days. There are **no exceptions** to this rule. No refill of the medication prescribed for ADHD can be made if these follow up visits are not kept.
______I will ensure that the medication is taken as instructed. No changes will be made without written consent by Dr. Boo or her staff.
______I understand that refills of the medication are authorized once every thirty days as long as the required follow-up office visits are kept. I will not be provided a refill prescription prior to this thirty-day period. Refill prescriptions cannot be mailed or faxed. They can only be sent electronically to the pharmacy. The prescription refill request must be sent to us through the patient portal every 30 days. I understand that to obtain a refill, I must request one through the patient portal at least **THREE** days before this thirty-day period is up in order to remain compliant with the state monitoring system and proper documentation. **No exceptions**
______I will not utilize the urgent message line/ page after hours to request refills. I understand that it is important to make

sure the patient has enough medication to get through weekends, holidays, after hours, and vacations when the office is closed (which will be posted on the patient portal) because there is no guarantee that these prescriptions will be refilled during these time frames

_______I understand most controlled substances require a prior authorization and can take up to 72 hours for the staff to complete once they are informed by the pharmacy via fax or covermymeds.com.

_______I understand that prior authorizations can take 5-10 business days to be approved or denied by their insurance(s). I

_______understand no refills will be given if there is an outstanding balance or missed appointment.

_______I understand a full refill will not be given for missed/cancelled appointments. Enough will be given until next appointment depending on the medication.

_______No refills will be given for lost or stolen prescriptions. If the medicine is lost or stolen, I understand that it will not be replaced until the patient's next appointment or may not be replaced at all.

_______I understand that ADHD Medication Benefit Form/Parent and Teacher Vanderbilt ADHD Diagnostic Rating Scales must be filled out by teachers prior to appointments and after medication changes upon Dr. Boo's request

_______It is illegal to, and therefore will not, sell this medicine or share it with others. I understand that if I/I or my child does, the treatment will be stopped, and I/ I and my child may be discharged from the practice.

_______I know that this medication is given to help control the effects of ADHD. It is not a cure. The duration of use is determined by the effectiveness of the treatment.

_______I understand this medication is potentially addictive and chances of addiction are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider. This requires regular office visits to follow my progress

_______I agree that this medication will be stopped if my ability to function does not improve, if the medication loses its effectiveness, if I do not attend required office appointments, or if there is reason to believe I am misusing the medication in any way.

_______I understand this medication has potential side effects including, but not limited to: Headaches, appetite suppression, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping.

_______I have had the risks associated with taking this medication explained to me and have decided that the benefits outweigh the risks.

_______If the patient is unable to take the medication due to allergic or otherwise adverse reaction, I will notify the prescriber and discard the remainder

_______I understand that if any of this medication needs to be discarded, I will contact my local police department to locate a drug disposal location

_______I authorize Pediatric Neurology of Lehigh Valley to review medication information with other doctors, hospitals, and pharmacists; additionally, to contact any groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies.

_______I understand that the patient may lose their right to treatment in this office if I/ parents or the patient breaks any part of this agreement.

By signing below, you are acknowledging that you have read, reviewed carefully, and fully understand our **Controlled Substance Policy** and accept your responsibility to Pediatric Neurology of Lehigh Valley to stay compliant.

Patient Name:____DOB:________________

Guarantor Name:____DOB:________________

Patient/Parent/Guardian
Signature:____DATE:_______________

12/28/22 br/jb

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PNLV Policy for Divorced, Separated and Unmarried Parents

Pediatric Neurology of Lehigh Valley, PC is committed to providing high quality medical and behavioral health care to our patients and their families. Our primary concern is the physical, emotional and psychological well-being of our patients. We understand that each of our patients has a unique family dynamic, and we are committed to understanding that dynamic and providing care accordingly. While we value the insight and perspective of our patients' parents, and encourage both parents to attend appointments, we recognize that this may not be always be possible. This policy, which is meant to address such issues, governs the provision of care to patients whose parents are divorced, separated, or in the process of becoming divorced, separated, or were never married. As the circumstances of family dynamics may change, we are requesting that this form is **reviewed and signed for all patients** to indicate that you will comply with this policy in the event that this may apply to you.

Please Note: Our providers and staff are not party to, nor will they become involved in, any legal proceedings involving the families of our patients, including, but not limited to, proceedings regarding divorce, separation, or custody issues.

For the purposes of this policy, the term "**parent**" includes the term "**legal guardian.**" Please read this policy so that you are aware of our expectations and limitations:

1. Dr. Boo and staff will treat your child and communicate information based on Pennsylvania law and guidance from their respective professional licensure boards.
2. We request that you provide us with documentation of your court-ordered or court approved custody agreement. If you fail to provide us with such documentation, we will assume that you share legal custody.
3. When parents share legal custody, both parents are independently permitted to:
   - Schedule, attend, and cancel appointments.
   - Give consent to treatment.
   - Authorize other adults to bring the child to the appointment.
   - Access medical records, except psychology, psychotherapy, and social worker records.
4. A parent with sole legal custody is also independently permitted to take all the actions listed in Paragraph 3 of this policy.
5. Regardless of custody status, we will not release a child's psychotherapy, psychology, or social worker records without a court order even if there is a signed release by both parents.
6. We will not restrict a parent's involvement in the child's care unless we receive:
   - A court order conferring sole legal custody on a specific parent
   - A court order requiring a specific parent to refrain from involvement in his or her child's medical care.
7. A parent without legal custody does not have the right to any involvement in the child's care, unless the parent who has sole legal custody authorizes, in writing, the other parent's involvement.

8. While we strongly encourage the consent of both parents, we do not require it. However, if we become aware of a dispute between the parents regarding our provision of services to the child, we will encourage an office visit with both parents in attendance to discuss the benefits and/or potential complications with the contested treatment, as well as the risk of non-treatment, and work toward an agreeable course of treatment.
9. It is not our responsibility to communicate with each parent separately. To provide the best care of your child, we strongly encourage both parents to be involved and attend appointments when legally appropriate. Our system allows one parent to receive telephone reminders and alerts, and one parent to receive email notices regarding the patient portal for appointments and messages. It is the responsibility of the parents to communicate with each other regarding their children's medical and behavioral care, such as office visit dates, treatments, recommendations, and other pertinent information. Dr. Boo will not call the non-attending parent during or following visits. Please make decisions regarding appointments and treatments prior to appointments.
10. Payments, including copays, deductibles, coinsurance or any additional fees charged by your insurance, are due at the time of service, regardless of which parent is responsible for medical expenses. If the custody arrangement or divorce decree requires the other parent to pay all or part of the treatment costs, it is the attending parent's responsibility to collect from the other parent.
11. If our practice feels any of the above issues are compromising your children's care or our ability to provide care to your children, we will exercise our rights and legal obligations which may include filing a report with the Department of Children and Families or discharge from the practice.

I have read, understand, and will abide by the Policy for Divorced, Separated and Unmarried Parents.

Patient
Name:____DOB:___________

Parent/Guardian
Name:____DOB:___________

Parent/Guardian
Signature:____DATE:__________
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***Legal custody involves a parent's rights to make major medical, educational, religious, and legal decisions on the child's behalf, such as where the child should attend school or whether the child should undergo a major medical procedure. Parents may share legal custody, or one parent may have the sole right to make decisions for the child. (23 Pa. Cons. Stat. Ann. § 5322.)**

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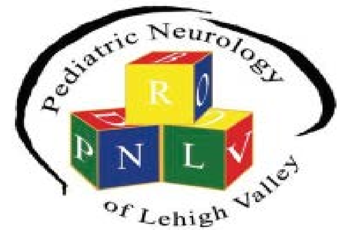

CONSENT TO RECEIVE TEXT MESSAGES

I ______________________________________ hereby give consent to Pediatric Neurology of Lehigh Valley, PC to text me in the event I am unavailable via the portal, Klara or personal phone call. I also reserve the right to rescind my consent by informing the office staff at Pediatric Neurology of Lehigh Valley, PC.

I am aware there may be some data charges and will solely be responsible for those charges.

____
Signature

____
Date