Ideal Pediatric and Adolescent Care
121 JPM Road
Lewisburg, PA 17837
(P) 570-551-0300
(F) 570-523-6391

Due to the Insurance company regulations, providers are required to report all services provided at each visit. Your insurance company may charge you for an office visit in addition to the well check/ preventative exam if there are medical/sick problems addressed during the preventative exam. Not all insurance companies are pushing this fee to the patients but we bill all patients the same regardless of type of insurance. If you have any further questions please feel free to contact your insurance company.

Please note:

_____ - I acknowledge that I may ask my provider to evaluate and manage my (child's) medical problem(s) during my preventative exam and that this treatment will result in a separate office visit be billed in addition to the preventative exam.

Additional office visits may apply at your annual preventative visit if you:

*Discuss a new medical issue, such as flu, rash, infection, fever, cough or sore throat, which would normally be treated at a sick visit.

*Discover a new condition which requires further testing or a referral to a Specialty Provider.

*Discuss a chronic issue such as, Attention Deficit, Asthma, Obesity, Thyroid, Diabetes or Growth Hormone

*Note: Prevenative services are subject to your plan's coverage guidelines. This is not a guarantee of coverage.

IDEAL PEDIATRIC & ADOLESCENT CARE

Patient Registration Form

Patient Name: _____ Nickname: _____ Birthdate: _____ Sex: M / F

Demographic Information:

Ethnicity (choose one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefers not to answer

Preferred Language: _____

Race (Choose one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefers not to answer

SIBLINGS

Other Children's Names	Birthdate	Sex	Demographics (same as above?)	If different, please specify
1.		M F	Y/N	
2.		M F	Y/N	
3.		M F	Y/N	
4.		M F	Y/N	
5.		M F	Y/N	

ACCOUNT INFORMATION

Custodian (patient lives with):

Name: _____

DOB: _____ SSN: _____

Address: _____

_____

Primary Phone: _____

Secondary Phone: _____

Email: _____

Guarantor (bills sent to):

Name: _____

DOB: _____ SSN: _____

Address: _____

_____

Primary Phone: _____

Secondary Phone: _____

Email: _____

Emergency Contact: (Name & Relation): _____ Phone#: _____

INSURANCE INFORMATION: **Please provide a copy of your current insurance card(s)**

Primary Insurance name: _____

Insurance subscriber's name: _____ Date of Birth: ____/____/____

Insurance subscriber's sex: M / F Subscriber's Relationship to Patient: _____

Secondary Insurance name: _____

Insurance subscriber's name: _____ Date of Birth: ____/____/____

Insurance subscriber's sex: M / F Subscriber's Relationship to Patient: _____

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PATIENT HEALTH QUESTIONNAIRE

Today's Date: _____

Patient's Full Name: _____ DOB: _____

PATIENT'S BIRTH HISTORY:

Place of Birth: _____

Circle One: Full Term or Pre-term (_____ weeks)

Circle One: Vaginal or C-Section (Reason for C-section: _____)

Complications: _____

PATIENT'S PAST MEDICAL HISTORY: _____

PATIENT'S PAST SURGICAL HISTORY: _____

PATIENT'S HOSPITALIZATIONS: _____

PATIENT'S CURRNT MEDICATIONS: _____

FAMILY HISTORY: (INCLUDE PARENT'S, PATIENT'S GRANDPARENT'S AND PATIENT'S COUSINS)

Asthma _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
Seasonal Allergies _____
Cancers _____
Sudden Death _____
High Blood Pressure _____
Psychiatric Illness _____
Seizures _____
Leukemia _____
Other _____

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PATIENT HEALTH QUESTIONNAIRE (CONTINUED)

SIBLINGS:

NAME	AGE	MEDICAL PROBLEMS/CONCERN

SOCIAL HISTORY:

Parent's are: (circle one) MARRIED DIVORCED SEPARATED OTHER

Patient's lives with: _____

Pets: _____

Any Family members that smoke: (circle one) yes/no

Who smokes: _____

Concerns for substance abuse (drugs or alcohol): Circle: yes/no

THIS INFORMATION IS PROVIDED TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____

DOB: _____

I, _____ _____ hereby authorize the release of medical information **TO:**

MARY BETH O'HARA, D.O., F.A.A.P.
IDEAL PEDIATRIC AND ADOLESCENT CARE, P.C.
121 JPM Road, Lewisburg, PA 17837
Telephone: 570-551-0300

FROM:
Doctor/Hospital/clinic: _____

Address: _____

Telephone: _____

FAX: _____

Please release the following:

__ All health information including growth charts and immunizations
__ History and Physical Exam
__ Progress Notes
__ Discharge Summary
__ Consultation Reports
__ Pathology Reports
__ Lab Results
__ Radiology
__ Diagnostic Test Reports
__ Other

I consent to release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical record.

__ Yes, I consent to release this information __ No, I do not consent to release this information

Purpose of disclosure:

__ Treatment/Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT: _____

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ACKNOWLEDGEMENT O : RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal Law, including HIPAA rules, to safeguard general and health related information. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and authorized representatives) when they first become a patient of the practice. The Notice of Privacy Practices is available on our website and it will be gladly printed for you at any of your office visits.

We are asking you to sign this form to acknowledge that you understand and were offered a copy of our Notice of Privacy Practices. Copies are available on our website, in our waiting room and a personal copy can be requested from our staff. By signing below, you are only acknowledging that you were offered a copy of the NOTICE OF PRIVACY PRACTICES. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of the document.

I acknowledge that Ideal and Pediatric and Adolescent Care, P.C. offered to provide me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed and how I can access this information.

I understand that if I have any questions or complaints I may contact: Privacy Officer/Owner:
Dr. Mary Beth O'Hara at 570-551-0300. I also understand that I am entitled to receive updates or amendments upon request, if Ideal Pediatric and Adolescent Care changes to its Notice of Privacy Practices.

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative	Relationship to patient

For OFFICE USE ONY

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above named patient, but was unable because:

[ ] Patient declined to sign this written acknowledgment
[ ] Other (specify):

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HEALTH INSURANCE REGULATIONS FOR PREVENTATIVE VISITS

Health Insurance company regulations require providers to report all services performed at each office visit.

Your health insurance company may charge you for an office visit in addition to a well child or preventative visit if there are follow up issues addressed, sick concerns, new findings or any diagnosis that require a referral. Most insurance companies will not cover this charge and it becomes the patient responsibility including any co-payments.

Some examples that may trigger you insurance company to bill you directly include but are not limited to:
Sickness- viral illness, flu, rash, fever, cough, sore throat, ear infection, etc
Chronic issues: ADHD, Asthma, Obesity, Poor Growth, Development Delay, Speech Delay, GERD, Thyroid Disease, Diabetes, Asthma, Eczema, etc
Any new condition discovered during the visit.

If you have any questions or disagreements these should be directed to your Health Insurance Carrier/Company.

I acknowledge that read and understand the above rules set forth by my Health Plan. I understand I may be billed a separate office visit at my preventative visit if other concerns are addressed or new findings are discovered and treated.

SIGNATURE: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____

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CONSENT TO TREAT

PATIENT'S NAME: _____ **DOB:** _____

This form gives Dr. O'Hara and any Ideal Pediatric and Adolescent Care provider permission to provide medical care to your child. It also allows you to designate other family members to bring your child on your behalf.

Option 1

I authorize Dr. O'Hara or any Ideal Pediatric and Adolescent Care providers to give medical care for my child.

In the event my child is brought to the appointment by anyone other then a legal guardian or me, I authorize my child to be treated in my absence. I understand I will be responsible for any cost associated with the visit.

The following person(s) have permission to authorize medical care for my child and sign for any treatment or waivers on my behalf:

Name	Relationship to Patient	

Signature for Option 1: _____ **Date:** _____

Option 2

I authorize Dr. O'Hara or any Ideal Pediatric and Adolescent Care providers to provide medical care for my child. In the event that my child is brought to the clinic by anyone other then a legal guardian or me, I do NOT authorize my child be treated in my absence. I understand that by signing below my child will not be treated unless the parent or legal guardian is present.

Signature for Option 2: _____ **Date:** _____

For patients 16 years and older only:

The patient listed above may present for treatment and be treated without an adult present. Circle one: yes/no

Signature for patients older then 16 years: _____ **Date:** _____

Form completed by: _____ Relationship to patient: _____

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PAYMENT POLICIES

Thank you for choosing **Ideal Pediatric and Adolescent Care, P.C.** for your child's medical care. We are providing the following information to help you understand our insurance and billing policies.

YOUR RESPONSIBILITIES:

YOU MUST SHOW YOUR INSURANCE CARD AT EVERY VISIT

This is to protect you from receiving a bill because we did not have correct insurance information. If we do not have correct information you are responsible for the full visit charge. We will attempt to validate your insurance benefits at the time of service and alert you to any lapse or problems with your insurance. **If we cannot validate your insurance or you did not bring your insurance card we will assign you to self-pay status and payment will be due at the time of the visit.**

YOU MUST CONTACT YOUR INSURANCE COMPANY AND LINK OR SELECT Ideal Pediatrics AS YOUR PRIMARY CARE PROVIDER

If our office and providers are not listed on your insurance card we cannot bill the insurance for the visit charge becomes **YOUR RESPONSIBILITY.**

We cannot schedule an appointment until we have been notified that you have been added to our patient panel. If you do not list us as the provider and arrive for an appointment you will be responsible to pay for the visit at the time of service.

YOU MUST PAY YOUR CO-PAYMENT AT THE TIME OT THE OFFICE VISIT

Our contracts with insurance companies require us to collect your co-payment at the time of service. We accept credit cards (MasterCard, Visa, American Express and Discover). We also accept personal checks. In the event a personal check is returned unpaid, your account will be charged an additional **$20.00 service fee.**

If the co-payment is not collected at the time of the visit you will be subject to an additional **$20.00 service fee.**

YOU MUST PROVIDE A CREDIT CARD TO BE KEPT ON FILE

Most insurance companies are subject to routine deductibles and co-insurances, thus we require a credit card on file so we can collect those charges as soon as the insurance company assigns the appropriate amount of the patient responsibility. Your credit card will only be charged after the insurance company determines your patient responsibility as listed on your explanation of benefits. Our office will run a report on the 15th of every month and you will be notified prior to any charges being placed on your credit card.

YOU MUST CANCEL AN APPOINTMENT FOR A WELL VISIT AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT

If you do not cancel the appointment a **missed appointment fee of $50.00** will be added to your account.

YOU MUST CANCEL A SICK APPOINTMENT WITHIN TWO HOURS OF THE APPOINTMENT

If you do not cancel a **missed appointment fee of $20.00** will be added to your account.

YOU MUST KNOW YOUR INSURANCE BENEFITS

Your insurance policy is a contract between you and your insurance company even if your employer provides the policy. You are responsible to know the coverage and know what cost is your responsibility. You will be responsible for any part of the visit that your insurance does not cover including deductibles and co-payments.

You **must** be aware of which **lab or X-Ray** facility your insurance company requires you to utilize in the event test are needed. Your insurance company may not cover test done in our office such as strep, urine or flu testing. It is your responsibility to pay for this test if the insurance company does not cover the studies. IT IS YOUR RESPONSIBILITY TO NOTIFY US IF YOU DO NOT WANT THE TEST SENT TO THE LOCAL HOSPITAL LAB.

YOU MUST NOTIFY YOUR INSURANCE COMPANY OF YOUR NEWBORN OR NEWLY ADOPTED CHILD

You child is only covered by the mother's policy for 30 days following birth or adoption. The first appointment will be covered but if you do not add your child immediately then your child will be uninsured and you will be responsible for the visit including any immunizations, which can be very costly.

YOU MUST PROVIDE DAYCARE, SPORTS, SCHOOL AND CAMP FORMS AT THE TIME OF THE VISIT

We are happy to fill out any forms, FREE OF CHARGE, at the time of you child's well visit, sport or camp physical appointment. If you do not bring the form and we have to complete at another time a **fee of $20.00** will be applied to the account regardless of faxing the form directly to you or the school/daycare. We keep a supply of forms on hand at the office so if you forget to bring the form just ask and this will avoid an extra charge to your account.

OUR COLLECTION POLICY

If your account is self-pay, all services must be paid at the time of the visit. The may include situations where we cannot validate your insurance coverage with you insurance carrier. In such cases, we will collect payment at the time of service and refund any amount that is collected once you provide proof of insurance.

If a non-participating insurance carrier insures you, we will expect payment at the time of the visit and it is your responsibility to submit claims to your insurance company for direct reimbursement.

All statements are due upon receipt. If charges remain unpaid after 30 days, a second statement will be sent with a notice requesting immediate payment. If the statement remains unpaid after 60 days your credit card on file will be charged. If we do not have a credit card on file the account will be sent to collections and we may need to notify you that our relationship is subject to cancellation after 30 days of providing emergent care.

We understand special circumstances may prevent timely payment and our billing specialist will work with families in need to arrange payment plan if necessary.

I have read and understand the policy and agree to them as written:

SIGNATURE: _____

NAME: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____

*These policies do not apply to Medicaid patients

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COVID-19

Ideal Pediatric and Adolescent Care, P.C.

Financial Policy Amendment

Ideal Pediatric and Adolescent Care has amended it financial policy during the COVID-19 pandemic on a temporary basis.

We are now offering Telemedicine Visits. If your insurance company does not cover these visits there will be a maximum charge of $75.00. We understand that many families are facing unemployment and we will make every effort to place patients on a budget plan. Medical Insurance companies are rapidly changing policies to cover Telemedicine during this crisis.

In addition, we will be charging for phone consultations with nursing staff or the practitioner. Health Insurances companies are now recognizing these visits as well. You will be charged a maximum of $20.00 for a phone consultation regardless of time. If the nurse is not able to answer your question the visit will be converted into a Telehealth appointment.

Ideal Pediatric will waive any late fees or no show fees during this time of crisis and make every effort to work with families on a budget plan.