Beacon Pediatrics

18947 John J Williams Hwy, Suite #212
Rehoboth Beach, Delaware 19971
Ph: 302.645.8212 Fax: 302.645.2199

Nancy Gideon, MD, FAAP
Meredith Luckenbaugh, MD, FAAP
Erin Fletcher, DO, FAAP
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Parental Consent for Medical Treatment

Patient Name(s): ____________________ DOB: ____________ ________________________ DOB: ____________
____________________ DOB: ____________ ________________________ DOB: ____________
____________________ DOB: ____________ ________________________ DOB: ____________

Parent/Guardian Name: ______________________________ Parent/Guardian Name: ____________________________
Parent phone number: _______________________ Parent Phone Number: _____________________

Address: ____ ________________ ___________ _____________
(Address) (City) (State) (ZIP)

** Below, list anyone (OTHER THEN PARENTS/LEGAL GUARDIANS) who have your consent to bring the child/ren listed above to any appointments: IE: Step Parents, grandparents, Aunt/Uncles, friends, etc. (list more on back if needed) the people listed NEED to have a picture ID and copy of the insurance card with them when bringing your child to any appointments for security reasons.

1. Name: ______________________________________ Contact Number: __________________________

   Relation to child: ____

2. Name: ______________________________________ Contact Number: __________________________

   Relation to child: ____

3. Name: ______________________________________ Contact Number: __________________________

   Relation to child: ____

The above named caregiver(s) shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures for the above named child which may be required during my absence.

This consent serves as permission for treatment by **Beacon Pediatrics, LLC** and its' providers/staff. Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall remain effective unless requested by me in writing **OR** until the following date listed: ________________ **(VALID UNTIL A CERTAIN DATE)**

____ ___________________

Parent/Legal Guardian Signature **Date**

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Present your Insurance Card and Driver's License to the receptionist with this completed form.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Child's Name____ Nickname: ________________________________

Child's Address____

City___________________________________ State ___________ Zip______________ Home Phone _________________

Childs age: _________ Childs DOB: _______________ Gender: Male Female Soc.Sec. # (optional) __________________

Race: circle one: Native American/Alaskan, Asian, Black or African American, White/Caucasian, Pacific Islander, Other

Ethnicity: Circle one: Hispanic or Not Hispanic Spoken Language: ___________________________

What pharmacies do you use: Local: ____________________/_________________ Mail Order: _____________________
Name / City

*May we have permission to view your prescription history from external sources such as a pharmacy: Yes No

Emergency Contact (other than parents/guardians)
Name: ________________________ Relation: ________________ Phone #____________________Cell #______________
Do you give us permission to discuss medical information with your Emergency Contact WITHOUT future written permission? (YES / NO)

PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian Name: ________________________________ DOB: __________

Home# ____________________ Cell# ___________________

Secondary Parent/Guardian Name: ________________________________ DOB: _________

Home# ____________________ Cell# ___________________

E-Mail Address: (Print clearly) ____
Do you want access to our secure web portal? If so we need your e-mail and please ask at check-in!

Marital Status: Divorced Married Partner Single Widowed Legally Separated

Can we leave messages on your Home #: Yes No

Can we leave a message on your Cell #: Yes No Text? Yes NO

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PRIMARY INSURANCE

Insurance Name: ________________________ ID/ Subscriber # _______________________ Account/Group # _______________

Policyholder's Full Name: _____________________________ *Policyholder's* relation to patient if not the patient: ________________

Policyholder's Gender: Male Female DOB: ____/____/_____ *Policyholder's* Soc. Sec # _______-_______-_______

Address (if different from patient's) _______________________________________ __________________ _________ ___________

STREET CITY STATE ZIP

Home Phone# (______) -_______-_________ Cell Phone# (______) -_______-_________

Policyholder Employed by _______________ Occupation ______________ Employer's Phone: (_______) - ________-_________

Employer's Address ______________________________ ____________________ __________ ____________

STREET CITY STATE ZIP

Name of other Dependents on this plan: ____

ADDITIONAL INSURANCE

Insurance Name: ________________________ ID/ Subscriber # _______________________ Account/Group # _______________

Policyholder's Full Name: __________________________ *Policyholder's* relation to patient if not the patient: ________________

Policyholder's Gender: Male Female DOB: ____/____/_____ *Policyholder's* Soc. Sec # _______-_______-_______

Address (if different from patient's) _______________________________________ __________________ _________ ___________

STREET CITY STATE ZIP

Home Phone# (______) -_______-_________ Cell Phone# (______) -_______-_________

Policyholder Employed by _______________ Occupation ______________ Employer's Phone: (_______) - ________-_________

Employer's Address ______________________________ ____________________ __________ ____________

STREET CITY STATE ZIP

Name of other Dependents on this plan: ____

OTHER INFORMATION

If you are new to our practice: How did you hear about us? ____

Previous Physician/Practice Name: _________________________ Phone: ____________________

If you are a vacationer /Seasonal patient:

Primary Care Doctor Name: __________________________ Phone: _______________ Fax: _________________

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Patient Name: ________________________________ DOB: ____________________

Birth History

1. Gestational Age (how on time was your child) ______weeks
2. Birth Weight: __________ Birth Length: __________
3. Any Complications DURING pregnancy: ________________
   ____
   ____
4. Did mom drink alcohol during pregnancy? YES NO
5. Did mom smoke during pregnancy? YES NO
6. Was the delivery:
   - Spontaneous Vaginal Delivery
   - Induced Vaginal Delivery
   - C-Section

   If induced or C-Section then why? ____________________
   ____
7. Delivery Complications? ___________________________
8. Nursery Complications? ___________________________

Age and gender of Siblings: _________________________
____
____

Moms Name: ____________________________
Dads Name: ____________________________

Medical History: Has your child had?

Chicken pox Disease	YES	NO
Chicken Pox Vaccine	YES	NO
Asthma	YES	NO
Allergies	YES	NO
Dry Skin (eczema)	YES	NO
Ear Infections (>3/year)	YES	NO
Feeding Problems	YES	NO
ADD/ADHD	YES	NO
Problems with BM (Stool)	YES	NO

Medical History Continued:

Problems with Urination (pee)	YES	NO
Growth/Language Delay	YES	NO

List any additional Medical Problems: ________________
____
____

Medications: (include doses) ________________________
____
____

Allergies: ____________________________________

Surgeries: ____________________________________

Hospitalizations: _______________________________
____

Procedure (& Age when done): ____________________
____
____

Social History:

Does your child Smoke	Y	N
Does anyone in household smoke	Y	N

If yes, WHO?
____

Pets, if yes what kinds: __________________________

Drinking Water: __Bottled __Nursery __Tidewater
__Artesian __Well __Town

Daycare: Y N

At Home with: mom/ dad/ grandparent/ Nanny

Family History of: __Asthma __Juvenile Diabetes __Seizures
__Allergies __Migraines __Sickle Cell __Cancers
__Congenital Heart Disease __Other

Child's Relatives	Age	Current Illness	Deceased/ Age	Cause of Death
Mother			Y N /	
Father			Y N /	
Sibling			Y N /	
Sibling			Y N /	

Additional Comments:
____
____
____
____

{{BARCODELEFTRIGHT}}

****Please sign and date each item below****

ACKNOWLEDGEMENT AND AUTHORIZATION (These forms will be handed to you to keep at your first appointment)

- **I have read and understand the Office Policies for Beacon Pediatrics, LLC**

  Signed: ____ Date: ________________

- **I have read and understand the HIPAA/Privacy Policy for Beacon Pediatrics, LLC**

  Signed: ____ Date: _________________

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

  Signed: ____ Date: _________________

- **I authorize Beacon Pediatrics, LLC to release medical information required to process my child's claim**

  Signed: ____ Date: ________________

- **I have read and understand the Financial Policy for Beacon Pediatrics, LLC**

  Signed: ____ Date: ________________

- **I authorize Beacon Pediatrics, LLC to obtain/have access to my child's medication history**

  Signed: ____ Date: ________________

Welcome to Beacon Pediatrics!

Visit our website at www.beaconpediatrics.net OR like us on Facebook for up to date information on office closings/delays, flu vaccines, and more!

Office hours:

Monday - Thursday	phones – 8am-6pm	Appointments - 8:30am-6:00pm	Walk-ins 8:15am-10am & 3pm-6pm
Friday (**October-April**)	phones – 7:30am-4pm	Appointments – 7:45am-3pm	Walk-ins 7:45am-3pm
Friday (**April-October**)	phones – 7:30 am -3pm	Appointments- 7:45am-2:15pm	Walk-ins 7:45am-2pm
Saturday & Sunday	phones- 8am-11am	Walk-Ins 8:15am-10am	

**these hours are subject to change. Please check our website for current information, closings or delays.

Office Policies:

1) ALL newborns must have **ACTIVE** insurance by their one month appointment. If the child has Delaware Medicaid, your child **MUST** have his/her OWN ACTIVE ID#; all other insurances **MUST** be active under the policy holder. IF this is not done by the one month appointment, then the visit will be self-pay (cash or credit card ONLY) or the appointment may be canceled.

2) Insurance Cards **MUST** be brought to every appointment; this is considered a form of payment for your visit. If not provided you may be responsible for payment.

3) Co-pays are due at the time of your visit. This is a contract between you and your insurance company. For any questions please call your insurance (numbers should be listed on back of insurance cards). If you do not have your co-pay, then the appointment may be rescheduled.

4) Visits are by appointment only, PLEASE be on time for your visit! ** The office may reschedule any appointment if you arrive more than 15 minutes late. ** We now offer walk-in acute visits. These are on a first come, first serve basis within the times listed above. At Times there may be a significant wait, however we do offer scheduled acute visits by calling the office.

5) The office gives COURTESY calls reminding you of your child's appointment 1-2 days prior. It is your responsibility to make sure that the office has updated phone numbers at all times; however, it is still your responsibility to remember appointment dates and times.

6) A **24hr notice is required to cancel/reschedule an appointment**. If not, you will be marked as a "No Show" and a fee may be applied to the account and must be paid before another appointment will be scheduled. After (3) No Shows, you may be discharged from our practice and a notice will be sent to your insurance company.

7) If anyone other than parents or legal guardian is to bring the child to his/her appointment, proper notification must be presented. (i.e. Consent form or note from parent/guardian, along with insurance card & Copay).

8) All school and insurance forms require at least one week to be completed (if not done at time of the child's visit). This does require a fee and must be paid before they can be picked up/faxed/mailed. If forms are done at the time of your visit, there is no additional charge.

9) If you leave a message on one of our voicemails, your call will be returned by the end of the business day and in order of urgency. Please do not make multiple calls as this will delay our return call to you.

10) All Controlled substance medications must have 24-48 hour notice for refills. Please note, if you call on a Friday, your prescription may not be ready until Monday.

HIPAA Notice of Privacy Practices: Effective as of: September 23, 2013

This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. PLEASE READ CAREFULLY.

This Notice of Privacy is NOT an authorization. It describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health information. "Protected Health Information" (PHI) is information, including demographic, that may identify your child and that relates to the past, present or future physical or mental health conditions and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION-(PHI): PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in the care and treatment for the purpose of providing health care services, to pay bills, to support the operation of the physician's practice and any other use as required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage the health care or any related services. This includes the coordination and management of health care with a third party. (I.e. a referred physician will have necessary information to diagnose and treat.

Payment: PHI will be used to obtain payment for services rendered.

Reminders/Appointments: We may use PHI to contact you by phone, text, mail or email for appointment reminders or with newsletters or announcements about special events.

As required by law: We must disclose PHI about you without authorization if federal, state or local laws require us to do so or if there is a serious threat to health and safety.

Judicial Proceedings: We may disclose PHI in response to a court order or subpoena or other lawful process.

Inspect and copy: You have the right to inspect and obtain copy of your child's PHI. You must state the reason for your request. The request must be in writing. There will be a charge for this as allowed by the State of Delaware.

Right to Amend: If you believe that any PHI we have is incorrect or incomplete, you have the right to an amendment. The request must be in writing. We may deny your request if you ask us to amend information that was not created by us, is not part of information that you would be permitted to inspect and copy or is accurate and complete. If the request is denied, you will be notified in writing.

Confidential Communications: You have the right to request that we communicate by alternative means or at an alternative location.

Restricted Use: You can restrict, in writing, that we restrict PHI disclosure to insurance payer if you pay cash at the time of service.

Right to Accounting of Disclosures: You have the right to receive an accounting of the disclosures made by us as required by law except for disclosures pursuant to an authorization, for purpose of treatment, payment, and healthcare operations.

Breach of PHI: You will be notified if you unsecured PHI has been breached.

Paper Copy of this Notice: You have the right to receive of paper copy of this Notice. The notice is available at our reception desk and from our website www.beaconpediatrics.net

Complaints: You may complain to us or the Secretary of Health and Human Services within 180 days. If you believe your privacy rights have been violated. **There will be no retaliation for filing a complaint.**

Assignment of Benefits and Permission to Treat

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize my insurance carrier(s) to pay and hereby assign directly to Dr. Nancy Gideon and/or Dr. Erin Fletcher and/or Dr. Stacey Fox, and/or Dr. Meredith Luckenbaugh, and/or Jeffrey Boxer, MD, FAAP and/or Cathy Haut, CPNP, DNP, and/or Beacon Pediatrics, LLC all benefits, if any, otherwise payable to me for any and all of his/their services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Nancy Gideon and/or Dr. Erin Fletcher and/or Dr. Stacey Fox, and/or Dr. Meredith Luckenbaugh, and/or Jeffrey Boxer, MD, FAAP, and/or Cathy Haut, CPNP, DNP and/or Beacon Pediatrics, LLC will be credited to my account, in accordance with the above said assignment.

Permission is hereby granted for physicians, residents, employees, or agents of Beacon Pediatrics, LLC to render such medical and surgical treatment as is deemed necessary.

In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay reasonable attorney's fees and collection expenses.

Financial Policy

1. Payment is due at the time of service. We accept cash, check, Visa, MasterCard and Discover.

2. Keep in mind that your insurance policy is a contract between you and your insurance company.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill these Plans for you. You are required to pay your **co pay** BEFORE you are seen and any **deductible** or **co-insurance** at the time you check out.

4. If you are insured by a plan that we do NOT participate with you must pay for your services at check out. We will provide you with a statement that you can submit directly to your insurance carrier and they will send any reimbursement directly to you.

5. Not all insurance plans cover all services i.e. complete physical exams, some lab work, immunizations, etc. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. If you have a bad debt or policy with a high deductible, you will be required to leave us a credit card on file. This card will only be used if you do not pay your account after receiving (2) statements from our office.

7. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

8. If you miss your appointment without giving 24 hours notice and we are unable to fill your time slot or you write us a bad check you will be billed a fee that must be paid BEFORE you can be seen again. This charge cannot be submitted to your insurance company-- It is YOUR responsibility.

9. Please bring in any forms that you need completed to a regular office visit. Forms that need to be filled out at other times will have a charge. This fee will need to be paid before any form is reviewed by our providers. Please make sure you complete your section of the form before turning them in.

10. If you have any special circumstances, please contact our Office Manager.

11. It is your sole responsibility to notify our office of any change in your insurance company, insurance policy, deductibles, co-pays, or any other changes. It is insurance fraud to knowingly have us bill the wrong insurance company and by signing below you attest that you are going to keep us up to date with your insurance changes and/or contact information.