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 Erin Fletcher, DO, FAAP Stacey Fox, MD, 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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## PATIENT INFORMATION

***PLEASE PRINT CLEARLY***

Child's Name_____ Nickname: _____

Child's Address_____

City_____ State _____ Zip_____ Home Phone _____

Child's 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?

| | | |
|---|---|---|
| Chickenpox 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:

_____

_____

_____

_____

****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!

| **Office hours:** | | | |
|---|---|---|---|
| | Monday - Thursday | phones – 8am-6pm | Appointments - 8:30am-6:00pm |
| | Friday (**October-April**) | phones – 7:30am-4pm | Appointments – 7:45am-3pm |
| | Friday (**April-October**) | phones – 7:30 am -3pm | Appointments- 7:45am-2:15pm |
| | Saturday & Sunday | phones- 8am-11am | Urgent visits by Appointment only |

**These hours are subject to change. Please check our website at www.beaconpediatrics.net 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 policyholder. If this is not completed by the one-month appointment, 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 the back of the insurance card). If you do not have your co-pay, 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. **

5) The office gives COURTESY calls reminding you of your child's appointment 1-2 days prior. Please 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 identification must be presented. (i.e. Consent form or note from parent/guardian, along with insurance card & Copay).

8) All forms (such as daycare, camp, school, insurance, etc.) require at least one week to be completed (if not done at the 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 healthcare or any related services. This includes the coordination and management of healthcare with a third party. (I.e., a referred physician will have the 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 processes.

**Inspect and Copy:** You have the right to inspect and obtain a 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 we did not create or is not part of the 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 the 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 your unsecured PHI has been breached.

**Paper Copy of this Notice:** You have the right to receive a paper copy of this Notice. The notice is available at our reception desk and on 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 Dr. Jeffrey Boxer and/or Elizabeth Baldwin, CPNP and/or Wendy Gatto, CPNP and/or Lauren Kuebeck, CPNP and/or Beacon Pediatrics, LLC. all benefits, if any, otherwise payable to me for any and all of 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 Dr. Jeffrey Boxer and/or Elizabeth Baldwin, CPNP and/or Wendy Gatto, CPNP and/or Lauren Kuebeck, CPNP 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. 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.

3. Co-pays and deductibles are not typically collected/assessed for well-child visits/physicals; nevertheless, please understand that you may be billed those charges after the visit in certain circumstances. This may occur if services above and beyond routine well-child care are provided. Some examples of this would be medication checks/monitoring, acute illnesses, and any other issues or concerns that are addressed, especially if prescriptions are given, or any labs/imaging are ordered and/or additional time is provided.

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. As of January 1st, 2022, all healthcare providers are required to provide estimates for the cost of their care. The Good Faith Estimate shows the cost of items and services that are reasonably expected for your child's healthcare needs and treatment. This will be provided to uninsured patients upon scheduling appointments 3 days or more in advance and/or as requested. This Good Faith Estimate does not include unexpected costs that could arise during treatment.

8. If you miss your appointment without giving 24 hours' notice and we are unable to fill your time slot, or you write us an insufficient 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 to be 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, you attest that you are going to keep us up to date with your insurance changes and/or contact information.