IDEAL PEDIATRIC & ADOLESCENT CARE

121 JPM ROAD
LEWISBURG, PA 17837
TEL: 570-551-0300

PATIENT HEALTH QUESTIONNAIRE

Date: _____

Patient Name: _____ D.O.B: _____

Patient Birth History:

Place of Birth: _____

Circle one: Full Term or Pre-Term Circle one: Vaginal or C-Section

Birth Complications: _____

Patient Past Medical History: _____

Patient Past Surgical History: _____

Patient Hospitalizations: _____

Patient Medications: _____

FAMILY HISTORY/Relationship to patient

Asthma: _____ Sudden Death: _____

Autism: _____ High Blood Pressure: _____

Heart Disease: _____ Seizure: _____

High Cholesterol: _____ Leukemia: _____

Allergies: _____ ADHD: _____

Cancers: _____ Anxiety: _____

Depression: _____ Eating Disorders: _____

Social History: Who lives in the home with the patient?_____

Circle one: Parents are: married divorced separated other

If parents not living together how is custody shared? N/A 50/50 Other:_____

Pets in home: _____

Smokers in family: Who smokes cigarettes or e cigarettes?

Concerns for substance abuse (drugs or alcohol)? _____

Signature: _____ Relationship to patient:_____

IDEAL PEDIATRIC & ADOLESCENT CARE

Permission to Bill Insurance

Child: _____ D.O.B.: _____ Sex: M/F

Mailing Address: _____

_____

Please Circle one of the following:

Race: Asian Black Hawaiian White Unknown

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Primary Language: _____

Parent Responsible for Bills/Account:

Parent Name: _____

Parent Billing Address: Same as above or as listed below

_____

_____

Primary Health Insurance Policy:

Policy Holder's Name: _____
D.O.B.: _____
Insurance Company Name: _____
Policy ID: _____
Employer:_____

Secondary Health Insurance Policy:

Policy Holders Name: _____
D.O.B.: _____
Insurance Company Name: _____
Policy ID: _____
Employer: _____

I give permission to Ideal Pediatric and Adolescent Care to provide medical treatment of the above-named child. I understand that I am financially responsible for non-covered charges. I hereby assign my insurance benefits to be paid directly to the physician and to release any information necessary to process my claim

Signature: _____Date: _____

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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 you the following information to help you understand our insurance and billing policies. We are committed to the care of your children and the practice expects that families are committed to paying for the exceptional care we provide.

Every time you visit our office there will be a charge for the appointment. This includes well visits, sick visits and recheck appointments. In addition, our office charges for Telehealth appointments, portal messages, telephone calls including those after hours. Insurance companies do not cover all cost associated with the these office visit and receiving bills from our office will be inevitable. These bills need to be paid in a timely manner.

If you receive a bill it means the claim was processed by the insurance company and the remaining portion is your responsibility.

YOUR RESPONSIBILITIES

YOU MUST SHOW YOUR CURRENT INSURANCE CARD AT EVERY VISIT
We will attempt to validate your insurance benefits at the time of service and alert you to any problems. If we cannot validate your insurance and you did not bring your card we will assign you to self-pay status and payment will be due at the end of the visit.

YOU MUST PAY YOUR CO-PAYMENT AT THE TIME OF THE OFFICE VISIT
Our contracts with insurance companies require us to collect your co-payment at the time of service. We accept cash, credit cards (MasterCard, Visa, American Express and Discover), and checks as forms of payment. In the **event a personal check is returned unpaid** from your bank, your account will be charged a **$25 fee.**

YOU MUST PROVIDE A CREDIT CARD TO BE KEPT ON FILE
Most insurance companies are subject to routine deductibles and co-insurance, thus we require a credit card on file so we can collect those charges as soon as 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 spelled out in your Explanation of Benefits. Our office will run a report on the 15th of every month and you will receive notification on the day prior to being charged.

YOU MUST CANCEL AN APPOINTMENT FOR AN OFFICE VISIT AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT/MISSED APPOINTMENT FEE
If you do not cancel or miss the appointment a **$50 missed appointment fee** 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 how much of the cost is your

responsibility. You will be responsible for any part of the visit cost that your insurance does not cover including deductibles and co-payments.

You **Must** be aware of which Lab/X-ray facility your insurance company requires you to use in the event that labs or radiology tests are needed. If you do not go to the proper lab or X-ray facility you may receive a bill from that lab or X-ray facility. This is beyond our control so to avoid cost know this information before your visit.

It is your responsibility to notify us regarding lab or X-Ray facility preference otherwise we send to the lab locally.

YOU MUST CONTACT THE INSURANCE COMPANY AND SELECT OUR OFFICE as your PRIMARY CARE PROVIDER AS SOON AS YOUR MEDICAL RECORDS ARE TRANSFERRED

If our office and providers are not listed on your insurance card we cannot bill for the visit and the account will be assigned to Self Pay. The visit charge then becomes your responsibility and will be collected on the day of service.

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

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

Your child will be covered for 30 days under the mother's insurance policy. The fist appointment is covered but you must call your insurance company to have your child added to the policy. You must have your child added by the 1 month appointment so call the insurance company immediately and prior to the 1 month appointment to be certain you have the new insurance card. If not, you will be responsible to pay the bill at the time of the visit. If your newborn is not added by the 1 month appointment the visit will be self pay and payment required at the time of the visit.

YOU MUST KNOW YOUR INSURANCE COMPANIES POLICY REGARDING PHONE CALLS, PORTAL MESSAGES AND TELE HEALTH

Our office will bill the insurance company for phone calls and portal messages placed to the office during regular business hours. This applies to phone calls and portal messages when medical advise is given by our nursing staff or the providers. If your insurance company does not cover this service a maximum charge of **15.00** will become patient responsibility.

Telehealth visits with the provider not covered will be billed and become patient responsibility with a maximum charge of **$75.00.**

AFTER HOURS PHONE CALLS to the Tell-A-Nurse are **NOT** covered by insurance and are costly to the practice. We can no longer incur this expense as a courtesy.

GIVEN THE RISING COST, A CHARGE OF **$15.00** WILL BE ADDED TO THE ACCOUNT FOR ALL AFTER HOURS CALLS TO THE NURSEc

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

We are happy to complete forms at the time of the visit for free and keep universal forms on file. If you do not bring or request a form at the time of the appointment there will be a $25 dollar form fee applied to the account.

OUR COLLECTION POLICY

IF YOUR ACCOUNT IS SELF-PAY, all services must be paid at the time of your visit. This may include situations where we cannot validate your insurance coverage with your 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 you are insured by a non participating insurance carrier, we will expect payment from you at the time of service and it is your responsibility to submit any claims to your insurance company for direct reimbursement.

We do not send bills to self pay families and the charge will be collected at the time of the visit.

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 you will be notified and your credit card on file will be charged. If a credit card is not available and the account remains unpaid after 60 days, we may need to send a letter informing you that our relationship is subject to cancellation after 30 days of urgent or emergent care.

We reserve the right to place your account with our collection agency after all internal efforts to obtain payment have been exhausted.

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

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

Signature: _____ Date: _____

Name: _____

Relationship to Patient: _____

- These policies do not apply to Medicaid patents
- **REVISED 1/2022**

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AUTHORIZATION TO RELEASE 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

FROM:
Doctor/Hospital/Clinic: _____

Address: _____

_____

Telephone: _____ Fax: _____

Please release the following:
___All Health information (including growth charts and immunizations) ___Labs and Radiology
___History and Physical Exams
___Progress Notes ___Consultation Reports
___Consultation Reports ___Other

I consent to the 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 or drug abuse with the medical records.

___ YES, I CONSENT TO THE RELEASE OF THIS INFORMATION
___ NO, I DO NOT CONSENT TO THE RELEASE OF THIS INFORMATION

PURPOSE OF DISCLOSURE

___ Treatment/Continuing Medical Care

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

Signature: _____

Date:_____

Printed Name: _____ Relationship to Patient: _____

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CONSENT TO TREAT

PATIENT NAME: _____ DOB: _____

This form give the providers at Ideal Pediatric and Adolescent Care, P.C. 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 the care team at Ideal Pediatric and Adolescent Care, P.C. to give medical care to my child.

In the event I cannot bring my child to an appointment, the following persons have my permission to bring my child to the appointment and to authorize any medical care, testing or treatments including any waivers, for my child, on my behalf.

	Name	Relationship to Patient
1.		
2.		
3.		
4.		

==========

Signature for Option 1:_____
Relationship to Patient:_____

Option 2
I authorize the care team at Ideal Pediatric and Adolescent Care, P.C. to give medical care to my child but I do NOT authorize my child be treated in my absence.

Signature for Option 2: _____
Relationship to Patient:_____

For children over age 16 years, the above patient may be treated without an adult present. Circle one:
YES NO

Signature for patient older than age 16 years: _____
Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

We are required by State and Federal Law, including HIPPA 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 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 Web site and it will be gladly printed for you at any of your office visits.

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

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

I understand that if I have any questions or complaints, I may contact the Privacy Officer/Owner: Dr. Mary Beth O'Hara at 570-551-3100. I understand I am entitled to receive updates or amendments upon request if Ideal Pediatric and Adolescent Care, P.C. changes its Notice of Privacy Practices.

_____

Signature of Patient or Patient's Representative Date

_____

Printed Name Relationship to Patient

For OFFICE USE ONLY

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Policy from the above named patient but was not able

____ *Patient declined to sign*

____ *Other (specify)*