FOR PARENTS

(Advice for Teen to Adult)

Dear Parent or Guardian:

Turning 18 years old is an exciting time in your child's life and you have spent rewarding time preparing your child for this moment - becoming an adult. Because your child has turned 18 years old, many things are changing rapidly and one of those things is healthcare. We would like to share some tips in hopes that the information provided helps you to understand what it now means to be an adult and what that means for your child 's healthcare. We recently provided your child with information regarding turning 18. To help you through this process, we are providing you with information as well.

Upon turning 18, your child is now considered to be an adult and is responsible for their own healthcare, among other things. Because of this, we asked your child to complete a new patient registration form and packet. The information and forms have been provided to your child in order to treat them appropriately as an adult. Your child will be given a new patient account, separate from your family account. That account will contain all their medical history and visit details from the time your child turns 18 years old. Their previous medical history and visit details will remain with the family account.

What you need to know as a parent –

- In the past, we were able to talk with you about your child's health. Now that your child is 18, your child is considered an adult and, due to Federal laws, we are not able to discuss anything with you without your child's consent. We can talk with you if your child authorizes consent by completing the Consent to Share Health Information with Parents form. Your child was given this consent form in the packet. This needs to be received and on file for us to discuss any health issues with you.

- If you need to access your child's records, your child must consent *in writing* to provide you access by signing the Consent to Share Health Information with Parents form. Under HIPAA, *medical providers are no longer permitted to discuss health issues with you without express consent from your now young adult.* This is important to keep in mind when trying to call for health questions when your young adult is away at college. They will need to call themselves.

- Due to Federal laws, as an adult, your child is the only one that can access their medical records. Any requests for medical records must be made *in writing* by your child. Your child can call our office to request a medical records release form. This means that if they are away at college and need information, they will need to complete a medical records release form themselves and fax or mail it to us. Your child may request that the information is released to you, but again, we must have written authorization for this by having a signed Consent to Share Health Information with Parents form on file.

- Bay Area Pediatrics will continue to provide care for your child for a time past 18 years old. We ask that the transition to an adult provider happen before the 23rd birthday.

- Your child has their own patient account. The bills may come to your address but will be under their name.

- We can still bill your insurance for your child, if your child is eligible. Even though the Explanation of Benefits (EOB) comes to you, the bill is still your child's responsibility and we are not able to discuss billing with you unless the previously discussed consent form has been completed.

These changes are not intended to cause difficulty; however, due to Federal laws, when your child turned 18, they became a legal adult. All these changes are designed to appropriately treat your child as an adult. We understand that this time can be challenging and is changing fast. We recommend that you take this time to talk with your child about what it means to be responsible for their healthcare, offer help if they need it, and discuss what they would like for their care.

Please feel free to discuss these changes with any of the Bay Area Pediatrics staff as we are here to help and would like to help if you need it.

FOR YOUNG ADULTS

Dear Young Adult:

When you turn 18, seeking medical care is a new responsibility. Your parents can help guide you in seeking medical care; however, as an adult, you have the right and responsibility for your medical care.

This means that you may now seek medical care without your parents' consent and call for your own appointments, as needed.

In this packet, you will find our forms that you will need to fill out and a few things you need to know about being responsible for your own medical care.

FORMS and DESCRIPTIONS

The following forms can be found in this packet and will need to be filled out by you and returned to our office:

PATIENT REGISTRATION:

• Please fill out this form so that we can create your own patient account. While you may still be on your parent or guardian's insurance policy, any statement will be mailed to you under your name.

ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES:

• This form needs to be completed to acknowledge your understanding of our HIPAA privacy practices as defined by the Federal government.

CONSENT TO SHARE HEALTH INFORMATION WITH PARENTS:

• This form needs to be completed to inform us of your wishes to provide information to your parents or any other individual to have access to your medical records.

FINANCIAL POLICY:

• This form outlines our financial policies. By signing this form, you acknowledge that YOU, as an adult, are responsible for any payment that needs to be made to our office.

PATIENT PORTAL REGISTRATION:

• This form needs to be completed to register you to access your medical records online via our patient portal.

THINGS TO KNOW:

• Under the Federal Health Information Portability and Accountability Act or HIPAA, medical records are now records between you and your health care provider. Access to your health records and any discussion about your health is only provided to people that you consent to, including your parents.

• Bay Area Pediatrics will continue to provide medical care for you for a time past 18 years old. We ask that your transition to an adult provider happen before your 23rd birthday.

• When calling for an appointment, you need to let the receptionist know why you need to see a provider (provide the most honest description of why you need to be seen so that appropriate time is scheduled), and when you need the appointment.

• Your parents may come to the appointment with you, but you will need to check in and sign forms yourself. Some of the forms you may be asked to sign are contact information (called demographics) verification, financial responsibility and medical treatment consent forms.

• You will need to be prepared to pay any copays or billing portions required.

• You will need to sign for any medical treatment consents, including vaccinations. Your Mom, Dad or guardian can no longer sign for you.

• Unless specific consent is given, we are not permitted to talk with your parents about your health care. You will need to have the discussion with the provider. Your parents may only be involved if you provide consent to do so.

• You have the right to be informed of your medical care and treatment. You also have the right to refuse medical treatment if you so wish.

• A physical examination helps your PCP to determine the general status of your health. The exam also gives you a chance to talk to them about any health concerns you may have. A yearly physical examination is required to remain a patient of Bay Area Pediatrics.

Please feel free to discuss these changes with any of the Bay Area Pediatrics staff as we are here to help and would like to help if you need it.

Welcome!

18+ PATIENT REGISTRATION FORM
(PLEASE PRINT)

D. James Kalliongis, MD **Jaime Schell, CPNP** **Courtney Freimuth, CPNP** **Jill Tierney, MD**

PATIENT INFORMATION

Patient Name: First: Last:

Date of Birth: Assigned Sex at Birth: M F

Street Address: Preferred Pronouns:

City, State, Zip:

Home Phone: Cell Phone:

Email Address: Occupation: SS#

PARENT INFORMATION (Primary Insurance Card Holder)

Parent Name: First: Last:

Relationship: Mother Father Stepmother Stepfather Guardian Marital Status: Married / Single / Divorced / Widowed

Street Address: Email Address:

City, State, Zip:

Date of Birth: Home Phone: Cell Phone:

Employer: Occupation: SS#

OTHER PARENT CONTACT INFORMATION

Full Name: Relationship:

Home Phone: Cell Phone:

INSURANCE INFORMATION

We will need to make a copy of your insurance card. It is your responsibility to provide us with timely updates to your insurance. Should claims be denied because you haven't provided us with updated information, you will be billed for the visit(s).

If you have a secondary insurance, you MUST make both insurance companies aware that you have double coverage. If the secondary insurance is not aware of your primary insurance, we will not file with the secondary. If you have a commercial policy and a Medicaid policy, the Medicaid policy is always your secondary coverage.

Patient Signature: _____ ***Date:*** _____

Please provide insurance card(s) with this form.

BAY AREA PEDIATRICS
18+ FINANCIAL POLICY - 2025

As a patient you have certain responsibilities for your care. Those responsibilities include, but are not limited to:

● Providing current, accurate billing information at all visits including a copy of insurance card

● Providing physician with complete medical history

● Being aware of your insurance coverage, including which benefits are and which are not covered

Copays must be paid at the time of the visit. Failure to do so may result in an additional fee.

Failure to cancel an appointment at least 24 hours in advance, as well as missed appointments, will result in a "No Show" fee as follows: sick/recheck appointments $25.00; well visits and medication appointments $50.00.

There will be a $35.00 fee for returned checks.

You hereby authorize treatment by Bay Area Pediatrics, LLC, and agree to pay all fees and charges for such treatment. You authorize the release of any pertinent information to your insurance company and any other doctors involved in your care.

You hereby authorize your insurance benefits to be paid directly to Bay Area Pediatrics, LLC.

You agree to be financially responsible for any balance due.

You agree to reimburse Bay Area Pediatrics, LLC, the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

Your signature acknowledges understanding and consent to all the above information.

Signature: _____

Printed Name: _____

Date: _____

BAY AREA PEDIATRICS

18+ Acknowledgment of HIPAA Privacy Practices - 2025

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that the patient's health information is private and confidential. I understand that Bay Area Pediatrics works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Bay Area Pediatrics may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations.

Bay Area Pediatrics has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location. This Notice of Privacy Practices may be updated periodically.

SIGNATURE: _____ DATE: _____

Print Patient Name: _____ Patient DOB: _____

BAY AREA PEDIATRICS - PATIENT INSURANCE INFORMATION

Patient name & date of birth: _____

Name of Insurance Company: _____
(PLEASE PROVIDE COPY OF CARD)

Is this policy covered under an employer group? Y N

Is this policy covered under MD Medicaid? Y N

Member ID Number: _____

Member Group Number: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

Relationship to Patient: _____

Does patient have secondary coverage? Y N
(IF YES, PLEASE COMPLETE COVERAGE INFO ON BACK OF FORM)

Today's Date: _____

BAY AREA PEDIATRICS - PATIENT SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company: _____
(PLEASE PROVIDE COPY OF CARD)

Is this policy covered under an employer group? Y N

Is this policy covered under MD Medicaid? Y N

Member ID Number: _____

Member Group Number: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

Relationship to Patient: _____

Non-Covered Service Waiver

Bay Area Pediatrics, LLC, is committed to providing only the **highest quality care**. We utilize current suggested guidelines created by the American Academy of Pediatrics and other trusted sources for evidenced-based clinical outcome information.

As prompt and appropriate treatment is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary.

The following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Examples of Screening Services include but are not limited to:

- Vision screening
- Hearing screening
- Maternal depression screening
- Developmental screening
- Mental health screening questionnaires
- Adolescent questionnaires
- Autism screening (MCHAT)

*** all laboratory and/or radiology services performed or referred by our providers may result in additional bills and/or charges from other companies that may include but are not limited to: Quest/Labcorp/Anne Arundel Laboratory Services, Anne Arundel Medical Center, etc. You may receive separate billing statements for these services.*

This pediatric medical practice is committed to providing the most up to date, comprehensive care possible, which is why we address these issues at recommended or indicated visits. Further, we will strive to eliminate the need for the patient to return to the office, whenever possible. ***It is the responsibility of the policyholder to be aware of their insurance plan's benefits and coverage. Deductible, copay, coinsurance or out-of-pocket expenses agreed upon between you and your insurance company are out of our control.***

Please read and sign the back of this form.

BAY AREA PEDIATRICS

Non-Covered Service Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does not pay for these services.

_____

Patient's Name:

_____

Patient's Signature:

_____

Date: _____ / _____ / _____

Thank you!

Understanding office visit and billing practices

The providers and staff at Bay Area Pediatrics are committed to providing and maintaining the best possible care for our patients. Your review of billing practices in advance allows for good communication and common understanding.

Insurance company billing policies dictate that we differentiate between two types of services.

- ♦Wellness Services
- ♦Problem-Oriented Services

What <u>may</u> be included in Wellness Services? (also known as preventive visit or physical or well child check)

- ♦Age appropriate history
- ♦Age appropriate medical exam
- ♦Anticipatory guidance
- ♦Review and interpretation of any recommended labs
- ♦Preventive counseling (such as proper nutrition)
- ♦Review of vaccine history

What other preventive related services will be billed separately?

- ♦Vaccine products
- ♦Routinely recommended labs*
- ♦Vaccine administration services (including counseling)
- ♦Screenings (e.g., vision, hearing, developmental, depression screens)

During wellness visits, we perform all recommended screenings appropriate to age and gender and seek to uncover any conditions that would lead to suboptimal health in the years to come. These screens are recommended by the American Academy of Pediatrics. The use of screening tools also allows us to begin treating conditions in their earliest stages. These screens are considered a problem-oriented service by most insurance plans and therefore may generate cost sharing in the form of a copayment, co-insurance, and/or deductible.

The Affordable Care Act makes many wellness and/or preventive services covered in full by most insurance plans. However, this is not true of many problem-oriented services. Management of medical diagnoses, including the need for medication refills of any sort, are categorized by insurance companies as problem-oriented services. <u>Evaluation and/or management of ***any complaint and/or symptom*** offered by a patient or identified upon questioning during a wellness exam constitutes a problem-oriented service which may result in your insurance company processing your claim using both wellness benefits and problem-oriented benefits.</u>

Problem-Oriented Services

Some common examples of problem–oriented services include but are not limited to:

- ♦Illness addressed (ears, eyes, nose, throat, cough, fever, etc.)
- ♦Chronic conditions addressed
  - ♦e.g., obesity, asthma, ADD/ADHD
- ♦Behavior Concerns
- ♦Lactation services
- ♦Suture removal
- ♦Anxiety/Depression

Examples of screening services include but are not limited to:

- ♦Vision tests
- ♦Hearing screening
- ♦Developmental screenings (e.g., 9, 12mo questionnaires)
- ♦Mental health questionnaires
- ♦Adolescent questionnaires
- ♦Autism screening (MCHAT)

*all laboratory, radiology services performed or referred by our providers may result in additional bills and/or charges from other companies that may include but are not limited to: Quest/Labcorp/Comnexus laboratories, AAD/CM Imaging, etc.. You may receive separate billing statements for these services.

Our medical practice wants to provide the most up-to-date, comprehensive care possible, which is why we address these issues during wellness visits. Additionally, we try to eliminate the need for the patient to return to the office, whenever possible. ***<u>It is the responsibility of the policy holder to be aware of their insurance plan's benefits and coverage. Deductible, copay, coinsurance or out-of-pocket expenses agreed upon between you and your insurance company are out of our control.</u>***

Signature: _____ Date: _____

Patient Name and DOB: _____

BAY AREA PEDIATRICS, LLC

165 Log Canoe Circle, Suite E, Stevensville, MD 21666 p: 410-643-1000 f: 410-643-5200

BAY AREA PEDIATRICS

EXCLUSIVE OF COVID AND FLU VACCINE

Dear Bay Area Pediatrics Patients:

Given the significant increase in vaccine preventable disease and the dangers unvaccinated children pose to some of our most vulnerable patients we can no longer accommodate families who delay or refuse to vaccinate their children. This policy will be in effect immediately.

We know, and want you to know, that the recommended vaccines and their schedule are the results of years and years of scientific study and research, with data gathered on millions of children, by thousands of our brightest scientists and physicians.

We understand that there has always been, and will likely always be, discussion surrounding vaccinations. But that discussion does not change the facts, or the science, or the evidence about vaccines.

The vaccine campaign is a victim of its own success. It's precisely because vaccines are so effective at preventing illness that we even discuss whether they should be given. Because of the safety and effectiveness of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. And that, of course, is a wonderful thing.

We write this statement not to scare you or coerce you but to make you aware of the facts and to emphasize the importance of vaccinating. We recognize that the choice may be emotional for some. So, we will do everything we can to support you and to help you understand that vaccinating according to the schedule is the right thing to do.

Please understand, however, that delaying or "breaking up" vaccines over multiple visits goes against expert recommendations and can put you at risk for serious illness or even death. These alternate vaccine schedules go against both our medical advice and our core principles at Bay Area Pediatrics. Should you choose these options, you will be asked to sign a "Refusal to Vaccinate" acknowledgement.

If you refuse to adhere to the vaccination schedule, despite all our efforts and recommendations, we will ask you to find another health care provider who shares your views.

As medical professionals, we know that vaccinating on schedule with currently available vaccines is absolutely the right thing to do for *all* children and young adults.

We're always happy to answer any questions, or to discuss any concerns, you may have about vaccines.

D. James Kalliongis, MD

I have read and agree to comply with the above statement regarding Bay Area Pediatrics' vaccine policy. I also understand that should I disagree with the above statement that I will be expected to find another health care provider who shares my views regarding vaccines.

_____ _____

(Signature of Patient) (Date)

_____

(Name of Patient and DOB)

Consent for Telemedicine Services

Telemedicine is the delivery of healthcare services using technology when the healthcare provider and patient are not in the same physical location.

Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically transmitted information may be used for diagnosis, therapy, follow up and/or patient education, and may include any of the following:

- patient medical records
- medical images
- interactive audio, video, and/or data communications
- output data from medical devices and sound and video files

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:
1. Improved access to medical care by enabling a patient to remain at home or a site remote from the provider's office.
2. Obtaining the expertise of a distant specialist.

Potential Risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
1. Information transmitted may not be sufficient, e.g., poor resolution of images, to allow for appropriate medical decision making by the provider(s).
2. The consulting provider(s) are not able to provide medical treatment to the patient using telemedicine equipment nor provide for or arrange for any emergency care that the patient may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

Alternative: Seek in-person medical care.

I confirm that at the time of the visit, the patient is physically located in Maryland, DC or Virginia. I give consent to participate in a telemedicine visit with a provider at Bay Area Pediatrics, LLC. I understand that this consent remains in place unless revoked by me in writing.

_____
Patient Name and DOB

_____ _____
Signature of Patient Date

BAY AREA PEDIATRICS, LLC
Telemedicine Waiver

Telemedicine services were introduced and expanded during the COVID-19 pandemic. This benefit has an expiration which varies from one insurance carrier to another.

Therefore, telemedicine services may not currently be considered a "covered benefit" under your health insurance plan and, as such, your insurance may not pay for this service.

By signing this waiver, you understand that telemedicine services may not be a covered benefit. In addition, you agree to pay for telemedicine services that are not covered under my insurance plan.

I acknowledge that I have been informed in advance that future telemedicine services may not be covered by my health insurance plan and agree to pay for such services should a balance result for this not covered service.

_____ _____

(Patient signature) (date)

Patient's Name: _____ DOB: _____