BAY AREA PEDIATRICS

Welcome!

NEW PATIENT REGISTRATION FORM

(PLEASE PRINT)

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

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#	

PARENT INFORMATION

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#	

CHILD(REN) INFORMATION

Full Name (First, Middle, Last)	Date of Birth	Gender Assigned at Birth
1.		M F
2.		M F
3.		M F
4.		M F
5.		M F
6.		M F

EMERGENCY CONTACT INFORMATION (Not living with you)

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.

Parent Signature: _____ ***Date:*** _____

Please provide insurance card(s) and a copy of your child(ren)'s immunization record with this form.

BAY AREA PEDIATRICS
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: _____
Patient or Parent/Guardian if signing for minor

Date: _____

Please list all patients and dates of birth: _____

_____

_____

BAY AREA PEDIATRICS

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: _____
(Patient or Responsible Party, if patient is a minor)

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

BAY AREA PEDIATRICS - NEWBORN INSURANCE INFORMATION

Name of Newborn: _____

Newborn Date of Birth: _____

Will this patient be covered under MD Medicaid? Y N

Is Mother covered under MD Medicaid? Y N

If yes, which MCO is Mother assigned? _____
(PLEASE PROVIDE COPY OF CARD)

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

Is this policy covered under an employer group? Y N

Member ID Number: _____

Member Group Number: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

Relationship to Patient: _____

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

Name of person completing this form: _____

Today's Date: _____

BAY AREA PEDIATRICS - NEWBORN 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: _____

BAY AREA PEDIATRICS

ENROLLING YOUR NEWBORN ON INSURANCE

The providers and staff of Bay Area Pediatrics would like to congratulate you on the new addition to your family! Thank you for choosing us as the healthcare providers for your newborn. We look forward to addressing all of their healthcare needs.

During the registration process, we would like to bring to your attention that it is very important to enroll your newborn on your insurance as soon as possible. Some insurance companies only allow 30 days for this to take place and may deny a claim for your newborn if they feel they were not properly notified. Unfortunately, we have seen several instances where parents have forgotten to add their newborn to their insurance and thus are faced with paying a substantial bill.

If you miss the deadline to enroll your newborn it may be extremely difficult, if not impossible, to enroll your baby under your plan until your insurance plan's next annual enrollment period. Therefore, at the time of your baby's 2-month physical examination, you MUST have proof that you've added your baby to your policy. THIS ID card MUST be presented at your baby's 2-month physical exam.

If you do not have this ID card, we will ask you to reschedule or remit payment at the time of service. Having the ID card as proof of coverage is the best way for you to ensure that your insurance will pay your baby's exam and vital immunizations.

This policy is to protect you from the financial hardship associated with the costly vaccines given at this visit.

Thank you in advance for your cooperation and we look forward to caring for your family.

Child's Name _____ _____/_____/_____
Last Name First Name MI *Date of Birth*

Parent/Guardian's Signature _____ _____/_____/_____
Date

BAY AREA PEDIATRICS

Dear Bay Area Pediatrics Parents: EXCLUSIVE OF COVID & FLU VACCINE

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 your child. We recognize that the choice may be emotional for some parents. 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 your child 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 children 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 Parent/Guardian) (Date)

_____

(Relation to Patient)

BAY AREA PEDIATRICS
Parent/Guardian Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

Caregiver's Information (OTHER THAN PARENT/GUARDIAN)

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

1. I give permission for the above-named caregiver(s) to authorize/consent for all medical treatment, all medical procedures, all diagnostic testing, all immunizations, all screenings, etc., for the above-named child(ren), which may be required during my absence, while being seen at Bay Area Pediatrics.

   Consents are NOT required in emergency situations.

   This authorization shall remain in effect until: (circle one of the following)

   A) _____ OR B) unless revoked by me
   month, day, year

2. I do not give permission for the above-named patient(s) to be seen in the office in the absence of a parent/guardian, as listed below, other than in an emergency. _____
   Initial of parent/guardian

Signature

_____ _____ _____
Parent/Guardian (circle one) Relationship to Patient Date

_____ _____ _____
Parent/Guardian (circle one) Relationship to Patient Date

BAY AREA PEDIATRICS

Portal Registration

PLEASE PRINT CLEARLY

Relationship of Person to Patient Completing this Form: _____

Name (first): _____

Name (last): _____

Email: _____

Cell Phone: _____

Signature of Person Consenting to Portal Use: _____

How would you like to be notified of a pending portal message? _____ Cell _____ Email
must select one or both

Name of Patient	Date of Birth

What is My Kid's Chart?
Our patients can securely access their personal medical record online, from the privacy of their home or any other location with an internet connection utilizing the My Kid's Chart patient portal. Bay Area Pediatrics remains an independent private pediatric practice, but we have partnered with My Kid's Chart to utilize the patient portal system.
My Kid's Chart members can:
Go online to view their current health issues
View details of past appointments
Request renewals of prescriptions
Request specialist referrals
Check results of lab and imaging tests
Send questions or requests to our Bay Area Pediatrics team

for office use only

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 Parent/Guardian/Patient Date

_____
Printed Name of Parent/Guardian/Patient

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.

_____ _____

(signature parent/guardian) (date)

Relationship to patient: _____

Patient's Name: _____ DOB: _____