BAY AREA PEDIATRICS

Welcome!

NEW PATIENT REGISTRATION FORM

(PLEASE PRINT)

D. James Kalliongis, MD Jaime Schell, CPNP Courtney Freimuth, CPNP

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
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 - 2021

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, may 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 of 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 - 2021

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
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

New Patient Questionnaire

*Patient's Name*_____ *Date of Birth*_____

HOUSEHOLD- Please list all those living in the child's home

Name	*Relationship to Child*	*Birth Date*	*Health Problems*

Are there siblings not listed? If so, please list their name and age and where they live. _____

_____

If mother & father are not living together, or if child does not live with parents, what is the child custody status. _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Mother's Occupation _____ *Mother's Employer* _____

Father's Occupation _____ *Father's Employer* _____

Does anyone in the house use tobacco? Yes □ No□ *Are there any pets in the home? Yes □ No□*

Activity Level? Sedentary Active Competitive Sports

Amt of TV/Video Games daily? _____*min/day*

Uses seatbelts Car seat Booster Seat

DEVELOPMENT

Are you concerned about your child's physical development? Yes □ No□ Explain _____

*Are you concerned about your child's emotional development? Yes □ No □ Explain*_____

*Are you concerned about your child's attention span? Yes □ No □ Explain*_____

Is your child in school? Yes□ No □

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special resource classes? _____

BAY AREA PEDIATRICS

New Patient Questionnaire

Birth History

Any problems during the pregnancy? Yes □ *No*□ _____

Was mom on any medications? Yes □ *No*□ *If yes* _____

Birth Hospital? _____ *Birth Weight* _____ *lbs* _____*oz*

Was your child born: On Time *Early (weeks _____)* *Late (weeks _____)*

How was your baby born? Vaginally Delivery C-Section Vacuum Forceps

Any Problems with baby at birth? Yes □ *No*□ *If Yes* _____

Did child/children go home with mom from the hospital? Yes □ *No*□ _____

Past Medical History

*When was your child's Last well- check?*_____

Previous Doctor? _____ *Dentist?* _____

Does your child take any medications? Yes □ *No*□ _____

Any Medication Allergies? *No* □ *Yes*□ _____

Prior Hospitalization? *No* □ *Yes*□ _____

Is your son circumcised? *No* □ *Yes*□ _____

Other Prior Surgeries? *No* □ *Yes*□ _____

Has your child had a history of:

Please circle all that apply:

ADHD/ADD *Anemia* *Asthma* *Wheezing* *Bedwetting*

Cerebral Palsy *Constipation* *Diabetes requiring insulin/Type 1 DM*

Developmental Delay *Ear infections* *Eczema* *Food Allergies*

Headache *Hearing Loss* *Heart Murmur* *Broken Bones*

Chicken Pox *Insulin Resistance/ Type II DM* *Obesity* *Pneumonia*

Seasonal Allergies *Seizures* *Sports Injury* *Urinary Tract Infection*

Urticaria/ Hives *Vaccine Reaction* *Vision Problems* *Vitamin D deficiency*

*Other*_____

BAY AREA PEDIATRICS

New Patient Questionnaire

Family History

Considering the child's parents, grandparents, aunts, uncles, and siblings, is there a family history of:

Asthma? *Whom:* _____

Alcohol or Drug Abuse? *Whom:* _____

Anemia? *Whom:* _____

Bleeding Disorder? *Whom:* _____

Cancer? *Whom:* _____

Skin Cancer? *Whom:* _____

Breast Cancer? *Whom:* _____

Childhood or Sudden Infant Death? Whom: _____

Deafness? *Whom:* _____

Developmental Delay? *Whom:* _____

Diabetes? *Whom:* _____

Hearing problems? *Whom:* _____

Heart disease (before 50 years old)? Whom: _____

High Blood Pressure (before 50 years old)? Whom: _____

High Cholesterol? *Whom:* _____

Intellectual Disability? *Whom:* _____

Kidney Disease? *Whom:* _____

Liver Disease? *Whom:* _____

Mental Illness/ Depression? *Whom:* _____

Nasal Allergies? *Whom:* _____

Retinoblastoma? *Whom:* _____

Stroke/ Blood Clots? *Whom:* _____

Tuberculosis? *Whom:* _____

Vision Problems? *Whom:* _____

BAY AREA PEDIATRICS

Portal Registration

PLEASE PRINT CLEARLY

Parent - Relationship to patient: _____

Name (first): _____

Name (last): _____

Email: _____

Cell Phone: _____

How would you like to be notified of a pending portal message? _____ Cell _____ Email

Children

Name	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

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: _____

BAY AREA PEDIATRICS

165 Log Canoe Circle
Suite E
Stevensville, Maryland 21666
Phone: 410-643-1000 Fax: 410-643-5200

PATIENT REQUEST FOR RECORDS

Authorization for Release of Protected Health Information (PHI)

Name of Patient: _____ **DOB:** _____

Address: _____ **Phone:** _____

_____

I hereby request that _____ provide health records as follows:
(physician name)

1. Records to be Released *(check ALL that apply)* Fax *(provide number)* _____

- ☐ History and Physical (most recent)
- ☐ Immunization Record
- ☐ Lab/Radiology Reports
- ☐ Progress Notes

2. Reason for Release

- ☐ Personal Copy
- ☐ Transfer to New Doctor
- ☐ Move
- ☐ Other *(specify)* _____

3. Select Delivery Method

- ☐ Pick up in person
- ☐ Fax *(provide fax number)* 410-643-5200

4. Release PHI to

- ☐ Patient (same as above)
- ☐ Parent/Guardian _____ *(name)*
- ☐ Physician Practice/Other Bay Area Pediatrics *(name)*
  165 Log Canoe Circle, Suite E *(street address)*
  Stevensville, Maryland 21666 *(city, state, zip)*

Fees: I understand that I may incur a reasonable, cost-based fee where applicable for copying, postage, preparation and labor.

- ☐ I agree to pay all charges.
- ☐ Please contact me with estimated full cost before proceeding.

I have read and signed this authorization.

_____ _____ _____
Signature *Date* *Relationship to Patient*