Ellicott City Pediatric Associates, PA

9011 Chevrolet Dr
Suite 1-6
Ellicott City, MD 21042
410-465-7550
410-465-6359 (Fax)
www.Ellicottcitypediatrics.com

Edward Cahill III, MD
Lesly Berger, MD
Oliver Galita, MD
Jennifer Landsman, MD
Amy Cheung, MD
Maria Santos, MD

Dear Patient,

Welcome to Ellicott City Pediatric Associates, PA. As a new patient, we ask that you review and complete the enclosed before your scheduled appointment. We require that all children under age 18 years be accompanied by a parent or legal guardian.

Since we will need to finalize your registration upon arrival, please plan to come about 20 minutes before your scheduled appointment time with the following documentation.

1. The enclosed forms filled out and signed.
   - √ ***New Family Registration***
   - √ ***Acknowledgement Form*** - Receipt of Privacy Practices, Office Policy, and Patient Portal Credentials (enclosed)
   - √ ***Medical Treatment Authorization & Consent Form***
   - √ ECPA ***Financial & Office Policy***
   - √ ***Past Medical History & Family Medical History***
   - √ ***Authorization to Release Medical Information*** to our Practice (Fill out and fax this to your previous provider if you don't already have a copy of your records.)
2. The patient's insurance card **with our name on it**. If you do not have your card, you may be asked to pay us directly and seek reimbursement from your insurance.
3. Your driver's license or a legal photo identification card.
4. An accurate record of your child's immunizations, a list of your child's medications that includes the strength and dose, and any relevant medical records. **Please obtain these records and information prior to your visit.** If you requested that your records be sent to us from another office, please call us ahead of time to verify that we received them.
5. Payment is expected at the time of the visit.
6. Directions to our office are located on our website, www.ellicottcitypediatrics.com.

Thank you for choosing our practice. We look forward to working together to provide the best pediatric care for your family.

Ellicott City Pediatric Association, PA

ELLICOTT CITY PEDIATRIC ASSOCIATES, P.A

TAX ID# 52-1049926

9011 CHEVROLET DRIVE, SUITE 1-6
ELLICOTT CITY, MARYLAND 21042
TELEPHONE (410) 465-7550

FAMILY REGISTRATION – *Please Print Clearly*

Date: ____________

PARENT/GUARDIAN INFORMATION:

First Name:______________________________________ Last: __________________________________MI:_____

Street Address:____ Apt#______________________

City:___________________________ State:_____ Zip Code:_________ Employer:_____________________________

Occupation:___________________________________ Relationship to Patient:______________________________

Home Phone: (______) ______-________ Work Phone: (______) ______-_______ Cell Phone: (______) _____- _______

Email Address:____________________________________ Social Security Number _______-_________-___________

PARENT/GUARDIAN INFORMATION:

First Name:______________________________________ Last: __________________________________MI:_____

Street Address:____ Apt#______________________

City:___________________________ State:_____ Zip Code:_________ Employer:_____________________________

Occupation:___________________________________ Relationship to Patient:______________________________

Home Phone: (______) ______-________ Work Phone: (______) ______-_______ Cell Phone: (______) _____- _______

Email Address:____________________________________ Social Security Number _______-_________-___________

INSURANCE INFORMATION

(Medical Assistance MUST be Secondary if you carry Commercial Insurance)

Primary Policy:

Policy Holder's Name:________________________________ Date of Birth:___________ Sex (Circle One): Male/Female

Insurance Name:____________________________________ ID#___________________ Group#_______________

Effective Date:_______________ S.S.N. ______-________-_________ Employer:______________________________

Secondary Policy:

Policy Holder's Name:________________________________ Date of Birth:___________ Sex (Circle One): Male/Female

Insurance Name:____________________________________ ID#___________________ Group#_______________

Effective Date:_______________ S.S.N. ______-________-_________ Employer:______________________________

BILLING INFORMATION

Financially Responsible Person (Circle One): Patient / Mother / Father / Other _________________________________

Name if different from Mother or Father____

Financially Responsible Person's Address (If Different from Patient)

_______________________________________ _________________________ __________ ________________

Street City State Zip Code

Employer:__________________________ Occupation: _________________________ S.S.N ______-_______-_______

Home Phone: (______) ______-________ Work Phone: (______) ______-_______ Cell Phone: (______) _____- _______

EMERGENCY CONTACT (other than parents): NAME AND RELATIONSHIP

1. ___________________________________Relationship______________Phone: (______) _______ - ___________

2. ___________________________________Relationship______________Phone: (______) _______ - ___________

AUTHORIZATION

I, ______________________________, hereby authorize Ellicott City Pediatric Associates, P.A. to apply for benefits on my behalf for covered services rendered. I request payment from ______________________________ be made directly to Ellicott City Pediatric Associates, P.A. **(Insurance Co. Name)**

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, ______________________________. I permit a copy of this authorization to be used in place of the original.

(Insurance Co. Name)

This authorization may be revoked by either me or above named carrier at any time in writing. I understand I am responsible for charges not covered by this agreement.

______________________________ ______________________

Signature of Subscriber or Beneficiary **Date**

HOW WOULD YOU IDEALLY PREFER TO BE CONTACTED REGARDING: (circle one)

Medical Issues: (e.g. test results)

No Contact / Mail / Home Phone / Work Phone / Cell Phone / Text to Cell / Fax / Home E-mail / Work E-mail

Appointment Reminders:

No Contact / Mail / Home Phone / Work Phone / Cell Phone / Text to Cell / Fax / Home E-mail / Work E-mail

Recall Notices:

No Contact / Mail / Home Phone / Work Phone / Cell Phone / Text to Cell / Fax / Home E-mail / Work E-mail

Billing Statements:

No Contact / Mail / Text to Cell / Fax / Home E-mail / Work E-mail

General Practice Notice:

No Contact / Mail / Home Phone / Work Phone / Cell Phone / Text to Cell / Fax / Home E-mail / Work E-mail

Patient Portal Notifications:

No Contact / Text to Cell / Home E-mail / Work E-mail

ABOUT YOUR FAMILY (PLEASE LIST ALL FAMILY MEMBERS LIVING IN YOUR HOUSEHOLD)

Please follow the number guide below for RACE and ETHNICITY

RACE: (Write all numbers that apply)

1. Asian **2.** African American **3.** Hawaiian **4.** Caucasian **5.** American Indian or Native American **6.** Declined to Answer

ETHNICITY: (Please choose only one)

1. Hispanic or Latino **2.** Not Hispanic or Latino **3.** Unknown **4.** Declined to Answer

Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY
Name: First	M.I	Last	SEX	DATE OF BIRTH	PRIMARY LANGUAGE	RACE	ETHNICITY

WRITTEN ACKNOWLEDGEMENT FORM

Patient Name:______________________________DOB:__________

I hereby acknowledge receipt of:

1. Notice of Ellicott City Pediatric Associates Privacy Practices
2. Ellicott City Pediatric Associates Office Policies

Name [please print]: __________________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____

Patient Communication & Medical Treatment Authorization Consent Form

Patient Full Name (PLEASE PRINT) ______________________ **Date of Birth** ______________

A. MEDICAL TREATMENT AND CONSENT - This is used when minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent" gives authority to a designated adult to arrange for medical care for a minor. Medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

For the above named patient and for this section "A", you authorize the following people to accompany your minor child to obtain medical care from Ellicott City Pediatric Associates PA. (Please list first and last name)

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

B. PATIENT COMMUNICATION - It is the office policy of Ellicott City Pediatric Associates, P.A., not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For the above named patient and for this section "B", you authorize Ellicott City Pediatric Associates PA to release medical information to the following people. This can include family members, friends, caretakers, etc. (Please list first and last name).

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

By signing below, this grant of temporary authority shall begin on the date signed and shall remain in effect until terminated by the undersigned or until there is a change in the legal status of the patient.

Parent or Guardian Signature ______________________ **Date:** ______________

Print Name ______________________ **Contact Phone#** ______________

FOR OFFICE USE:

Changes to above authorize by patient over phone: Date Staff Initials

______________________ ________ ________

______________________ ________ ________

Ellicott City Pediatric Associates, P.A.

FINANCIAL & OFFICE POLICY

Thank you for choosing Ellicott City Pediatric Associates, P.A. as your pediatric provider. It is our hope that our patients understand our credit, collections and office policies are a necessary part of assuring the financial resources required to maintain vital health care service for our patients. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have questions, please ask a member of our staff.

Appointments:

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate no less than 2 hours cancellation notice. Please remember that all of our appointments are scheduled appointments and if notice is not received, a **$25.00** no-show and late cancellation fee may apply. If there are 3 no shows within one year you may be asked to transfer care to another practice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may not be possible and it may be necessary to reschedule your appointment.

Initial:___________

Permission for Medical Care:

- All children under the age of 18 must be accompanied by an adult. Any adult who is not the patient's legal guardian must have written permission to authorize medical treatment for the child.
- Patients who are age 18 or older will be given the option to sign a release allowing our office to discuss their care (including diagnoses and lab work) with their parents or guardians. By law, we are not permitted to disclose medical information pertaining to any patient aged 18 or above to their parents unless the patient has given us written permission to do so.
- Parents of adolescents should be aware that Maryland State law permits adolescents to obtain certain confidential services without notifying the parents.

Initial:___________

Referrals:

- Advance notice is needed for all non-emergent referrals, typically 3-5 business days.
- Retroactive referrals cannot be written.
- Generally, we will not agree to a referral for a problem we have not been consulted about first.
- It is your responsibility to know if a selected specialist or lab participates with your insurance.

Initial: ___________

Forms:

- We require 3-5 business days to complete your forms, please plan accordingly.
- The child must have an up-to-date (within the past 12 months) physical exam on file with our office.
- $10.00 form completion fee is due at time of pick-up.

Initial:___________

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. At each visit you will be asked to present your insurance card to ensure our office has the most up-to-date card on file.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- As we are your primary care provider (PCP), make sure our physician or practice name appears on your most up to date card. If your insurance has not been informed that we are your child's PCP and we cannot confirm that we are, you must pay for the visit or reschedule.
- It is your responsibility to understand your benefit plan.
- Not all plans cover well child visits, vision and hearing exams/screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

Initial:___________

Financial Responsibility:

- We do not get involved with domestic disputes and custody issues. Our policy is to obtain the co- payment at the time of service from the parent/guardian bringing the child to the appointment. Any balance left from the insurance company will be billed to the guarantor on the account. If bills are ignored, we will hold the accompanying parent responsible for full payment. It will then be that parent's responsibility to seek repayment from the other party.
- According to your insurance plan you are responsible for any and all co-pays, deductibles and co-insurances.
- Co-pays are due at the time of service.
- Patient balances are billed monthly; we ask that you pay your balance upon receipt of the statement.
- If previous arrangements have not been made with our billing office, any account balances 60 days past due will have a $15.00 late fee applied to the account. Balances reaching 90 days overdue will have a block placed on the account in which no well-child visits can be scheduled until payment is received. Balances reaching 120 days past due will be forwarded to a collection agency. If your account is sent to a collection agency you will be asked to transfer your care to another practice.
- A sick patient present in our office will not be denied care due to financial difficulties.
- A $25.00 fee will be charged for any checks returned by the bank. Repeatedly presenting checks that are returned will result in your account being placed on a "cash only" restriction.
- For your convenience the following forms of payment are accepted: Cash, Personal Check, Visa, Master Card and Discover.
- Ellicott City Pediatric Associates, P.A. reserves the right to change fees without notice.
- Any families asked to transfer care for non-compliance of our policies will not be accepted back into our practice.

Initial:__________

I have read and understand this office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name – please list all children that are patients of Ellicott City Pediatric Associates:

____________________ **DOB** ________ ____________________ **DOB** ________

____________________ **DOB** ________ ____________________ **DOB** ________

____________________ **DOB** ________ ____________________ **DOB** ________

____________________ **DOB** ________ ____________________ **DOB** ________

Responsible Party's Name (Print): ____________________ **Relationship:** ____________________

Responsible Party's Signature: ____________________ **Date:** ____________________

ONE PER FAMILY PATIENT NAME______________________ DOB:______________

SOCIAL HISTORY

① Does your child / teenager have any siblings? Yes No

② Do you have any pets? Yes No

③ Does anyone smoke at home? Yes No

④ Are there any guns in the home? Yes No

⑤ Are guns locked and kept separate from ammunition? Yes No

==

FAMILY HISTORY

*Please note any family history (siblings, parents, grandparents) for the following conditions:

Condition	Yes	No	MOM	DAD	SIBLING	Grandma (Mom's side)	Grandpa (Mom's side)	Grandma (Dad's side)	Grandpa (Dad's side)	Other relative (please specify who)
Nasal allergies or other allergies?	Yes	No								
Asthma or lung disease?	Yes	No								
Heart disease or other condition?	Yes	No								
High blood pressure?	Yes	No								
High cholesterol?	Yes	No								
Diabetes or other endocrine problems?	Yes	No								
Cancer?	Yes	No								
Anemia?	Yes	No								
Bleeding disorders?	Yes	No								
Epilepsy?	Yes	No								
Mental retardation or developmental disorders?	Yes	No								
Neurologic disorder, including ADHD / ADD?	Yes	No								
Liver disease?	Yes	No								
Other GI disease / disorder?	Yes	No								
Kidney disease?	Yes	No								
Bed-wetting (after 10 years of age)?	Yes	No								
Hearing impairment?	Yes	No								
Vision impairment or eye disorder?	Yes	No								
Immune problems, recurrent infections, or HIV/AIDS?	Yes	No								
Alcohol abuse?	Yes	No								
Drug abuse?	Yes	No								
Mental illness?	Yes	No								
Tuberculosis?	Yes	No								
Additional pertinent conditions?	Yes	No								

PATIENT NAME: ______________________________ **DOB:** ____________

PAST MEDICAL HISTORY
Has your child ever had any of the following:

Serious Injuries or accidents?	Yes	No
Surgeries?	Yes	No
Hospitalizations?	Yes	No
Chickenpox?	Yes	No
Frequent ear or sinus infections?	Yes	No
Pharyngitis/tonsillitis?	Yes	No
Other infectious illnesses?	Yes	No
Allergic rhinitis or other allergy?	Yes	No
Asthma, bronchitis, bronchiolitis, pneumonia, or croup?	Yes	No
Heart problems or heart murmur?	Yes	No
Abdominal pain or GERD?	Yes	No
Constipation requiring doctor's visits?	Yes	No
Bladder or kidney infection, or other urologic problem?	Yes	No
Bed-wetting (after 5 years of age)	Yes	No
Eye conditions or corrective lenses?	Yes	No
Problems w/ ears or hearing?	Yes	No
Chronic or recurrent skin problems (acne, eczema, etc.)?	Yes	No
Anemia or bleeding problems?	Yes	No
Blood transfusions?	Yes	No
Frequent headaches?	Yes	No
Seizures, developmental delays, ADD/ADHD, or other neurologic disorder?	Yes	No
Mental health concerns?	Yes	No
Orthopedic problems?	Yes	No
Diabetes?	Yes	No
Thyroid or other endocrine problems?	Yes	No
If female, have menstrual periods started?	Yes	No
If female, any problems w/ periods?	Yes	No
Use of alcohol or drugs?	Yes	No
Emotional problems?	Yes	No
Other significant problems?	Yes	No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Send this to your previous physician and obtain your records BEFORE your visit to us.

RECORDS TO BE RELEASED FROM: (your previous physician)

Address: ______________________________

____

____

phone# ____________________ fax # ____________________

I hereby request and authorize you to furnish records for the purpose of____________________

or at my request.

<u>Release</u> : (*Please select only 1*)

- o All Records *(fees might apply, please check with provider)*
- o Immunization Records
- o Abbreviated Records (Immunization, Growth Chart, Last Physical, recent Lab, Xray)
- o Release Records from ___________ to ______________

RECORDS TO BE SENT TO :

Ellicott City Pediatric Associates

9011 Chevrolet Drive, Suite 1-6

Ellicott City, MD 21042

Phone: 410-465-7550 fax 410-465-6359

<u>PATIENT INFORMATION</u> :

Patient name: ______________________________ DOB: ____________________

Address ______________________________ Phone # : ________________

____

The authorization is **effective for one year** from the date on which it was signed. I further understand that I may revoke this authorization (in writing) at any time, except to the extent that action has been taken in reliance on it. I understand that the medical records to be release may contain medical information pertaining to psychiatric, drug and/or alcohol, HIV/AIDS diagnosis and treatment. I further understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws and may be subject to re-disclosure.

______________________________ ________________

Signature of Patient or Legal Guardian *Date*

Understanding Office Visits and Billing Practices

The physicians and staff at Ellicott City Pediatric Associates PA 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 may be included in Wellness Services? (Also known as a preventative visit or physical or well child check)

- Age appropriate history
- Age appropriate medical exam
- Anticipatory guidance (such as reducing fall risks for early walkers)
- Review and interpretation of any recommended labs
- Preventative counseling (such as proper nutrition)
- Review of vaccine history

What other preventative related services will be billed separately?

- Vaccine products and administration
- Routinely recommended labs (these are typically performed by another provider and you may receive a separate bill)
- Screenings (such as vision, hearing, developmental & behavioral 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 screenings 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 preventative covered services covered in full by most insurance plans. However, this is not true of many problem-oriented services. Management of medical diagnosis, including the need for medication refills of any sort, is categorized by insurance companies as a problem-oriented service. 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 and problem oriented benefits.

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)
- Changes to chronic conditions (ADHD/ADD, asthma, obesity, etc)
- Behavior Concerns
- Suture Removal
- Anxiety/Depression

Examples of screening services include but are not limited to:

- Cholesterol, Lead, Hemoglobin Screening
- Vision test
- Hearing Screening
- Developmental Screenings
- Spirometry
- Mental Health questionnaires
- Adolescent questionnaires
- Autism Screenings (MCHAT)

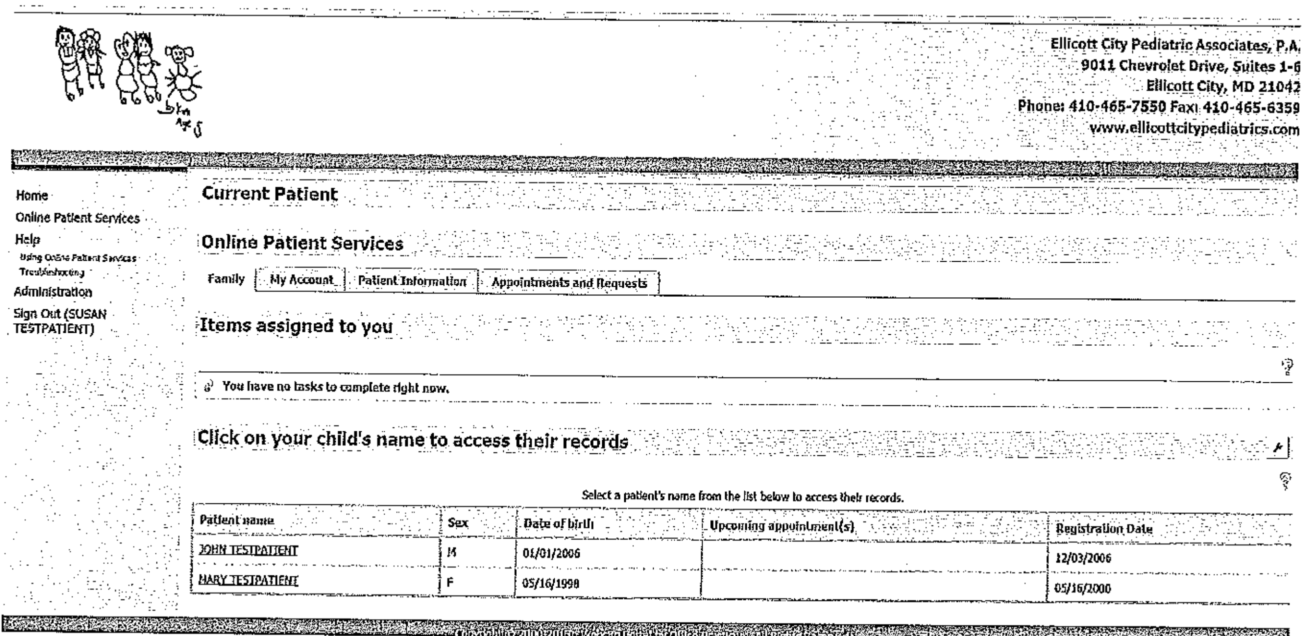
** All laboratory services performed or referred by our providers may result in additional bills/or charges from other companies that may include but are not limited to: such as Quest Diagnostics, LabCorp, etc.

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. **It's 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.**

Welcome to the Ellicott City Pediatric Associates Patient Portal

The Patient Portal is a safe and secure website that allows parents quick access to certain parts of their children's medical records, including immunization & visit history, labs, forms, etc. You can see, print and download information at your convenience, without having to call the office. You may request prescription refills, certain types of appointments, or a copy of your medical records.

Once your Patient Portal account has been set up during an office visit, you can log on to the Portal using your email address and your temporary password. Go to our website www.ellicottcitypediatrics.com and select the Patient Portal tab on the left side. You will want to change the password and create a security question immediately.



On the home page, you will see the name(s) of your child(ren) who are linked to your portal account on the "Family" tab. If you do not see your child's name, please bring it to our attention at your next office visit. Young adult patients, aged 18 years or over will have their own portal accounts.

For further instructions, please use the "Help" section on the left side of the portal or call our office at 410-465-7550.

Ellicott City Pediatric Associates
Patient Centered Medical Home

GOALS:

We are committed to providing the best possible care to our patients and their families. By serving as your child's medical home, we will be the central resource for all of your child's medical care. We will ask you to choose a primary physician who will address your child's healthcare needs and coordinate their care across all settings, including the medical office, hospital, clinics, testing facilities, and other places where you receive healthcare. We have trained triage nurses to assist you with medical advice during office hours, an on-call physician to take care of medical needs after hours, Saturday and evening hours four days of the week, a medical records person to assist with access to your health care records, a referral coordinator to assist you with appointments with specialists and a patient portal to allow you to access your medical records including growth charts, immunization records, lab slips and visit summaries.

ACCESS:

Our normal business hours are:

Monday-Thursday: 8:30 a.m. to 7:30 p.m.

Friday: 8:30 a.m. to 4:00 p.m.

Saturday: 8:00 a.m. to 11:30 a.m.

You may reach the office by calling us at 410-465-7550.

Press 1 --- Our Emergency Line

Press 2 --- Appointments

Press 3 --- Referrals

Press 4 --- Nurse Line and Medication Refills

Press 5 --- Medical Records

Press 6 --- Billing and Insurance

Press 7 --- Office Directions and General Information

Press 8 --- On-Call Physician After Hours

Press 9 --- Leave a Message for a Doctor

EXPECTATIONS:

To help provide your child with the best care, we expect you to provide us with their medical history, as well as information about any care they obtain outside of our practice including current medications, recent test results, visits to other doctors and healthcare providers, hospitalizations, urgent care and emergency department visits.