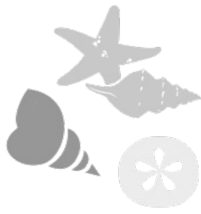


Beachside Pediatrics
of Naples

Child/Children Name(s) (first and last)	Date of Birth	Sex
		M F
		M F
		M F
		M F

PARENT/GUARDIAN

Name: ____ DOB: ________________

Address: ____ Apt # _________

City/State: _______________________ Zip: ________

Cell Phone : ________________________________ Alternative Phone: ___________________________

Relationship to patients (circle): Mother Father Other________Email:______________________________

Employer: ____

PARENT/GUARDIAN

Name: ____ DOB: ________________

Address: ____ Apt # _________

City/State: _______________________ Zip: ________

Cell Phone : ________________________________ Alternative Phone: ___________________________

Relationship to patients (circle): Mother Father Other________Email:______________________________

Employer: ____

EMERGENCY CONTACT (other than parents)

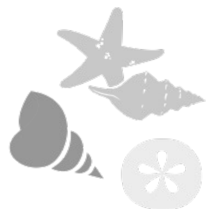
Name: __________________________________ Relationship: _____________ Phone #: ____________

PATIENT PORTAL

Our patient portal “My Kid’s Chart” is an *essential component to our practice*. Once you receive your enrollment email you will have 1 week to complete enrollment before the link expires. If the link expires or you forget your password, please call the office we can reset this for you.

Preferred email for portal account:

____



Beachside Pediatrics
of Naples

INSURANCE, FINANCIAL, and HIPAA POLICIES

1. I understand it is my responsibility to confirm Beachside Pediatrics of Naples is contracted with my insurance plan. If not, I am aware I could be responsible for “out of network” benefits. Questions about medical benefit coverage should be directed to my insurance company prior to my visits.
2. I agree to provide accurate insurance information at each visit
3. If I do not have proof of insurance coverage, I understand I **have one week to provide this information.** Otherwise the office visit will be considered my financial responsibility.
4. I understand if there is delay in providing insurance information or not updating insurance information in a timely manner my claim could be denied due to timely filling and I would be financial responsible for payment.
5. I understand if I have an HMO policy it is my responsibility to make sure Dr. Najm, Lisa, or Shannon is assigned as my child's PCP prior to their visit. (In the scenario that the child is not assigned to either provider we will ask you to call your insurance company to update your PCP. If we have not received confirmation of this change within 5 days of your visit. The office visit will be considered your financial responsibility).
6. *I understand my insurance policy is a contract between myself and my insurance company.*
7. I understand that my insurance may not cover certain procedures and tests during my child's visit and that I will be financially responsible for any charges that are not paid based on contractual agreement with my insurance company.
8. If my insurance company does not pay my claim within 90 days, I will pay Beachside Pediatrics and wait for my insurance to reimburse me.
9. I understand Beachside Pediatrics may bill my insurance for phone/portal encounters that result in evaluation and management of my child's health.
10. I am aware of the “Notice Of Privacy Practices“ and if requested, I will be provided a copy of this notice.

Primary Insurance Company: ________________________________ Effective Date: ________________

Policy holder's name: ____________________________________ DOB: __________________________

Policy #/ ID: ________________________________ Group #: ____________________________

Responsible party: ____

If you would like to keep your HSA or credit card on file please speak to front desk personnel.

You will be responsible for the full amount of payment at the time of service for the following reasons:

1. You do not have insurance.
2. You are covered by a company that Beachside Pediatrics is not contracted with.
3. Your child receives a service that is not covered by your policy. For example some plans do not cover certain immunizations, vision screenings, or developmental screenings.
4. Your insurance company denies your claim for any reason that is not resolvable.
5. You did not provide us with updated insurance information resulting in claim denial due to filing deadlines.
6. You didn't verify that Dr. Najm, Lisa Romano APRN, or Shannon Segaloff APRN is the assigned PCP for your HMO insurance policy at the time of service.
7. Your insurance company does not pay the claim within 90 days.

Signature of parent or guardian____ Date _______________