



Locations:

1475 Taney Ave, Frederick, MD 21702
504 E. Ridgeville Blvd, Ste 101, Mt. Airy, MD 21771
610 Solarex Ct, Ste 200, Frederick, MD 21703
3020B Ventrie Ct, Myersville, MD 21773
3430 Worthington Blvd, Ste 204, Frederick, MD 21704

Correspondence to:

The Pediatric Center of Frederick
1475 Taney Ave. Ste 201
Frederick, MD 21702

Phone: 301-662-0133
Fax: 301-695-8604

www.thepedcenter.com

Dear Parent or Guardian,

Welcome to The Pediatric Center of Frederick! We are glad that you have chosen us to provide your child's primary care, and we are looking forward to working with your family.

Enclosed with this letter, you will find helpful information for new patients.

- **Patient Registration Form:** This form provides your address and phone number, emergency contacts, and insurance information. Please complete this form and return to our office staff prior to or at the time of your first visit. Unfortunately, we cannot accept this form back electronically due to the Protect Health Information (PHI) on it. This form is also available in Spanish.
- **Release of Records:** It is important that we obtain copies of your child's previous medical records from those who have treated your child in the past. If you haven't already had your child's records transferred, please complete a separate release form for each doctor your child has seen.
- **Financial Policy:** Please take a moment to familiarize yourself with our expectations regarding billing and payment for services.
- **Vaccine Policy:** This document explains our vaccine policy. Please read it over and understand that if you do not wish to vaccinate your child, we will ask that you seek medical care elsewhere.
- **Financial, Privacy and Vaccine Policy Acknowledgement Form:** This document acknowledges that you have read and understand our financial, privacy and vaccine policies. Please return this with the Patient Registration Form.

It is also important that you contact your insurance company and inform them that The Pediatric Center of Frederick will be serving as your child's primary care physician. Also, please be sure to bring your insurance card(s) and required co-payment (if any) to every appointment.

For more information about our practice, including office hours, locations and helpful medical advice for parents, please visit our website at www.thepedcenter.com.

Once again, welcome to The Pediatric Center of Frederick! Should you have any questions, please do not hesitate to contact us at (301) 662-0133.

Warm Regards,

The Doctors, Nurse Practitioners and Staff of The Pediatric Center



PATIENT REGISTRATION FORM

PATIENT INFORMATION	Patient's First Name:		Middle:	Last:	Nickname:	
	Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Cell Phone (if applicable):		
	Street Address:				Apt #:	
	City:	State:	Zip:	Preferred Language:		
	Primary Phone:			Primary Care Provider:		
	Preferred Pharmacy/Location:					
	Ethnicity (please check one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to specify					
	Race (please select all that apply): <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to specify					
	Siblings					
	Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:		

INSURANCE INFORMATION	Primary Insurance				
	Insurance Name:		Member ID #:	Group #:	
	Subscriber's Name:		Date of Birth:		
	Subscriber's Relationship to Patient:				
	Secondary Insurance				
	Insurance Name:		Member ID #:	Group #:	
	Subscriber's Name:		Date of Birth:		
	Subscriber's Relationship to Patient:				

ACKNOWLEDGEMENT	THE POLICY IN OUR OFFICE IS THE PARENT/ GUARDIAN WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.	
	<p>I realize verification of insurance coverage is my responsibility. In the event the listed medical service is not covered by my insurance, I agree to be financially responsible for the charges for these services. If my account is assigned to a collection agency, I agree to pay all agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5% late charge per month on the unpaid monthly patient balance. I do hereby authorize The Pediatric Center of Frederick, LLC, to apply for benefits on my behalf for services rendered. I request payment to be made directly to The Pediatric Center. I verify the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my insurance company.</p>	
	_____ Patient's Name	_____ Patient's DOB
	_____ Signature of Parent/Guardian or Responsible Party	_____ Today's Date

Patient Names (include all siblings for whom this information applies): _____

Parent/Guardian #1		
Full Name:		Date of Birth:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Patient:	Social Security #:
Address (if different from child):		Apt #:
City:	State:	Zip:
Primary Phone:	Cell Phone:	Work Phone:
Email:		Employer:
Choose one way to receive appointment reminders: <input type="checkbox"/> Call Primary <input type="checkbox"/> Call Cell <input type="checkbox"/> Text Cell <input type="checkbox"/> Email <input type="checkbox"/> Opt Out		
Choose one way to receive notices (weather closings, due for appointment, etc.): <input type="checkbox"/> Text Cell <input type="checkbox"/> Email <input type="checkbox"/> Opt Out		
Parent/Guardian #2		
Full Name:		Date of Birth:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Patient:	Social Security #:
Address (if different from child):		Apt #:
City:	State:	Zip:
Primary Phone:	Cell Phone:	Work Phone:
Email:		Employer:
Choose one way to receive appointment reminders: <input type="checkbox"/> Call Primary <input type="checkbox"/> Call Cell <input type="checkbox"/> Text Cell <input type="checkbox"/> Email <input type="checkbox"/> Opt Out		
Choose one way to receive notices (weather closings, due for appointment, etc.): <input type="checkbox"/> Text Cell <input type="checkbox"/> Email <input type="checkbox"/> Opt Out		

Other than Parent/Guardians, please list two emergency contacts		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

*Practice use only: Updated in computer Initials: _____ Date: _____



Main Office: 1475 Taney Avenue
Frederick, MD 21702

Main Phone: (301) 662-0133
Medical Records Phone: (301) 631-8055
Medical Records Fax: (301) 662-8108
www.thepedcenter.com

Authorization for Disclosure of Protected Health Information

If patient is 18 years or older, form must be completed & signed by patient. If patient is under 18 years of age, form must be completed & signed by parent/guardian.

Patient Information

Patient Last Name

Patient First Name

Patient DOB

Information to be Disclosed to:

I, the undersigned, hereby authorize The Pediatric Center of Frederick, LLC

to **release** copies of medical records to:

to **obtain** copies of medical records from:

Name of Person/Organization

Address

Telephone

Reason for Disclosure

Relocation

Child's Age

Change of Insurance

Specialist

Other (please specify):

Information to be Disclosed

Immunizations

Records of office visits

Copies of consultations from other physicians

Developmental/ behavioral evaluations (if allowed)

Other (please specify):

Laboratory test results

X-ray reports

Newborn records

Hospital summaries

Disclosure of Sensitive Information (if applicable)

Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release.

HIV/AIDS Testing or Treatment Y N

Substance Use/Abuse Y N

Pregnancy/Sexual Health Y N

Mental/Behavioral Health Information Y N

Signature

This authorization will expire within 1 year from the date of signature. I understand that I may revoke this authorization by submitting written notice of revocation to The Pediatric Center of Frederick, LLC.

Signature of Parent/Guardian or Patient (if 18 years or older)

Date

Printed Name

Relationship to Patient

Forwarding Address (if applicable)

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Patient Financial Policies (rev 1/2025)

Timely Payment

Full payment, including deductibles and copayments, is expected at the time of service unless you have made advance arrangements with our business office. The Pediatric Center accepts cash, personal checks and credit cards.

Help us to submit claims to your insurance company correctly by presenting your child's insurance card **at each visit**. We make a reasonable effort to submit claims to all health insurance companies, even those with which we are not contracted, as a courtesy to our patients. The parent who **brings the child in for treatment** is expected to pay the copayment and/or deductible.

Collections

Any charges that remain unpaid after 30 days after the date of service are considered past due. If no effort is made to pay the balance due, the bill may be subject to our collections process. In this case, the family may be discharged from the practice and the parents asked to seek medical care for their child/children elsewhere. If an account is assigned to a collection agency, the parents agree to pay all collection agency fees, court costs and attorney fees.

We will not see patients for routine exams/well visits, evaluations or follow-ups if a patient's account is in collections.

Billing Fees

There is a \$50.00 charge for any check returned unpaid to us from the bank.

Form Fees

Our fee to complete a form (camp, sports, etc.) is \$10.00. There is no charge if the form is completed at the time of visit.

After Hours Charge

The Pediatric Center doctors and nurse practitioners are in the office evenings, weekends and holidays to take care of your children. Effective Oct 2010, Maryland State legislation (HB435) requires many insurers to pay an additional fee to primary care physicians who see patients weekdays between 6pm and 8am, during weekends or on national holidays. ***The current fee is \$50 and will be passed on to the patient should the insurance company not cover it.***

Missed Appointments/Late Cancellations

Broken appointments are costly to us, to you, and to other patients who could have used the time set aside for your child. Please call at least four hours prior to the appointment time to make scheduling changes and to avoid a **\$50 missed appointment fee**. Repeatedly missing or canceling appointments without adequate notice may result in discharge from the practice.

We will not reschedule missed appointments for behavioral evaluations or ADD/ADHD appointments until the missed appointment fee is paid in full.

Miscellaneous Expenses

Your insurance may not cover every type of service we provide (some well visits may not be covered depending on your insurance coverage and the timing of the well visit). Such fees should be paid at the time of service. Additionally, you may be charged certain administrative fees for duplication of medical records and for completion of school/camp/sports forms **not presented at the time of the visit**.

How to Contact Us

If you need assistance or have any questions, our billing staff can be reached at (301) 662-1930 between the hours of 9am- 4pm, Monday through Friday.

Please read and understand our financial policies and keep us informed of your child's insurance status and any changes in your address or telephone number(s). Thank you!



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Vaccine Statement

There has been an increasing amount of media attention given to vaccine safety and side effects. The information presented is understandably concerning to families and has resulted in many questions regarding our vaccine policy. The following is our response to these statements.

We firmly believe in the effectiveness and safety of our vaccines to prevent serious illness and to save lives. ***We believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the American Academy of Pediatrics.***

We believe that vaccinating children and young adults may be the single most important health promoting intervention we perform as health care providers, and that you can perform as parents or caregivers. We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox or known a friend or family member whose child had died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. Vaccination of preventable disease is very important to both your child's health and to the public health of our community. Disease rates of vaccine preventable infections have increased when communities have seen decreasing vaccination rates.

As medical professionals, we feel very strongly that vaccinating on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. ***As a guideline we expect our patients to be up to date with all vaccines.***

For those wanting more information we recommend the following websites:

- www.vaccineinformation.org
- www.vaccine.chop.edu
- www.vaccinateyourfamily.org

Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,

The Doctors and Nurse Practitioners at The Pediatric Center



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Financial Consent, Privacy Practices and Vaccine Administration Policy Acknowledgement

Financial Consent

I authorize The Pediatric Center to submit each visit to my insurance company on my behalf. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize payment of medical benefits directly to The Pediatric Center.

I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for services provided by The Pediatric Center including but not limited to; co-insurance, copayment and/or deductibles and agree that I am to pay any of these non-covered charges at the time of service.

I also understand and agree that if my insurance company subsequently notifies The Pediatric Center that my child is not covered as of the date of service, has no well coverage, has exceeded well-child coverage or service provided is a non-covered service, I am to pay in full the amount not covered upon receipt of the patient statement.

I understand and agree that administrative costs including but not limited to: *form completion, medical letters of necessity and/or copies of medical records* will incur a charge that is the responsibility of the parent/guardian and can not be submitted to my insurance carrier. I understand and agree to pay these charges either up front or upon receipt of the patient statement as dictated by office policy.

I understand and agree that fees may be assessed for appointments cancelled less than 4 hours from the appointment time and no-show appointments. The fee will be billed and payable upon receipt.

Should the account be referred to an agency for collection, I will pay reasonable fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate.

Acknowledgement of Privacy Practices

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

I understand that The Pediatric Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

The Pediatric Center 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.

Acknowledgement of Vaccine Administration Policy

I understand that The Pediatric Center will administer vaccines in accordance to the American Academy of Pediatrics Guidelines. I also understand that I will be given information about these vaccines and the opportunity to discuss them prior to administration.

Patient Name: _____

Patient DOB: _____

Signature of Parent/Guardian: _____

Date: _____

Relationship to Patient if other than parent/guardian: _____