Christopher E. Beney, M.D., P.C.

1149 Lincoln Ave ~ Lockport, NY ~ 14094 ~ 716-433-2674 ~ Fax: 716-433-2677
Chad Shepherd, DNP, FNP ~ Karey M. Schmelz, RPA-C~
Shannon L. McCrory, DHEd CPNP-PC ~ Lindsey Thering, RPA-C~
Christopher Pease, RPA-C ~ Emma Harrington, FNP-BC~
Mary Pegan, RPA-C

Pediatric Registration

Patient Name: _____ Sex: Male or Female

Date of Birth: _____ Mothers Maiden Name: _____

Address: _____ City:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Cell Carrier:_____

Preferred/Primary Language: _____ Pharmacy: _____

Race: White / African American / American Indian / Asian / Other

Ethnicity: Hispanic/Latino / Not Hispanic/Latino

Email: _____

Mother's Name: _____

Date of Birth: _____ Phone Number: _____

Address (if different than child): _____

Occupation: _____ Employer:_____ Phone: _____

Father's Name: _____

Date Of Birth: _____ Phone Number: _____

Address (if different than child): _____

Occupation: _____ Employer:_____ Phone:_____

Emergency Contact other than Parent/Guardian:

Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

PLEASE BE PREPARED TO PRESENT YOUR INSURANCE AT EVERY VISIT.

Primary Insurance: _____ Insured: Father _____ Mother _____

Subscriber's Name: _____

Patient ID Number: _____ Group Number: _____ Effective Date:_____

Claims Address: _____

Secondary Insurance: _____ Insured: Father _____ Mother _____

Subscriber's Name: _____

Patient ID Number: _____ Group Number: _____ Effective Date:_____

Claims Address: _____

Insurance Assignment and Relase

Christopher E.Beney M.D., P.C.

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Dr.Beney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named physician may use my health care information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for such services and determining insurance benefits payable to related services.

Signature of Parent/Guardian: _____ Date:_____

Signature of Parent/Guardian: _____ Date:_____

Insurance

If you have insurance, we will help you receive the maximum benefits. However, INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will inform you if we participate with your insurance company, and will handle your claims as a courtesy to our patients. In the event of a dispute with the insurance company regarding deductibles, co-pays or covered charts, we will only supply the factual and relevant information. It is ultimately the guarantor's responsibility to deal with their insurance company to assure payment and keep the account current.

Family Medical History

For the list below please indicate which blood relatives have had complications with the following problems. Blood relatives include the child's Mother, Father, Grandparents, Siblings, Aunts, Uncles, and First Cousins. The information you offer will enable us to maintain your child's health.

Anemia/Other Blood Disease (Specify which)_____
Asthma_____
Mental Handicap _____
Drug Problem _____
Alcoholism _____
Cancer (Specify type) _____
AIDS/HIV _____
Cystic Fibrosis_____
Muscular Dystrophy _____
Tuberculosis _____
Arthritis _____
Epilepsy/Seizures _____
Heart Disease _____
High Blood Pressure _____
Kidney/Urine Problems _____
Cholesterol Problems _____
Smokers _____
Diabetes _____
Migraines _____
SIDS (Sudden Infant Death Syndrome) _____
Birth Defects _____
Deafness at Birth _____
Mental Health Concerns _____
Other Chronic Illnesses (Please Specify)_____

Family Profile

Patient's Mother: Highest Schooling Completed: _____

Patient's Father: Highest Schooling Completed: _____

Sibling: _____ Date of Birth: _____

Sibling: _____ Date of Birth: _____

Sibling: _____ Date of Birth: _____

Sibling: _____ Date of Birth: _____

Pregnancy And Birth

Mother's Age at pregnancy: ____ Illnesses while pregnant: _____

Medications while pregnant: _____(Exclude Vitamins and Iron)

Smoking/Alcohol/Street Drugs while pregnant: _____

Pregnancy Full Term or Pre-Term? _____ Delivery Type: _____

Birth Weight: _____ Length: _____ Discharge Weight: _____

Were there any birth complications? _____

Breathing: _____ Jaundice: _____ Other: _____

Problems in nursery or at home soon after birth? _____

Patient Past Medical History

Previous Medical Care: _____ Were records transferred?_____

Are Vaccinations up to date? _____

Serious Injuries (When, Where): _____

Surgeries (Type and Date): _____

Hospitalizations:

Illness:_____ Date:_____ Length Of Stay:_____ Hospital:_____

Illness:_____ Date:_____ Length Of Stay:_____ Hospital:_____

Medical **Please Check if your Child has had any of the following:**

( ) Chicken Pox	( ) Mononucleosis	( ) Exposure to Tuberculosis
( ) Hay Fever	( ) Hives	( ) Bladder/Kidney Infection
( ) Asthma/Wheezing	( ) Pneumonia	( ) Fainting/Syncope
( ) Elevated Lead	( ) Anemia/Blood Problems	( ) Eczema/Skin Rashes
( ) Yellow Jaundice	( ) Broken Bones	( ) Heart Murmur/Disease
( ) Vision Problems	( ) Severe Burns	( ) Concussion/Head Injury

( ) Other (Please specify): _____

Medications: Please list all prescription medications, non-prescription medications and vitamins your child is taking.

Medication: _____ Dose: _____ Frequency:_____
Medication: _____ Dose: _____ Frequency:_____
Medication: _____ Dose: _____ Frequency:_____

Allergies: Does your child have any allergies to any medication, food or environmental factors?

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____

Christopher E. Beney, M.D., P.C.
Late Arrival Policy

Christopher E. Beney M.D., P.C. would appreciate all patients to be on time for their scheduled appointments. We do understand that things come up and are sympathetic to this. In the event of a patient coming to their appointment 10 minutes late or more after their scheduled appointment time, this would be deemed as "LATE".

"LATE" is the term we use when a patient arrives later than their scheduled appointment time. Unfortunately being late to an appointment is an inconvenience to those patients present at their scheduled time, and those who need access to medical care in a timely manner. In the event that you arrive "LATE" to your appointment please note that you may be asked to reschedule.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "LATE". You will be sent a letter alerting you to the fact that you have been late for a scheduled appointment. This is a warning letter. A copy of that letter will be placed in your medical record. After 6 "LATE" Appointments are recorded in the chart, that will result in dismissal from the practice.

By signing below I acknowledge and read Christopher E. Beney M.D., P.C.'s Late Policy.

Name (Please print): _____

Signature: _____ Date: _____

Missed Appointment Policy

We would appreciate 24 hours notice in the event a scheduled appointment needs to be changed or cancelled. In order to help control health care costs it is important for the patient/parent to notify our office if they are unable to keep a scheduled appointment so that we can book another patient. In the event that our office is not notified and an appointment is missed you will be charged $50 for the visit. If three (3) appointments are missed without notification, you will be asked to leave our practice.

By signing below I understand my financial obligation that pertains to my insurance and missed appointments.

Responsible Party Name (Please print): _____

Signature: _____ Date: _____

Vaccination Policy

We firmly believe that vaccinating children and adolescents is to be the single most important health promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. We firmly believe that all children and young adults should receive the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP). We believe in the safety and effectiveness of vaccines and the many years of scientific study that has gone into their creation and scheduling. We believe that every child has the right to be protected from preventable disease and that to provide the best possible care to all of our patients, we must protect those too young or too ill to receive vaccines themselves. We DO NOT believe that there is any link between any vaccine and autism or any other disability. The literature, evidence, and continued monitoring of vaccines supports this.

New Patient Policy

- We do not accept new patients that choose not to vaccinate according to the CDC immunization schedule.
- All new patients will be required to provide proof of immunizations in order to make an appointment to see a provider.
- Alternate vaccine schedules will NOT be considered.

Current Patient Policy

Members of this practice prior to our vaccine policy going into effect August 2016, may continue with their current non-vaccinated status, but ongoing efforts will be made to encourage vaccinations.
Current Patients on an alternate vaccination schedule may continue with their current status but we will no longer be administering these vaccinations in office. You will be asked to contact the Health Department to receive further vaccinations until the patient is caught up.

As always the health of our patients and community is a top priority, and we feel vaccines are a safe and important part of maintaining healthy patients to thrive in a healthy community. We encourage you to reach out to any of our providers with questions about the safety and efficacy of vaccines, and why we feel they are so vital.

Sincerely,

Christopher E. Beney M.D.
Karey Schmelz RPA-C
Lindsey Thering RPA-C
Emma Harrington FNP-BC
Chad Shepherd DNP, FNP
Shannon McCrory DHEd, CPNP-PC
Christopher Pease RPA-C
Mary Pegan RPA-C

New Patient Vaccine Contract

As per our New Patient Vaccine Policy (V01.1) all new patients and families welcomed into our practice must be fully vaccinated, and provide proof of vaccination status. **(This does not refer in any way to the vaccinations for COVID-19. All current and new patients will be seen regardless of their COVID-19 vaccination status.)**

By signing below I acknowledge and agree to following:

- All new patients will agree to being fully immunized to New York State requirements.
- Alternative schedules will not be considered. Our Practice follows the Centers for Disease Control (CDC) Guidelines.
- Our practice believes there are no legitimate objections to receiving vaccines. (This includes but is not limited to religious, personal or moral objections.)
- Medical exemptions will be the ONLY exception to this policy and documentation of such will be reviewed/verified by our providers.
- All new patients/families are asked to sign this policy. If you do not agree with or feel you cannot comply with this policy, our practice is not a good fit for you.
- Any patient/family who chooses at a later date to no longer adhere to the CDC vaccine administration schedule will be asked to find a new practice.
- I understand that these policies are in place for the health of myself, my child(ren) and the community, and are put in place by the office of Dr.Christopher Beney M.D., P.C. in order to provide the best evidence based healthcare possible.

I have read and understand the office vaccine policy and agree to adhere to all terms and conditions.

Patient Name: _____

Responsible Party Name: _____

Relationship to Patient: _____

Responsible Party Signature: _____

Christopher E. Beney M.D., P.C.
Patient Contract

By signing below, I state that I understand that, as a patient of Dr.Beney's Practice, I am held to the following:

I will follow the direction of the Providers in the practice, whether it is told to me personally by them or thru a staff member.
I will come to the office for a complete physical every year or as prescribed by my Provider.
I will follow thru on referrals my Provider sends me to in a timely manner.
I will get testing done that my Provider prescribes for me in a timely manner, or at the direction of the Provider.
I understand that it is my responsibility to arrange a time to have consultations or testing done.
I understand that the Providers will give me prescriptions to have preventative services done (for example colonoscopy, mammogram, etc.) and I will have these tests done in a timely manner, unless I have refused to have these done and it is documented in my electronic medical record.
When possible, I will contact the office prior to going to an Emergency Room or Urgent Care Center to see if the office can accommodate my acute problem.
If I have an emergency, I will go to the closest Emergency Room, or the Emergency Department the provider directs me to.
I will follow the posted policies of the practice.
I understand that the Practice expects me to pay my account balance in a timely manner.
I understand that the Practice can make financial arrangements with me if I am unable to pay off my bill.
I understand that the Practice will contact me ONCE if I am delinquent in following thru with referrals or testing.
I understand that there is a $50.00 charge for any missed appointments without 24 hours advanced notice.
I understand that if I miss 3 appointments without calling the office to cancel I will be DISCHARGED from the practice.
I understand that if I am delinquent, I risk being DISCHARGED from the practice.
If discharged, I understand that I will be given 30 days to find another Doctor, in accordance to New York State Law.

Patient Name: _____

Responsible Party Name: _____

Relationship to Patient: _____

Responsible Party Signature: _____ Date:_____

Christopher E. Beney, M.D., P.C.

Permission to release Medical Information

I authorize information regarding my care and treatment to be released as set forth on this form to the following person/persons:

I understand that: This authorization may include disclosure of information relating to my medical records, I have the right to revoke this authorization at any time by writing to the provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditional upon my authorization of this disclosure.

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Patient Name: _____ Date of Birth:_____

Responsible Party:_____

Relationship to Patient: _____

Signature:_____ Date:_____

Christopher E. Beney, M.D., P.C.

Financial Policy

*Insurance: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits- including eligibility, covered benefits, and medically necessary procedures is your responsibility, please contact customer service at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan. We do not accept Worker's Compensation.

*Proof of Insurance: All patients must complete and/ or update our Patient Information form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

*Co-Payments and Deductibles: All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to change for, and you to pay for, all required co-payments, coinsurances, deductibles, and non-covered services.

*Claim Submission: We will submit your insurance claims to assist you in a way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

*Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical care facility care, etc., It is your responsibility to inform the office of this requirement prior to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.

*Out-Of-Network Care/Self Pay: Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to our out-of-network patients, we will file your insurance claim if desired, and offer a 10% reduction from our usual fees. This benefit also applies to individuals without insurance.

I certify that I, and/or my dependent(s) have insurance and assign directly to Dr.Christopher Beney all insurance benefits, if any, otherwise payable to be for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also acknowledge the use of my health care information by the above physician may be disclosed to insurance companies and their agents for the purpose of obtaining payment for services and determining benefits payable to related services.

Patient Name: _____ Date Of Birth: _____

Signature:_____ Date: _____