Keystone Pediatrics
a service of Keystone Health

830 Fifth Avenue, Suite 103, Chambersburg, PA, 17201
Phone: (717) 709-7950 Fax: (717) 263-8898

On behalf of everyone at Keystone Pediatrics, we welcome you to our practice. We are honored that you have chosen us to provide medical care for your children. We pride ourselves on providing you with the highest level of patient satisfaction possible. We have provided this letter to help familiarize your family with our practice so that we may better serve you.

Our Phone Policy

If you have questions about your child's health, we encourage you to call during regular office hours, Monday- Friday 8 am- 5 pm, whenever possible so that your family's records are available to the nurse or physician as they discuss your concerns. During regular office hours, your call may be answered first by a triage nurse to determine whether your child needs to be seen immediately. Call during regular business hours for the following:

- Referrals, forms or copies of records
- Refills of medications
  *Please note: all referrals, forms and refills require a 24-48 business hour notice
- Questions about colds or minor infections
- Questions about bowel movements
- Behavioral issues

Our After Hours Policy

We all know that urgent medical problems will occur after regular office hours. We provide walk-in care Monday- Friday 8 am- 7 pm, **at our Chambersburg Keystone Pediatrics location**, except major holidays. We also provide an after-hours emergency line 24/7 to assist you with those urgent needs. Please follow the following guidelines:

- After hours number: (717) 709-7950
- A triage nurse will return your call and answer any questions you may have
- The Physician on call will be paged if it is required
- Routine questions (non-urgent) should be answered by the office during regular hours.
- **PLEASE NOTE: Our after-hours line is not intended or equipped to handle major life threatening emergencies. Call 911 immediately.**

Insurance

Please note that it is the responsibility of the patient to know what benefits and services their insurance entitles them. If your insurance requires you to select a PCP please do so before your appointment or you may need to reschedule. All co-pays and deductibles will be due at the time of the service. If you have a plan in which we do not participate or do you not have a current card, you will be responsible for

paying at the time of service. *Please note that your insurance policy is a contract between you and your insurance company.*

We encourage you to take time to understand your benefits as Keystone Pediatrics cannot guarantee payment of your claim. We will render the patient responsible for any uncovered services.
For Insurance and Billing questions: (717) 709-1222

Billing

Patients are advised to bring along with them their most current insurance card when visiting our office. This ensures accuracy of documentation such as a group number, provider number. Provider contact is valid at the time of service. Please note that incorrect or out-of-date information will cause delays in processing your claims and may ultimately be held responsible for the full payment of the claim.

Payment

All charges (co-pays, deductibles and self-pay fees) must be made at the time of service. Payment may be made with cash, check, MasterCard, Visa, Discover and American Express. Your co-payment is determined from your insurance card, which you must bring with you to each visit.

Notification of Changes

We expect that you notify our office immediately of any changes to your insurance and bring your new card into the office for a copy to be placed into your chart. Likewise, any changes in your personal information such as change of address or telephone number should be made known as soon as possible.

Our Forms Policy

Parents often need forms that are required for a child's attendance in school, sports, daycare, etc. completed by your pediatrician. Please complete your portion of the forms prior to arrival. Forms may be completed at the well child check appointment at no charge. Please allow 5-7 days for completion of these forms. The child must have a well child check completed by our office within the past year or sooner if specified by your form. We cannot fax completed forms.

Referrals

Prior to getting a referral, you must first be seen at our office. If medically necessary, you will be referred to a participating specialist. We cannot issue referrals after the fact, so please obtain referrals prior to visiting the specialist. Please allow AT LEAST 48 hours to process your referrals.

Medical Records

We require a release form signed by parent or legal guardian to release records. Please allow 7-14 days for release to be processed and sent. For copies of vaccine records, please call 24-48 hours in advance for us to prepare those records.

Guardianship

Minors MUST be accompanied by a parent or legal guardian for all appointments & vaccinations unless proper consent paperwork has been completed. If we do not have consent, the appointment may be rescheduled.

Online Portal

Keystone Pediatrics now offers a patient portal. This is an online portal protected by user name and password that includes but is not limited to scheduling appointments, printing vaccine records, and requesting prescription refills/referrals. The portal can give you an inside look to your child's medical records, medications, and correspondence with practice.

Scheduling Well Child Care

Our schedule is usually available for the next three months. We encourage parents of infants to schedule their next well child check up at the end of each visit. In an event where this was not done, we suggest you call 4 weeks ahead of the time you wish to be seen for the next well child appointment. We recommend the scheduling of children 5 years & older for their (school, camp, sports, etc.) physicals early in the summer. Please allow 6 weeks for scheduling WCC's during this time. This will help to ensure your child's physical is completed by any needed deadlines and prevent your child from missing important school time. Evaluating growth and development at regular intervals is very important in maintaining your child's health. We recommend scheduling well child checks at the following interval or as directed by your insurance:
1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months (as directed by insurance), yearly age 2 and over.

Scheduling Sick Child Care

You must call the office to schedule these appointments. We now offer "walk in" appointments Monday- Friday, 8 am- 7 pm **at our Chambersburg Keystone Pediatrics location**, except major holidays. Acute appointments are based on a first call, first serve & medical necessity basis.

We are committed to providing you with the highest level of patient satisfaction possible. We value our relationships with our patients. If for any reason you have questions, comments or concerns, please do not hesitate to bring it to our attention. We especially value patient feedback. We want this to be a positive and rewarding experience for you and your children.

Sincerely,

Keystone Pediatrics Staff

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NO-SHOW/LATE ARRIVAL AGREEMENT

Welcome to Keystone Pediatrics. We are eager to offer our services to you for your child's health care needs. In order to receive the necessary standard of care and have your family remain patients in our practice, we ask that you agree to the following:

1. It is your responsibility to keep all scheduled appointments made for your child.
2. If you cannot keep an appointment, it is your responsibility to call and cancel at least 24 hours before the scheduled appointment. Please be sure you call to cancel as soon as you are able, even for same day appointments. That courtesy will allow Keystone Pediatrics the opportunity to offer that time to another patient. To cancel and reschedule appointments with the provider, please call 717-709-7950 and choose option 1 to reach the scheduling desk.
3. It is your responsibility to arrive on time for your child's appointment. If you arrive after your scheduled appointment time, your child's appointment may be rescheduled. If you arrive late for your child's appointment and are not able to be seen, it will count as a "no-show".
4. Keystone Pediatrics has the right to discharge a patient from the practice if within a six month period any three appointments are not canceled within at least a 24 hour notice or are missed. We do understand, however, that there may be unforeseen circumstances that would prevent timely cancellation of appointments. If that occurs, please discuss that with us as soon as possible.

Thank you for your cooperation and attention to this important matter, since keeping your child's scheduled appointments is essential to their health care.

Sincerely,

Keystone Pediatrics

Keystone Health Vaccine Schedule

	Birth	2mo	4mo	6mo	12mo	15mo	18mo	4-6yr	10yr	11yr	16-18yr
Hep B	X										
Pediarix		X	X	X							
Prevnar		X	X	X	X						
Rotavirus		X	X								
Dtap						X					
Hib		X	X			X					
Kinrix								X			
Hep A					X		X				
MMR					X						
Varicella					X						
Meningococcal										X	X
Tdap										X	
HPV *for boys and girls*									X (Ages 9-26)	X	X (will only need 3rd dose if started after age 15)
MMR-V								X			
Men B											X

Pediarix- Dtap, IPV, and Hep B
Kinrix- Dtap and IPV
MMR-V- MMR and Varicella

Updated 2/2020

Keystone Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some forms of the influenza vaccine, does not cause autism or other developmental disabilities.
- We firmly 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/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians. Trusted information can be obtained here: http://vec.chop.edu/service/vaccine-education-center/home.html

PATIENT REGISTRATION

Patient Information

Name: _____
First *Middle* *Last*

Address: _____

Social Security Number: _____Home phone: (____)_____ Cell Phone: (____)_____

Date of Birth: _____ Marital Status: _____ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information (Complete this section for a patient less than 18 years old)

Mother's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Father's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

_____/_____
Address *Phone*

Person Responsible for Payment (Complete this section for a patient less than 18 years old)

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____Telephone:_____

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone :_____(you will receive a text message)

E-mail:_____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This Permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

(Patient's 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

7/30/18 ksw

PERMISSION FOR TREATMENT OF
CHILDREN

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____

Name of Parent/Legal Guardian: _____

If I can't bring my child to a medical/behavioral health or dental appointment, I give permission for the person(s) listed below to go with my child to visits at Keystone Health Center. He/she can also approve treatment for my child during the visit, including shots and minor dental and medical procedures.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Please Note: Sometimes, the provider may decide that a parent must be present for certain dental procedures: Extractions, Root Canal's, Surgical procedures, Nitrous visits and Operating Room visits.

This permission remains in effect until revoked in writing.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

_____
Staff Initials

7/30/18 ksw

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:
□ **White/Caucasian** □ **Black/African American** □ **Asian** □ **American Indian**
□ **Native Hawaiian** □ **Other Pacific Islander** □ **Multi-racial**

Ethnicity- relates to nationality and culture:
□ **Latino/Hispanic** □ **Non Latino**

Do you live in public housing:
□ **Yes** □ **No**

Family Size	**Annual Family Income**		
1	☐ $12,140 and below	☐ $18,210 and below	☐ $24,280 and below
	☐ $24,281 and above		
2	☐ $16,460 and below	☐ $24,690 and below	☐ $32,920 and below
	☐ $32,921 and above		
3	☐ $20,780 and below	☐ $31,170 and below	☐ $41,560 and below
	☐ $41,561 and above		
4	☐ $25,100 and below	☐ $37,650 and below	☐ $50,200 and below
	☐ $50,201 and above		
5	☐ $29,420 and below	☐ $44,130 and below	☐ $58,840 and below
	☐ $58,841 and above		
6	☐ $33,740 and below	☐ $50,610 and below	☐ $67,480 and below
	☐ $67,481 and above		
7	☐ $38,060 and below	☐ $57,090 and below	☐ $76,120 and below
	☐ $76,121 and above		
8	☐ $42,380 and below	☐ $63,570 and below	☐ $84,760 and below
	☐ $84,761 and above		
9	☐ $46,700 and below	☐ $70,050 and below	☐ $93,400 and below
	☐ $93,401 and above		
10	☐ $51,020 and below	☐ $76,530 and below	☐ $102,040 and below
	☐ $102,041 and above		

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