Carolina Pediatrics Plus

Date_____

Pediatric Patient Registration

First Name_____ Middle Initial_____ Last Name_____

DOB_____ Gender (circle one): Male / Female SS#_____

Race (circle one): Native Hawaiian/Other Pacific Islander American Indian/Alaska Native Asian White Black/African American

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino

Address_____

City_____ ZIP_____

Primary phone _____ Secondary phone _____

Email: _____ Child lives with: Mother / Father / Other: _____

Who is financially responsible for medical services? Mother / Father / Other: _____

Mother/Guardian Information Male / Female **Father/Guardian Information** Male / Female

Name _____ Name _____

DOB_____ SS# _____ DOB_____ SS# _____

Primary phone _____ Primary phone _____

Insurance Information

Primary _____ Secondary _____

Policy ID# _____ Policy ID_____

Group_____ Group _____

Policy holder's name_____ Policy holder's name_____

Policy holder's DOB _____ Policy holder's DOB_____

Policy holder's SS# _____ Policy holder's SS# _____

I authorize my insurance benefits to be paid directly to Carolina Pediatrics Plus's providers, realizing that I am responsible to pay non-covered services, and I also authorize the release of pertinent medical information to insurance carriers. This authorization shall be valid unless rescinded in writing.

Parent/Guardian signature_____ Date _____

Does your child have any **allergies** to food, medications, insects, other? IF yes, give name and reaction. Include vaccine reactions. _____

Please list persons <u>(other than those above)</u> who are allowed to authorize medical treatment and immunizations in your absence. Attach additional paper if necessary.

_____ Phone#_____ Relationship_____

_____ Phone#_____ Relationship_____

Date_____

Pharmacy Information

Name of Pharmacy _____ Phone _____

Address / Street _____

Medical Records

If you need a copy of your child's medical records from our office, you will have to fill out a Release of Information form. There will be a fee of $15 for medical records per child. It may take up to 24-48 hours per child to process copies of medical records.

If you request a copy of your child's medical records, they can only be delivered by fax or be picked up from the office. Once you order a copy of your medical records, you have **30 days** from time of notification that they are ready, to pick up your child's records or you will pay an added fee.

I understand it is my responsibility to obtain my child's medical records as needed. I recognize that obtaining patient records may take up to 24-48 hours per child to process. I understand there may be a fee for obtaining copies of my child's medical records of up to $15 per child.

Patient Name (PRINT) _____ DOB _____

Parent/Guardian Signature _____ Date _____

Whom may we thank for referring you? _____

Healow Patient Portal

Carolina Pediatrics Plus has switched over to a new patient portal. With our new patient portal, you will have access to the following:

- Appointment Reminders – Email, Voice, and Text
- View Lab Results
- Health Maintenance
- Request Refills
- Receive Practice Notifications
- Provider Messaging

If you would like to participate in the new patient portal, please provide the following information:

Child's name_____ DOB _____

Email Address _____ Relationship _____

Phone Number _____

Can we leave voice messages at this number? Yes / No Can we send text messages to this number? Yes / No

Please check at least one:

_____ I DO authorize Carolina Pediatrics Plus to sign my child up for Healow Patient Portal.

_____ I DO NOT authorize Carolina Pediatrics Plus to allow my child to participate

Parent/Guardian signature_____ Date _____

Carolina Pediatrics Plus

Date_____

Patient History

Child's Name _____ DOB _____ Age _____ Male _____ Female _____

Mother's Maiden Name_____ Date of Last WELL EXAM: _____

Family History

Please list all people living in child's home: Name / Age / Relationship to Child / Health Problems

_____

_____

_____

_____

_____

_____

Are child's parents: ___married ___unmarried ___separated ___divorced

Father's Occupation _____

Mother's Occupation _____

Childcare: Who? _____ Hours per Day? _____

Please circle any illnesses that run in <u>mother</u> and <u>father</u>'s families: allergies anemia asthma diabetes seizures or epilepsy deafness birth defects bleeding disorder drug/alcohol abuse high cholesterol heart disease (before 50 years old) kidney disease migraine headaches high blood pressure SIDS

Pregnancy and Birth

Mother's age at birth _____ Did mother take any medications? If yes, what? _____

Was delivery difficult? _____ Vaginal or C-section? If C-section, why? _____

How many weeks gestation? _____ Birth weight _____

Did mother have any illnesses during pregnancy? (If yes, what) _____

List any problems during newborn hospital stay? _____

Was your child breastfed? _____ If yes, how long? _____

Medical History

Do you consider your child to be in good health? If not, why? _____

Does your child take any regular medications? _____ If yes, what are they? _____

_____

Allergic reactions to foods, medications, insects, other? If yes, give name and reaction. _____

_____

Has your child been hospitalized or had surgery? If yes, why and when? _____

_____

Any serious reactions to immunizations? If yes, which ones? _____

Date_____

Please circle any illnesses your child has or has ever had any of the following: allergies asthma eczema anemia frequent ear infections frequent strep throat difficulty hearing vision problems heart problems heart murmur urinary tract infections diabetes bleeding problems constipation seizures headaches growth problems Other _____

Development

At what age did your child: sit alone_____ walk alone _____ toilet train _____

Did your child have any words by 18 months? If so, about how many? _____

Do you have concerns about attention span or activity level? _____

Has your child failed or repeated a grade in school? _____

Has your child required tutoring outside of the classroom or placement in a special or resource class? _____

Safety/Environment

Do you live in a: private home _____ apartment _____ mobile home _____

Is there a working smoke alarm on each floor of the house? _____

Does your child always use a car seat/belt? _____

Does your child always wear a helmet when skating or bicycling? _____

Any concerns about lead exposure? (Old home/peeling paint) _____

Is the child exposed to smokers? _____ If so, who? _____

Any pets in the home? _____ If yes, what kind? _____

Any guns in the home? _____ If yes, are they securely locked? _____

What is your primary drinking water? Well _____ City _____ Bottled _____

Date_____

Carolina Pediatrics Plus

FINANCIAL POLICY AND OFFICE FEES

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH COMPLETE INSURANCE INFORMATION INCLUDING SUBSCRIBER'S NAME, DOB, ADDRESS, AND SS#. YOU MUST INFORM US OF ANY CHANGES THROUGHOUT THE YEAR. IF WE ARE UNABLE TO FILE CLAIMS, YOU WILL BE HELD RESPONSIBLE FOR THE COST OF YOUR VISIT.

1. All new patients must complete ALL the patient forms in their entirety prior to being reviewed. Established patients must provide the office with any insurance changes prior to being seen.
2. Your insurance card should be available at each visit. All insurances require that we have a copy of your insurance card on file.
3. Medicaid patients must present their card at each visit. Those who cannot provide a card may be required to pay for the visit or reschedule.
4. For newborn patients, you have 30 days from the time the child is born to provide insurance information. If unable to do so you can reschedule your next appointment until insurance is processed or you can pay for your visits out of pocket.
5. Please be aware of your insurance benefits. Your insurance is a contract between you and the insurance carrier. It is your responsibility to know your insurance company's provision for payment of office visit, well-child visits, immunizations, co-payments, and deductibles.
6. Co-pays and co-insurance amounts are expected at check in, if you are unable to pay, you will be rescheduled.
7. We accept cash, checks, and Visa and Mastercard. You may also make payments by credit card over the phone.
8. Returned check fee is $25 and future payments will have to be made by cash, money order or credit card.
9. A medical record copying fee of $15 per child will be charged for all medical records requests.
10. A fee of $5 per form applies to physical forms, asthma and allergy forms, and vaccine records; FMLA forms $20; medical letters $15.

*****For billing questions, please call our billing service at 1-866-258-3517*****

TELEPHONE CONSUMER PROTECTION

In order for us to service your account, notify you of an appointment, or collect any amounts you owe, we may contact you by phone at any of the phone numbers associated with your account, including wireless, which could result in charges to you. Please update your phone numbers with us if any changes occur. We may also leave voice messages on these lines. ***If you do not want us to leave voice messages, please initial here***_____

NO SHOW POLICY ACKNOWLEDGEMENT

Carolina Pediatrics Plus has a no-show policy. A fee of $25 will be charged for any appointment missed. After 3 missed appointments your child may be dismissed from the practice.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY, NO SHOW POLICY, AND TELEPHONE POLICY AND DO HEREBY AGREE TO THE TERMS LISTED ABOVE.

Patient Name (PRINT) _____ DOB _____

Parent/Guardian Signature _____ Date _____

Date_____

NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to

- Conduct, plan, and direct your child's treatment and follow-up among multiple health care providers who may be involved in your child's care both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments, training, and physician certifications.
- Facilitate community based specialized health care available in the school system by various disciplines.

Signed acknowledgement:

I have received, read, and understand Carolina Pediatrics Plus's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I also understand that I may obtain a copy of the Notice of Privacy Practice at any time at my request. I understand that I may restrict how my child's private information is used or disclosed to carry out treatment, payment, or other health care operations. This request should be made in writing. I also understand that Carolina Pediatrics Plus is not required to agree with restrictions if it impedes quality care. If Carolina Pediatrics Plus does not agree, I will be informed, otherwise Carolina Pediatrics Plus is bound to abide by such restrictions.

Patient Name _____ DOB _____

Parent/Guardian/Patient Signature _____ Date _____

Relationship to Patient _____

OFFICE USE ONLY
I attempted to obtain the parent's signature in acknowledgement of this *Notice of Privacy Practice*, but was unable to do so as documented below:
Signature and Date:
Reason:

Date_____

Office Policies

Zero Tolerance Policy

Carolina Pediatric Plus is committed to providing a safe, secure, and respectful environment for all patients and staff. Words or actions that make others feel threatened or demeaned will not be tolerated and decisive action will be taken to protect patients and staff. Our office considers the use of inappropriate words, actions, or inactions as disruptive behavior. Immediate action will be taken when incidents described above occur. Individual(s) may be asked to leave, the police may be called, or the individual(s) may face dismissal from our office.

- Inappropriate actions or inactions include:
    - violence (physical attacks or threats of harm)
    - intimidation
    - throwing or damaging property
    - unwelcomed physical contact
    - failure to observe office policies
    - stealing
    - refusing to leave the property

- Inappropriate words (in person, by phone, or any means of communication include:
    - abusive language and yelling
    - disrespectful or demeaning language/comments
    - remarks, jokes or innuendos that degrade, ridicule or offend
    - discriminatory remarks
    - threats or threatening behavior
    - bullying
    - sexual harassment

Running Late to Your Appointment

We understand that life happens. We offer a 15-minute grace period after your appointment time to make it to your scheduled visit. You may be asked to reschedule your child's appointment if you do not arrive on time or within this window. If you cannot make your appointment time, please call our office to either let us know you are running late or to reschedule for a later date.

Annual Well Child Appointments

Due to insurance requirements, we are required to perform annual well child checks. As a patient at our office, you are responsible for maintaining your child's annual well check appointments.

I HAVE READ AND UNDERSTAND CAROLINA PEDIATRICS PLUS'S OFFICE POLICIES AND DO HEREBY AGREE TO THE TERMS LISTED ABOVE.

Patient Name (PRINT) _____ DOB _____

Parent/Guardian Signature _____ Date _____

Date_____

Carolina Pediatrics Plus
538 Sandhurst Dr.
Fayetteville, NC 28304
Phone: (910) 321-7337
Fax: (910) 321-0003

Patient Name: _____ DOB: _____

Phone: _____ Relationship to Patient: _____

_____ I authorize Carolina Pediatric to **obtain information from:**

Name/Facility/Provider: _____

Address: _____

Phone: _____ Fax: _____

_____ I authorize Carolina Pediatric to **release information to:**

Name/Facility/Provider: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure: ___ Transfer of Care ___ Legal ___ Specialist ___ Other: _____

Information to be Disclosed:

___ Specific Time Frame: _____ ___ Other: _____

___ Entire Medical Record ___ Well Checks and Shot Records only

****PLEASE NOTE THAT OUT OFFICE IS UNABLE TO PROCESS MEDICAL RECORDS FROM CD. WE ARE ONLY ABLE TO ACCEPT MAILED OR FAXED RECORDS****

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided on this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed
- The information may contain testing or treatment relating to sexually transmitted diseases.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

_____ I understand that this authorization stays in effect for 1 year from the date of my signature below and that a photocopy of this authorization is granted at the same authority as the original.

OR

_____ I understand that this authorization is valid until ___/___/_____ or until the following event: _____

Patient/ Legal Representative (PRINT): _____ Date: _____

Signature: _____ Relationship to Patient: _____