Registration Information

Wakefield Pediatric & Adolescent Medicine, P.A.

Comprehensive Healthcare for Infants, Children & Adolescents

Date: _____ (Please Print Legibly)

Patient's Name: _____ Age: _____
Last First Middle Initial

Sex: □M □F Date of Birth:_____ Social Security:_____ Nationality_____

Street Address: _____City:_____ State:____ Zip Code:_____

Home Phone:(____)-_____ Email: _____ Appt. Notification: □Text □Voice □Email

Who is responsible for the account? _____ Relationship: _____

Mailing Address:_____

Home #:_____Cell#:_____Work #:_____

Do you have medical insurance? □No □Yes

Primary Insurance Name: _____Policy Holder Name:_____

Subscriber/ID #:_____ Group #: _____

Do you have secondary insurance: YES____NO____If yes: Secondary Insurance Name:_____

Subscriber/ID #:_____Group #: _____. Please provide copy of card/s.

Father's/Legal Guardian Information	Mother's/Legal Guardian Information
Name: _____ Last First Middle Initial	Name: _____ Last First Middle Initial
Birthdate: _____ Social Security: _____	Birthdate: _____ Social Security: _____
Occupation: _____ Work Phone #: _____	Occupation: _____ Work Phone #: _____
Employer's Name: _____	Employer's Name: _____
Education: _____	Education: _____
Health Status: _____	Health Status: _____

Marital Status: □Single □Married □Separated □Divorced Single Parent: □No □Yes

Legal Guardian's Name:_____ SS#:_____ DOB:_____

Siblings:	Full Name:	M/F	Birthdate	Social Security
1.				
2.				
3.				
4.				

Who referred you? _____

Emergency Contact: _____ Relationship:_____

Home Phone #: (____)_____Cell Phone#: (____)_____Work#:(____)_____

We request that charges for office visits including prior balances, missed appt fees, copays be paid at time of service.

ACKNOWLEDGEMENT OF FINANCIAL POLICY: I hereby acknowledge that I have reviewed WPAM, PA office financial policy. I understand and agree that such terms may be amended by the practice from time to time.

Signature: _____ Date:_____

Print name: _____Relationship to Patient:_____

Birth History

When was the baby born? □On time □Early □ Late Indicate Age of Gestation: _____weeks APGARS:_____

Who delivered the baby? □Midwife □Doctor □Others:_____

Place of Birth: _____ Type of Delivery: □Vaginal Delivery □ C Section □Other:_____

Were there any complications with pregnancy? □No □Yes_____

Were there any complications with delivery? □No □Yes_____

At birth, what was your baby's: Weight:_____ Length:_____ Head Circumference:_____

What type of feeding? □Breastfeeding □Formula □Mixed

Family History:

Has anyone in your child's family had:

Please Indicate Yes (Y) or No (N) Below

Y / N	Illness	Relationship	Y / N	Illness	Relationship	Y/ N	Illness	Relationship
	Asthma			Mental Illness			Stroke	
	Allergic Disorder (Hay Fever, Eczema)			Heart attack at age less than 60			Thyroid Problems	
	High Blood Pressure			Kidney Problems			Sickle Cell Anemia/ Disease	
	Diabetes			Cancer			Migraine	
	Seizures			Cystic Fibrosis			Tuberculosis	

□No □Yes Other Illnesses? _____ Relationship_____

Past Medical/Surgical History:

Allergies to Medicine? □No □Yes_____

Does your child have any current medical conditions? □No □Yes_____

_____

Any Medications? □No □Yes_____

Has your child had any hospitalizations/surgical procedures? □No □Yes If yes, please list dates/facilities:

_____

_____

Social History:

Any smokers? Y/N Who? _____ Drugs? Y/N Who?_____

Alcohol use? Y/N Social Drinking_____ Dependency_____ Rehab_____

Travel History:

Any recent travel outside the US? Y/N Where? _____ How Long? _____

Any pets? _____

Education:

School Problems? □No □Yes Promoted: □No □Yes

Name of School: _____ Grade Level:_____

Completed by:_____ Relationship to patient:_____ Date: _____

Reviewed by: _____ Updated: _____ _____ _____ _____

FINANCIAL AGREEMENT

We are dedicated to provide the best possible medical care. We believe that part of good health care practice is to establish and communicate our financial policy.

- Please present your current health insurance card and valid ID at each office visit.
- If you do not have insurance, you will be self pay and payment in full is required at the time of service.
- Newborns should be added to the insurance plan before the date of service.
- Co-pays, co-insurances, and unmet deductibles must be paid at the time of service.
- As a courtesy we will file your insurance claims but prior to services being rendered **you are ultimately responsible for verifying your insurance whether our physician and/or services rendered will be covered by your plan.** We will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. However, some insurance carriers do not reimburse for certain procedures and/or diagnosis. In the event a claim is filed and denied for charges not covered, you are ultimately responsible for all denied charges.
- You will be held responsible for payment in full regardless of any insurance company's arbitrary determination of rates unless we have a contractual agreement with that company to write off disallowed amounts.
- If the insurance company fails to pay, or does not pay within sixty (60) days of the service being rendered, the balance in full will become the responsibility of the guarantor.
- **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.
- You will need to reschedule your appointment if co-pay is not paid at check-in.
- Check payments more than $25 will be processed electronically and it will be debited from your bank account immediately.
- Returned check fee for (NSF) non-sufficient funds is $25.00. You must pay for the NSF check and NSF fee within 10 days of notice.
- When an account remains unpaid after 90 days we reserve the right to refer the account to an outside collection agency. If your account is sent to a collection agency you may be asked to find another provider.
- Wakefield Pediatrics also reserves the right to reschedule or deny future appointments for delinquent accounts.
- **DIVORCED PARENTS of PATIENTS:** In the case of separated or divorced parents, the parent/legal guardian who brings the minor in for treatment accepts responsibility for payment. The office does not promise to send bills to the other parent for issues of payment or communication. We will communicate about the treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issue.
- We require 24 hour notice to cancel or reschedule an appointment. Failure to give proper notice for cancellation or reschedule may result in a $20.00 charge for missed appointment. Your family may be discharged from the practice if your child missed three appointments.
- **FORMS FEES**: completing forms, letter, and written communication by the doctor/staff requires office staff time and time away from patient care for our doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence please allow 5 business days for your request, if needed less than 5 days additional $5.00 will be charged.
- **MEDICAL RECORDS FEES**: Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.25 per page in excess of twenty. Pre-payment is required. Please allow 7 business days for processing , these 7days will commence after payment for copying has been received and form authorizing records' release has been signed.
- I have read and understand the practice's financial policy and I agree to be bound by its terms.
- I also understand and agree that such terms may be amended by the practice from time to time.

I hereby authorize my insurance company to pay Wakefield Pediatric & Adolescent Medicine, PA. directly. I do hereby consent and authorize the performance of all examinations, treatments, and medical services by Wakefield Pediatrics and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.

Wakefield Pediatric & Adolescent Medicine, P.A.

Patient's Name: _____ Date of Birth: _____

Print your Name: _____ Relationship to Patient: _____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand Wakefield Pediatric & Adolescent Medicine P.A.'s Notice of Privacy Practices for Protected Health Information. I authorize the release of information for medical treatment and consultation as well as release of information to my child's insurance company necessary for billing and processing of claims.

  I acknowledge that I was provided with the Notice of Privacy Practices of Wakefield Pediatric & Adolescent Medicine, P.A.

Signed _____ Date: _____

- I hereby assign my child's insurance benefits to be paid directly to the healthcare provider. I authorize and direct my child's insurance carrier(s) including Medicaid (assigned charges), to pay directly to Wakefield Pediatric & Adolescent Medicine, P.A. any benefits due under my child's insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.

Signed _____ Date: _____

- I have read and understand the Financial Policy for WAKEFIELD PEDIATRIC & ADOLESCENT MEDICINE PA

Signed _____ Date: _____

- I authorize WAKEFIELD PEDIATRIC & ADOLESCENT MEDICINE PA to obtain/have access to my child's medication history

Signed _____ Date: _____

FOR OFFICE USE ONLY

Patient ID/ Chart Number: _____

Signature of Staff: _____

Date: _____

Wakefield Pediatric & Adolescent Medicine, P.A.

PATIENT CENTERED MEDICAL HOME (PCMH)

PATIENT/PROVIDER AGREEMENT
ACUERDO DE PACIENTE/PROVEEDOR

Good communication between patients and physicians is the key to better outcomes. Our staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.
La buena comunicación entre los pacientes y los médicos es la clave para obtener mejores resultados. Nuestro personal y yo nos comprometemos a brindarle atención médica de la más alta calidad. Esto se puede lograr mejor mediante una comprensión clara de nuestras responsabilidades para con usted, y sus derechos y responsabilidades como paciente en nuestra práctica.

Our Responsibilities to You:
Nuestras Responsabilidades Hacia Usted:

- ***Respect you as an individual*- we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.**
  Respetarte como un individuo- No emitiremos juicios basados en raza, etnia, origen nacional, religión, género, edad, discapacidad mental o física, orientación sexual o información genética.
- ***Respect your privacy*- your medical information will not be shared with anyone else unless you give permission or as required by law**
  Respetar su privacidad- su información médica no será compartida con nadie más a menos que usted lo autorice o lo exija la ley
- ***Provide the best possible treatment and advice based on current medical evidence***
  Brindar el mejor tratamiento y asesoramiento posible en base a la evidencia médica actual
- ***Manage your health status*- including well child/person preventive care as well as treatment for acute and chronic diseases and self-management support**
  Administrar su estado de salud- incluido el cuidado preventivo para niños y personas sanas, así como el tratamiento de enfermedades agudas y crónicas y el apoyo de autocontrol
- ***Provide you timely access to care* in our practice, as well as facilitate timely access to specialists, diagnostic services, behavioral healthcare, and other services if needed**
  Proporcionarle acceso oportuno a la atención en nuestra práctica, así como facilitar el acceso oportuno a especialistas, servicios de diagnóstico, atención de la salud del comportamiento y otros servicios si es necesario
- ***Provide culturally and linguistically appropriate services*- we offer bilingual services and printed materials to meet the language needs of our population**
  Proporcionar servicios cultural y lingüísticamente apropiados- ofrecemos servicios bilingües y materiales impresos para satisfacer las necesidades lingüísticas de nuestra población.

What we ask of you:
Lo que pedimos de usted:

- **Ask questions, share your feelings and be part of your care**
  Haga preguntas, comparta sus sentimientos y sea parte de su cuidado
- **Be honest about the history, symptoms and other important information about you/your child's health**
  Sea honesto acerca de la historia, los síntomas y otra información importante sobre la salud de usted/su hijo
- **Tell the practitioner about any changes in the health and well-being of you/your child**
  Informe al profesional sobre cualquier cambio en la salud y el bienestar de usted/su hijo
- **Give your child's/take your medications as ordered and follow your practitioner's advice; if you are unwilling or unable to do so, be honest with the practitioner**
  Dele a su hijo o tome sus medicamentos según lo ordenado y siga los consejos de su médico; si no está dispuesto o no puede hacerlo, sea honesto con el médico
- **Make healthy decisions about you/your child's daily habits and lifestyle**
  Tome decisiones saludables sobre los hábitos diarios y el estilo de vida de usted / su hijo

- **Prepare for and keep scheduled visits or reschedule visits in advance whenever possible**
  Prepárese y mantenga las visitas programadas o reprograme las visitas con anticipación siempre que sea posible
- **Call your doctor first with all problems, unless there is a medical emergency**
  Llame a su médico primero con todos los problemas, a menos que haya una emergencia médica
- **End every visit with a clear understanding of the practitioner's expectations, treatment goals, and future plans**
  Termine cada visita con una comprensión clara de las expectativas del médico, los objetivos del tratamiento y los planes futuros

PLEASE NOTE: **Our office is open Monday 8am to 5pm, Tuesday to Thursday 9am to 5pm, and Friday 9am to 12nn.**
POR FAVOR NOTE: Nuestra oficina está abierta Lunes 8am a 5pm, Martes a Jueves 9am a 5pm, y Viernes 9am a las 12 del mediodía.
When the office is closed, please contact us by calling (919)570-7010; we have an answering machine that will inform the physician on call to address medical issues, which cannot wait until regular office hours.
Cuando la oficina esté cerrada, por favor contactenos al (919)570-7010; contamos con un contestador automático que informará al médico de guardia para atender los problemas médicos que no pueden esperar hasta el horario habitual de oficina.
It is important that you keep all scheduled appointments and notify us sufficiently in advance if you need to cancel or reschedule appointments.
Es importante que cumpla con todas las citas programadas y nos notifique con suficiente antelación si necesita cancelar o reprogramar citas.
Urgent or Emergent Care: Please attempt to call the office first before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.
Atención Urgente o de Emergencia: Por favor intente llamar a la oficina antes de acudir a un centro de atención urgente fuera del horario de atención o a una sala de emergencias, a menos que considere que tiene un problema grave que requiere atención médica inmediata.
Transferring Records: Please have all records transferred to our office by fax (919)570-7020 or mail to Wakefield Pediatrics 11081 Forest Pines Dr Suite 122 Raleigh NC 27614 Attention to: Medical Records.
Transferencia de registros: Haga que todos los registros se transfieran a nuestra oficina por fax (919) 570-7020 o por correo a Wakefield Pediatrics 11081 Forest Pines Dr Suite 122 Raleigh NC 27614 Atención a: Registros Médicos.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but it is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.
Al firmar a continuación, usted indica que ha leído este documento y que desea unirse a nuestro hogar médico y hacer todo lo posible para cumplir con las declaraciones mencionadas anteriormente. Este no es un contrato legalmente vinculante, pero tiene la intención de proporcionar un marco sobre el cual podamos construir una relación que le permita maximizar su estado de salud en un ambiente cómodo y acogedor.

_____	_____	_____
Patient Name/Nombre del Paciente	**DOB**/Fecha de Nacimiento	**Parent or Guardian Signature**/Firma del Padre o Tutor

_____	_____
Physician or Representative Signature/Firma del Doctor o Representante	**Date**/Fecha

Wakefield Pediatric & Adolescent Medicine, P.A.

PATIENT PORTAL USER AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, Athena Health for the exclusive use of established patients. The Patient Portal is designed to enhance patient-physician communication. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:

- Request appointments
- Request prescription refills
- View your medical history
- View and pay your bills online
- Send messages to clinical staff

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also to apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is SEEN by the physician.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.
- No requests for narcotic/ controlled medications will be accepted.
- No request for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 24 to 48 hours to receive a response to an email request. If you do not receive a response within 48 hours you should contact the office at 919-570-7010.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.
- Do not allow anyone else to have access to your username and password.
- Advise us of any changes in your primary contact, email address.
- Always follow up your inquiry in person or over the phone if a portal inquiry is not responded to within a reasonable time.

The patient portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persist, we reserve the right , at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein.

I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications.

_____

Patient Signature Date

_____

Secure/Private Email

Wakefield Pediatric & Adolescent Medicine, P.A.

GENERAL CONSENT TO TREATMENT

Patient's Name: _____

Date of Birth: _____

I _____, am the parent or legal guardian duly authorized to give consent on behalf of the patient listed above. I understand that by signing below, I am providing a general consent for the patient listed above to receive health care services from Wakefield Pediatric & Adolescent Medicine, P.A. I understand that I may revoke this general consent at any time. The consent will remain in full force and effect until it is revoked.

I further acknowledge that Wakefield Pediatric & Adolescent Medicine, P.A may request that I review and execute additional informed consent documents prior to the above-named patient receiving certain treatment or undergoing certain procedures. Prior to signing an additional informed consent document, Wakefield Pediatric & Adolescent Medicine, P.A will provide me with all information that is material to deciding whether to consent to the recommended procedure or treatment for the above-named patient. Such information will include, but not limited to: 1) the nature of the recommended treatment; 2) the risks, complications, and expected benefits of the recommended treatment including, but not limited to, the likelihood of success; and 3) any alternatives to the recommended treatment, and the risks and benefits to the alternative treatments.

I have read the above and hereby generally consent to the above-named patient receiving health care services from Wakefield Pediatric & Adolescent Medicine, P.A.

_____

Parent/Guardian Date

_____

Print Name Date