Carolina Pediatric Group

FINANCIAL POLICY

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 of 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 are required to present their card at each visit. Those who cannot provide a card may be required to pay for the visit or reschedule.
4. 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.
5. Co-pays and co-insurance amounts are expected at check in, if you are unable to pay, you will be rescheduled.
6. We accept cash, checks, and Visa and Mastercard. You may also make payments by credit card over the phone.
7. Returned check fee is $25 and future payments will have to be made by cash, money order or credit card.
8. A medical record copying fee of $15 per child will be charged for all medical records requests.
9. A fee of $5 per form applies to physical forms, asthma and allergy forms, and vaccine records; FMLA forms $15 ; medical letters $10

*****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 messages, please initial here_____.

NO SHOW POLICY
ACKNOWLEDGEMENT

Carolina Pediatric Group 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.

Parent /Guardian
signature_____(date)

Patient_____

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 Pediatric Group'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 Pediatric Group is not required to agree with restrictions if it impedes quality care. If Carolina Pediatric Group does not agree, I will be informed, otherwise Carolina Pediatric Group is bound to abide by such restrictions.

Patient Name_____

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_____

Carolina Pediatric Group Patient Registration

Child's name_____ DOB_____ M / F SS#_____

Address_____ City_____ZIP_____
Primary phone number_____ __Other phone contact_____
Child lives with:_____
Who is responsible for payment of medical services?_____
May we leave detailed messages on your voice mail? Yes No @ Phone number_____
Email address_____ May we send you information via email? Yes No

Mother/Guardian Information

Name_____
DOB_____ SS#_____
Primary phone_____ land/cell
Occupation and work phone_____

Father/Guardian Information

Name_____
DOB_____ SS# _____
Primary phone_____ land/cell
Occupation and phone_____

*If either parent/guardian is active duty military, please provide the following:
Unit_____ CO_____ Unit phone_____

Insurance Information

Primary_____
Policy ID#_____ Group_____
Claims address_____
Phone number_____
Policy holder's name_____
Policy holder's DOB _____
Policy holder's SS#_____

Secondary_____
Policy ID#_____ Group_____
Claims address:_____
Phone number_____
Policy holder's name_____
Policy holder's DOB_____
Policy holder's SS#_____

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

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

_____ Phone#_____relationship_____

_____ Phone# _____ relationship_____

I authorize my insurance benefits to be paid directly to Carolina Pediatric Group'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) _____

Whom may we thank for referring you?_____