KidzCare PEDIATRICS

Accessible, Affordable, Quality Care
@ Patient Centered Medical Home

Location_____

PATIENT REGISTRATION

Child :*Last Name:* _____ *First Name:*_____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy *Holder's SSN:* _____

Insurance Carrier: _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy *Holder's SSN:* _____

Insurance Carrier: _____

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____*Email Address:* _____

Who lives at this household?

_____

Contact 1:*Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No

Date of Birth: ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

5617 Ramsey Street Suite 102 Fayetteville NC 28311
Tel: 910-483-PEDS (7337) Fax: 910-483-0648
www.kidzcare.com
info@kidzcarepediatrics.com

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Contact 2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Social Security #: ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If parents are divorced or separated please fill out this section:

Who has custody?

_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical
treatment for the child or from obtaining information about the child's medical treatment?
Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____/_____ *Phone*: (____) _____ - _____

2: _____/_____ *Phone*: (____) _____ - _____

Pharmacy Information: What pharmacy do you routinely use so we may process prescription and prescription refills?

_____

_____ _____

Signature of Parent/Legal Representative **Date**

_____ _____

State relationship if other than parent **Signature of Witness**

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INSURANCE POLICY

1.All insurance recipients must present their current insurance card at the time of service. If you do not have your insurance card you will be considered a self-pay patient.
2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.
3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes in your insurance coverage or change of insurance of carriers.

This is to certify that I (we) the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.
I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates. If for any reason I fail to meet my financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates, to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by **KIDZCARE PEDIATRICS, PC** in order to carry out treatment, payment, or health care operations. I understand that I should review **KIDZCARE PEDIATRICS, PC** Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.
KIDZCARE PEDIATRICS, PC reserves for itself the right to change the term of its Notice of Privacy Practices for Protected Health information at any time. If **KIDZCARE PEDIATRICS, PC** does change the terms of Notice of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.
I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. **KIDZCARE PEDIATRICS, PC** is not required to agree to such requested restriction(s); however, if **KIDZCARE PEDIATRICS, PC** does agree to my requested restriction(s), such restriction(s) are then binding on **KIDZCARE PEDIATRICS, PC.**
At all time, I retain the right to revoke this consent in writing, to **KIDZCARE PEDIATRICS, PC** except to the extent that action has already been taken.
KIDZCARE PEDIATRICS, PC may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, **KIDZCARE PEDIATRICS, PC**

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has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals).

I fully understand and have read the ***INSURANCE POLICY*** and the ***CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS*** and agree to abide by these policies.

_____ _____

Signature of parent/legal representative **Date:**

_____ _____

State relationship if other than parent **Signature of Witness**

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RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

OFFICE POLICIES & PROCEDURES

Effective January 1, 2013 the following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and identification (DL, state ID, military ID or any legal ID). All insurances will be verified upon arrival. All deductibles, co-pays, and/or coinsurance amounts will be due at the time of service.

2. If you are a new patient, please come to your appointment at least 15 minutes before the scheduled appointment time to complete the registration process.

3. Any routine call backs, prescriptions, or documents left for the physician will be completed within 48 hours.

4. At the time of service, if your account reflects and outstanding balance, you will be asked to pay the balance in FULL before you can check0in.

5. If you do not have your insurance card at every *office visit you will* be considered as self-pay for that date of service.

6. There is a $25.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately (including but not limited to collection agency fees and legal fees).

7. To better serve all our patients, if you miss 3 appointments without calling 24 hrs. prior to the appointment you may be released from practice. This is not intended to cause any inconvenience to you, but to make these appointments available to patients who need appointments.

MEDICAL RECORDS RELEASE POLICY AND PROCEDURES

Effective as of January 01, 2011 our medical records release policy has made the following changes:

1. A medical records release must be filled out or requested on our patient portal by the parent or legal guardian of the patient **PRIOR** to the copying of any medical records. Please request or fill out one release per patient.

2. All medical records 12 pages or more will be copied for our personal use for a fee of $15.00 per patient. Medical records less than 12 pages will copied for your personal use one (1) time free of charge. All additional requests will have a $15.00 charge. Please allow 10 business days for this to be completed.

3. If you are transferring to another physician you may complete a medical records request for your child's records to be forwarded to your new provider at no charge to you. Please allow 30 business days for this transfer to be completed.

4. All shot records will be copied one-time as a courtesy for your personal use. All additional copies will have a charge of $5.00. Please allow 2 business days for this process to be completed.

5. All school, sports, daycare physicals or similar forms will be completed within 2 business days at no charge. Duplicate copies of these forms will be available within 5 business days and will have a charge of $10.00.

I have read and understand the ***OFFICE POLICIES & PROCEDURES*** and ***MEDICAL RECORDS RELEASE POLICY AND PROCEDURES.***

_____ _____

Signature of parent/legal representative ***Date***

_____ _____

State relationship if other than parent ***Signature of Witness***

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____
DOB:_____/_____/_____

Specific Information to be released:

☐ All Medical Records ☐ Lab Results
☐ Shot Records ☐ Medication Forms
☐ Current Medical Exam / Physical Forms ☐ Other_____
Reason for MR Release: ___Transfer of Care___Moving____Parent Rec. Copy
___PCS___Other

Release To: **Release From:**

_____ _____
_____ _____

Please state how you would like information released:
____Mail (provide address above +50pgs) ____Fax (provide number above -50 pgs)
____Pickup

I DO___**DO NOT**___ authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including AIDS, if present.

I understand that this consent is revocable except to the extent that action has already been taken. This
consent will automatically expire 90 days from the date of signature, unless another date is specified below.*
NOTE: Unless otherwise permitted by law, further release of this information is prohibited without my prior consent.

_____ _____
Signature of parent/legal representative Date:
_____ _____
State relationship if other than parent
_____ _____
Signature of Witness Date:

*Authorization not valid beyond _____
Date cannot exceed one year from Date of Signature

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