Patient Registration

FOR CLINIC USE

Chart # _____

Primary Doctor: _____

Updated by: _____

FAYETTEVILLE
CHILDREN'S CLINIC

P. O. BOX 53127 · FAYETTEVILLE, NC 28305

Please note that insurance cannot be filed until ALL information is completed and a copy of your card is on file. Due to new guidelines set by the insurance companies, you may be required to present your insurance card at each visit. Please bring your most recent insurance card with you.

PATIENT INFORMATION

Name: First _____ Middle _____ Last _____ Sex: M F Date of Birth: _____

County: _____ Social Security #: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Please circle if your child is covered by one of these policies:

NC Health Choice Medicaid BCBS Blue Advantage

If you circled Blue Advantage, is the child the only one on this policy? Yes No

MOTHER / GUARANTOR INFORMATION

Name: _____ Date of Birth: _____ Social Security# _____

Relationship to child: Mother Step-Parent Grandparent Legal Guardian

Home address: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____ Occupation: _____

EMAIL ADDRESS: _____ Employer: _____

Do you have insurance with this employer? Yes No

If yes, is the above named CHILD covered by this policy? Yes No

If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: _____ Effective Date: _____

FATHER / GUARANTOR INFORMATION

Name: _____ Date of Birth: _____ Social Security _____

Relationship to child: Father Step-Parent Grandparent Legal Guardian

Home address: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____ Occupation: _____

EMAIL ADDRESS: _____ Employer: _____

Do you have insurance with this employer? Yes No

If yes, is the above named CHILD covered by this policy? Yes No

If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: _____ Effective Date: _____

MILITARY INFORMATION

If either parent/guardian is active duty military, please provide the following information:

Company Commander: _____ Unit: _____

Unit Phone # _____

AUTHORIZED PERSONS

Please list persons other than yourself that are allowed to authorize treatment:

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

COMMUNICATION PERMISSION

May we leave detailed messages on an answering machine? Yes No

(such as appointment reminders, lab or test results, or referral appointments)

If yes, what is that number? _____

Whom may we thank for referring you! _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Employee Signature Date

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Past Medical History

NAME _____ (M) (F) DOB: _____ Date: _____

ALLERGIC REACTION

Medicine _____

Food _____

Insect _____

Other _____

HOSPITALIZATIONS / SURGERIES

1. Date/Age: _____
   Hosp: _____
   Dx/Tx: _____
2. Date/Age: _____
   Hosp: _____
   Dx/Tx: _____

Are immunizations up-to-date? _____ Is your child taking any regular medication? _____

Has Development been normal? _____

Any physical or mental handicap? _____

School problems? _____

BIRTH HISTORY

Gestational Age _____

Delivery Weight _____

Type of Delivery _____

PROBLEMS/COMPLICATIONS:

NEONATAL

Infection: _____

Jaundice: _____

Other: _____

FEEDING

Breast _____ , Formula _____

Water supply:

City _____ Well _____ Bottled _____

FAMILY HISTORY

Mother _____ Age _____

Father _____ Age _____

Siblings of the Patient:

1. _____ Age _____
2. _____ Age _____
3. _____ Age _____
4. _____ Age _____

Please check any of the following which occur in the family.

Heart Attack/Stroke _____
Asthma/Eczema/Hay Fever _____
Bleeding Disorder _____
Congenital Heart Disease _____
Cancer _____
Anemia _____
Cystic Fibrosis _____
Mental Retardation _____
Migraine _____
Hypertension _____
Alcoholism/Depression _____

Muscular Dystrophy _____
Diabetes _____
Seizures _____
Arthritis _____
Tuberculosis _____
Sickle Cell _____
SIDS _____
GI Disorder _____
Deafness _____
AIDS _____

Other _____

General Consent and Authorizations

1. General Consent For Treatment

This is to certify that I, the undersigned, whether signed as guarantor or as patient, voluntarily consent to the administration and performance of diagnostic procedures and medical treatment by authorized agents and the employees of Fayetteville Children's Clinic and by its medical staff or their designees as may, in their professional judgment, be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment.

2. Authorization To Release Medical Information

I hereby authorize Fayetteville Children's Clinic to release the medical records and/or other information including copies concerning treatment to the following for the purpose of obtaining approval and processing claims for payment of medical expenses incurred:

- Governmental agencies or programs or health maintenance organizations (HMO);
- Preferred provider organizations and/or insurance companies;
- The utilization review organization contracted by my employer, insurance company or governmental agency or program;
- Physicians or healthcare institutions responsible for further care or follow-up treatment to serve the goal of continuation of my care.

This authorization includes the release of medical records and/or information concerning drug abuse, drug-related conditions, psychological, psychiatric conditions and/or communicable diseases (including AIDS), if applicable. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

3. Assignment Of Insurance Benefits

I hereby authorize payment directly to Fayetteville Children's Clinic of any benefits herein specified and otherwise payable to me but not to exceed the office's regular charges for any office visits. I understand that I am financially responsible to Fayetteville Children's Clinic for charges not covered under this assignment.

4. Financial Agreement

I, the undersigned, agree whether signed as guarantor or as patient, that in consideration of the services to be rendered to the patient, I do hereby guarantee payment to Fayetteville Children's Clinic on demand for all charges for said services incurred on behalf of such patient. In the event that the undersigned fails to pay on demand or in payment installments established by the practice and the account is turned over to a collection agency and/or attorney for collection, I hereby agree to pay all collection cost and expenses.

5. Personal Valuables

THE PRACTICE IS NOT RESPONSIBLE FOR VALUABLES OR PERSONAL BELONGINGS AND WILL NOT REIMBURSE ME IF ANY ARTICLES ARE LOST, STOLEN OR DAMAGED DURING MY OFFICE VISIT.

DATED THIS DAY OF ,

I THE UNDERSIGNED, CERTIFY THAT I HAVE READ AND UNDERSTAND THE FOREGOING. I FURTHER CERTIFY THAT I AM LIABLE TO FAYETTEVILLE CHILDREN'S CLINIC UNDER FINANCIAL PROVISIONS HEREIN ABOVE STATED.

Parent or Guarantor	To be Witnessed by a Employee of Fayetteville Children's Clinic

FAYETTEVILLE
CHILDREN'S CLINIC

EST. 1953 · FAYETTEVILLE, NORTH CAROLINA

Patient Acknowledgement and Consent

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of the Fayetteville Children's Clinic, P.A. Notice of Privacy Practices, version effective January 22, 2021. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative _____ Date _____

Please describe the Representative's authority to act on behalf of patient: _____

PATIENT COMMUNICATION OPT-IN FORM

Please fill out the following information to opt in for text and email communication.

Full Name: _____

Phone Number _____

Email Address _____

Text Messaging Opt-In:

By opting in, you agree to receive recurring messages which may include appointment reminders, important updates and requests for feedback in the form of reviews and/or surveys, via text message from Fayetteville Children's Clinic at the phone number provided. Standard messaging rates may apply, and message frequency may vary.

> **I consent and opt in to receive informational text messages like those listed above from Fayetteville Children's Clinic.**

*You can opt out at any time by replying "STOP" to any message. Please note that messaging is not a secure form of communication, and we recommend discussing any sensitive or personal information during your office visits. We do not share/sell your information for marketing or promotional purposes. Contact us at 910-484-3121 for help. Thank you for choosing Fayetteville Children's Clinic, P.A.

*No mobile information will be sold or shared with third parties for promotional or marketing purposes. We may share your Personal Data, including your SMS opt-in or consent status, with third parties that help us provide our messaging services, including but not limited to platform providers, phone companies, and any other vendors who assist us in the delivery of text messages.

Please return this form to our office or submit it online via our portal. If you have any questions or need assistance, please contact us using the information provided above. Thank you for choosing Fayetteville Children's Clinic, P.A. We look forward to serving you.

By signing below, I consent and opt in to receive optional text messages from Fayetteville Children's Clinic, P.A.

Signature _____ Date _____

FOR FAYETTEVILLE CHILDREN'S CLINIC, P.A USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it.

_____

_____

Immunization Policy

It is the policy of Fayetteville Children's Clinic, P.A. to follow the immunization schedule as recommended by the American Academy of Pediatrics and as required by the State of North Carolina. This policy aims to ensure comprehensive pediatric healthcare and to prevent disease.

Effective April 27, 2015, Fayetteville Children's Clinic, P.A. will not accept the risk that un-immunized or under-immunized children pose to other children and their families in our practice. Many of our patients are too young to be fully immunized and others have medical conditions that make them more susceptible to infections. As a result, the physicians at Fayetteville Children's Clinic, P. A. will not accept as patients those children whose parents choose not to immunize or choose to delay immunization contrary to doctor's advice.

I understand and accept this policy and will agree to immunize my child according to guidelines of the American Academy of Pediatrics. I understand that at any time should I not agree with this policy, I will be responsible for transferring my child's healthcare to another facility.

Date _____ **Parent/Guardian** _____

Witness — Fayetteville Children's Clinic _____

FAYETTEVILLE
CHILDREN'S CLINIC

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General Policy

Thank you very much for choosing **Fayetteville Children's Clinic, P.A.** as your child's healthcare provider. We are committed to providing high quality medical care and look forward to partnering with you in caring for your child. Our general policy, as well as your responsibilities are outlined below.

IMMUNIZATION POLICY: We require all our patients to be immunized as recommended by the CDC and as required by the State of North Carolina. We will not accept patients whose parents choose not to immunize or choose to delay immunization contrary to our doctors' advice.

AFTER-HOURS CALLS: Please call 910-484-3121, if you need urgent medical advice after hours. An operator will connect you with a triage nurse as appropriate. We ask that you consult our website, or call during our regular business hours for non-emergent medical questions, form completion, medication refills, appointment scheduling, referrals and such.

REFERRALS: We provide referrals for our established patients and help find a specialist or testing facility, based on recommendations from our doctors. An office visit may be required to initiate a referral or any testing. Please allow up to 10 business days to process a referral.

PRESCRIPTION POLICY: Please allow 48 hours for most medication refills. An office visit may be needed to determine whether a refill is appropriate. Medication refill requests are not addressed outside of our regular business hours, unless triage of symptoms indicates urgency, as determined by the on call nurse and doctor. To ensure your child's safety, we may not be able to prescribe a medication over the phone. Please call our office for an appointment, if you believe your child is sick enough to need a prescription.

SATURDAY APPOINTMENTS: We provide walk-in urgent care to our established patients on Saturday mornings between 9:30 – 11:30 am. There is an additional $35 fee for all Saturday visits.

NEBULIZERS AND SPACERS: As a service to our families, we provide nebulizers and spacers to our patients with certain respiratory issues. The equipment is supplied by Active Healthcare, Inc. They will bill your insurance company directly. Please contact Active Healthcare, Inc. at 919-870-8600, ext. 83, to verify your insurance benefits including deductibles, coinsurance and out-of-pocket costs. You may call them within 48 hours of receiving the equipment to estimate a private pay cash price, without filing insurance.

MUTUAL RESPECT: We expect our staff to treat each and every patient and family member with utmost respect and compassion. In return, we expect the same from our patients and families. Those who show unacceptable behavior may be asked to seek care elsewhere.

I have read and accept the above general policies.

Date _____ **Parent/Guardian:** _____ **Witness:** _____

Patient Name: _____ **DOB:** _____

FAYETTEVILLE
CHILDREN'S CLINIC

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Financial Policies

Thank you very much for choosing **Fayetteville Children's Clinic, P.A.** as your child's healthcare provider. We are committed to providing high quality medical care and look forward to partnering with you in caring for your child. Our financial policy, as well as your responsibilities are outlined below.

HEALTH INSURANCE, CO-PAYS AND DEDUCTIBLES: Our office contracts with a variety of insurance companies. In accordance with our agreements, co-pays and deductibles are expected to be paid on the day of service and cannot be waived. Please be ready to provide your current insurance card at every appointment. If we are unable to verify your insurance coverage on the day of your visit, you will be considered a self-pay patient. If a health problem is addressed during a well-child check, a co-pay may be required. As a convenience, we accept Visa, MasterCard, debit cards, cash and checks. A $25 fee will be added to your account for each returned check.

NEWBORNS: Parents are advised to add newborns to their insurance policy as soon as possible. If we are unable to verify your baby's coverage prior to their 2-month well check visit, the appointment will have to be rescheduled until coverage is in effect. Alternatively, they can be seen as a self-pay patient, with payment expected in full at the time of service.

OUT OF NETWORK: If your insurance considers us out-of-network, you are responsible for payment in full at the time of service. We will gladly provide you with proof of visit and a receipt so that you may file for your reimbursement.

SELF-PAY: If you do not have health insurance, your child will be considered a self-pay patient and you will be required to pay for all services at the time they are rendered. If interested, please call prior to your appointment for a good faith estimate of the charges.

DIVORCED/SEPARATED PARENTS: When services are provided for minors, the individual initiating the medical care for the child will be responsible for any payment at the time of service. Fayetteville Children's Clinic will not act as a mediator in collecting payments. Also, we require a copy of the up-to-date court ordered custody agreement.

NO-SHOW, LATE AND CANCELLATION POLICY: We strive to provide appointments as needed for all of our current patients, whether it be for a well or sick visit. As a courtesy, we provide text message appointment reminders at least 2 days before scheduled appointments and phone call reminders if needed. At least one (1) business day notice is required to cancel or reschedule appointments. **Starting JULY 1, 2024, *failure to notify the office one (1) business day in advance of your original appointment will result in a $50 no show fee***. Emergencies will be considered on a case-by-case basis for a waiver of this fee. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule. Repeated no-shows will lead to the family's dismissal from the practice.

PAST DUE ACCOUNTS: We expect that you will make every effort to pay your bill promptly. Please, call our office if you experience financial hardship. If no prior arrangements have been made, your account will become delinquent, when past due for 90 days, may be turned over to collections and/or you may be discharged from the practice.

FORMS AND LETTERS: We require 48 hours to complete most forms. More complicated forms and letters may take longer. **Starting July 1, 2024, *there will be an administrative charge of $10 associated with completion of each medication authorization, asthma action plan, allergy action plan or additional physical forms and $25 administrative charge for forms requiring extra time***, such as FMLA, EFMP or letter of medical necessity, due at the time of pick up. Due to HIPAA law, we cannot fax your child's forms to daycares and schools.

I have read and accept the above financial policies.

Date: _____ **Parent/Guardian:** _____ **Witness:** _____

Patient Name: _____ **DOB** _____

Notice of Privacy Practices

Effective 01/22/2021

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 910-484-3121.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.