Patient Registration Form

PLEASE PRINT YOUR ANSWERS TO THE FOLLOWING QUESTIONS Today's Date: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames please)
Last Name: _____ First Name: _____ Middle Initial: _____
SS# _____ Date of Birth: _____ Sex: Female [ ] Male [ ]
Race: _____ Ethnicity: Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Decline [ ]
Name your child prefers to be called:_____Preferred Language: _____

Mailing Address: _____
City: _____ State: _____ Zip: _____
Telephone number to best reach you through the daytime:_____
Emergency Contact Name: _____ Emerg Phone #: _____
Parent Email address: _____
Preferred Method of Contact: [ ] Phone Call [ ] Text Message [ ] Secure Web Message (patient portal)

PARENT INFORMATION:
Mother's First & Last Name: _____ DOB: _____
Mother's Address (if different than above): _____
City: _____ State: _____ Zip: _____
Mother's Cell #:_____ Mother's SSN_____

Father's First & Last Name: _____ DOB: _____
Father's Address (if different than above): _____
City: _____ State: _____ Zip: _____
Father's Cell #:_____ Father's SSN_____
Parent Social Security Numbers are used for ordering labs and sending out referrals, all information is confidential and HIPPA protected

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
PRIMARY INSURANCE:
Policy Holder's Name : _____Insurance Name:_____
Policy / ID #: _____ Group #: _____ Eff Date: _____
Employer:_____

SECONDARY INSURANCE:
Policy Holder's Name : _____Insurance Name:_____
Policy / ID #: _____ Group #: _____ Eff Date: _____
Employer:_____

Financial Responsible Party: Mother Father Other_____

A copy of patient's insurance card is requested in addition to completing all information on this form.

Other child(ren) attend the office [ ] yes [ ] no

Please continue>>

CONSENT FOR TREATMENT:

[ ] I hereby consent to treatment for myself, my child, or minor at any office owned and operated by Children's Health of Carolina, PA.

ASSIGNMENT OF INSURANCE BENEFITS:

[ ] I hereby authorize direct payment of my insurance benefits to Children's Health of Carolina, PA for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

[ ] I understand and agree that I will be responsible for any co-pay or balance due to Children's Health of Carolina, PA at the time that the medical services are rendered.

[ ] I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Children's Health of Carolina, PA on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

[ ] I certify that I have received and read a copy of Children's Health of Carolina, PA Patient Information Privacy Policy. I hereby authorize Children's Health of Carolina, PA to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

[ ] I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Children's Health of Carolina, PA representative or my physician or under his/her supervision to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Children's Health of Carolina, PA to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

[ ] I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Persons that I authorize consent to treat include: _____
_____, _____, _____

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
GUARANTOR NAME (Please Print):_____

Witness signature:_____Date:_____

Witness name (Please Print):_____

Chart# _____

Children's Health of Carolina, PA
HIPAA Consent Form

I understand that as part of my healthcare, Children's Health of Carolina, PA (d.b.a. Lumberton Children's Clinic, Pembroke Pediatrics, Raeford Pediatrics and Cumberland Children's Clinic) originates and maintains health records describing my child's/children's health history, symptoms, examination, test results, diagnoses and treatment plans (including referrals and future appointments). By signing this form, I am consenting to Children's Health of Carolina, PA to use and disclose my child's/children's health information to carry out treatment, payment and healthcare operations (TPO). I further understand this information serves as:

- A basis for planning my child's/children's care and treatment;
- A means of communication among the many healthcare professionals who contribute to my child's/children's care;
- A source of information for applying my child's/children's diagnoses to a bill;
- A means by which a third party payer can verify that services were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

With this consent, Children's Health of Carolina, PA may call my home or other designated locations provided by me as legal guardian and leave a message on voice mail or in person, FAX, or email me in reference to any items that assist the practice in carrying out my child's/children's TPO.

I understand and have been provided an opportunity to review the corporate HIPAA notice. I further understand that the corporation reserves the right to change the notice at any time, with the changes being posted in our reception areas. I also understand that I have the right to modify or revoke this consent form at any time, except to the extent that Children's Health of Carolina, PA has already taken action in reliance thereon.

I authorize Children's Health of Carolina to communicate my protected in the following methods:

____Leave detailed message on my home telephone answering machine
____ Leave detailed message on my office telephone answering machine
____ Leave detailed message on my cell telephone answering machine
____Leave detailed message on my FAX
____Email detailed medical information

I hereby give permission to the following person(s) listed below to receive information about the care of my child/children:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

In order to obtain information by telephone, the party calling must provide the practice with the patient's date of birth. With the exception of parents or legal guardians, if the party is not on the list, the staff will be unable to share any information regarding the patient.

_____	_____
Printed full name of child	Child's Date of Birth
_____	_____
Printed full name of child	Child's Date of Birth
_____	_____
Printed full name of child	Child's Date of Birth
_____	_____
Printed full name of child	Child's Date of Birth
_____	_____
Printed full name of child	Child's Date of Birth

I have read, understood and agree with the terms of this consent. I further acknowledge that I can legally represent the child/children listed on this document.

_____	_____
Printed name of parent/legal guardian	Date

_____

Signature of parent/legal guardian

Printed Staff's Name

Children's Health of Carolina, PA
Corporate Office Policies

Cumberland Children's Clinic Lumberton Children's Clinic Pembroke Pediatrics Raeford Pediatrics

We want to thank-you for choosing us to provide care for your child. It is an awesome responsibility…one that we take very seriously. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allow for a good flow of communication and enables us to achieve our mutual goal….a healthy child. ***Please read each section carefully and initial.*** If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) Your family will be assigned a primary provider. We will do all in our power that when your child has an appointment, they will see that provider.
2) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. Repeated failure to keep a scheduled appointment may result in your family being discharged from the practice.
3) If you are late for your appointment, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment or consider your child a "walk-in" patient and seen by another provider other than your child's primary care provider.
4) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding. Patients are seen in this order: emergencies, scheduled appointments, and walk-in (no appointment).
5) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
6) Just as in your family, things happen in our family. If the provider your child is to see is not going to be in the office (illness, working in the hospital, etc.,), we will give you as much notice as possible. We may need to reschedule your visit or have you see another provider for that one day. Do not worry… if you see another provider, your child's primary provider does not change.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.
4) Please be aware that many specialists require the parent's date of birth as well as the patient's social security number before making appointment.

Initial: _____

Insurance Plans

Please understand

1) It is your responsibility to present your insurance card at each visit. We understand that this may seem repetitive to you, but this ensures timely filing of your child's visit to your insurance company.
2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect or the information is not provided to us in a timely fashion, you will be responsible for payment of the visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual health (well) physicals, sports physicals, or hearing developmental testing and vision screenings. If these are not covered, you will be responsible for payment.
    b. For children over the age of 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service. A **$25 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be placed in collection status. If your child is in the collection status, we cannot see your child (or any other family member) unless half of the past balance is paid as well as the day's visit.
7) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
8) We accept cash, checks, Visa, MasterCard, Discover, American Express and debit cards.
9) Refunds of more than $10 are processed each week. Outstanding credit balances of less than $10 will remain on your child's account for use at a later time. Any uncollected credit balances will be sent annually to the North Carolina Escheat Division.
10) Any refunds to your child's insurance company due to incorrect billing or overpayment will be processed within one week.
11) We will file claims for those that we are contracted with. We accept the contractual write-off (adjustment) based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. You will then be responsible for that balance.

12) For patients that do not have insurance, we do offer a discount of 25% if the visit is paid in full on the day of the visit. Please make arrangements with our staff if you plan to utilize this.
13) Our Lumberton office is open nights, weekends and most major holidays. Please be aware that there is a $35 fee for seeing patients after-hours (4:20 p.m. – 7:00 p.m. M-F, 9:00 a.m. – 11 a.m. S-S), and around holidays (abbreviated office hours) for urgent/emergent illnesses. If your insurance does not cover this fee, you will be responsible for the balance. During these hours, your child will see the first available provider and you will not be able to ask for a certain provider. We know that we all have preferences, but we must insist on the first available provider to optimize patient flow.
14) We will bill the charge of the visit to the parent/guardian that we have on-file. If there are custody issues, the parents can work out those arrangements themselves.
15) Certain services such as circumcision and ear piercing are not covered by insurance. You will be responsible for paying for these services in advance.

Initial: _____

Forms

There is no charge for the initial forms given at the time of your child's visit. This is considered part of the visit. However**,** should you lose your form or require additional forms, there will be a **$5** charge that must be paid prior to picking them up. We require 3-day turnaround time for all forms. These include FMLA, school forms, and IRS-related forms. We must insist that the parent/guardian portion of the form be completed before our staff completes their portion.

Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your child's last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) A copy of your child's complete record is available from HealthPort for a fee.
3) We provide records of your child (including consultations from specialists) for visits rendered at our offices only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Prescription Refills

For medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

Inappropriate behavior

It is our desire to have a professional relationship with your child and family. This relationship is key to providing the quality of care that you and we expect. Because of this, the providers and staff of Children's Health of Carolina, PA must strictly prohibit any verbal abuse, physical abuse or threats from any family member. This behavior will lead to immediate termination of your entire family and we will pursue legal action if warranted. If we did not exceed your expectations at a visit, we would ask that you complete a satisfaction survey or speak to someone in administration.

Initial: _____

Treatment of minors

The State of North Carolina mandates that we treat minors for certain issues WITHOUT the consent of their parent/legal guardian. Such items include sexually-related conditions (birth control, sexually transmitted diseases, certain vaccines, etc.,). Due to the law, we cannot disclose any information concerning the visit without the consent of the minor. Under these circumstances, do you permit your child to use your insurance?

_____ yes _____ no initial: _____

Items that are required at each office visit

We require certain items at each office visit, regardless of why your child is being seen. These items include:

1. Valid photo ID of parent/guardian that includes accurate home address
2. Insurance/Medicaid card
3. Child's social security number (we only require this one-time if we have the number on file)
4. Child's immunization (shot) record
5. Co-payment (if applicable)
6. Any paperwork that is required to be completed at the time of visit

Initial: _____

I have read and understand this office policy and agree to comply and accept with them. I hereby assign all medical and surgical benefits to include medical benefits that I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Children's Health of Carolina, PA for services rendered to myself and/or dependents regardless of my insurance. I also understand that I am responsible for any amount not covered by my insurance.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____
(printed name)

Responsible Party Member's Signature _____ Date _____

Witness:_____ Date:_____

On completion, we will provide you with a copy for your records. The original will be scanned into our electronic health record and then destroyed.

Children's Health of Carolina, PA

Caring for our community for over 60 years!

Infants, Children and Adolescents

Cumberland Children's Clinic
1708 A. Owen Drive
Fayetteville, N.C. 28304
910-307-7330 (phone)
910-307-7334 (fax)

Lumberton Children's Clinic
400 Liberty Hill Road
Lumberton, N.C. 28358
910-739-3318 (phone)
910-671-3600 (fax)

Pembroke Pediatrics
812 Candy Park Road
Pembroke, N.C. 28372
910-521-0201 (Phone)
910-521-0773 (Fax)

Raeford Pediatrics
206 Southern Avenue
Raeford, N.C. 28376
910-875-8897 (phone)
910-875-8680 (fax)

Robeson Child Health Plus
460 Country Club Road
Lumberton, N.C. 28360
910-608-2100 (phone)
910-608-2012 (fax)

SRMC Pediatric Hospitalist
300 West 27th Street
Lumberton, NC 28358
910-737-3939 (phone)

Children's Health of Carolina Foundation
400 Liberty Hill Road
Lumberton, N.C. 28358
910-739-3318 (phone)
910-671-3600 (fax)

Robeson Child Health Plus Bus
400 Liberty Hill Road
Lumberton, N.C. 28358
910-739-3318 (phone)
910-671-3600 (fax)

Financial Policy

The Children's Health of Carolina, P.A. Financial policy is designed to inform you of your financial responsibilities that we have established for our corporation. We are committed to providing our patients with quality and compassionate care to infants, children and adolescents in Southern North Carolina while minimizing administrative cost.

We accept most major insurances including North Carolina Medicaid and Tricare. When services are rendered it's your responsibility to provide the most current card and insurance information.

It is the guardian's responsibility to understand what services are covered under their insurance plan. If we're not contracted with your insurance plan we will file as a courtesy. However, payment is expected at time of service.

We accept Cash, Check, MasterCard and Visa including Debit Cards. If charges are paid by check and returned to our corporation by your financial institute you are subject to a $30 returned check fee in addition to the check balance. Unpaid balances are expected to be paid in a timely manner. Delinquent accounts will be turned over to collections.

A patient refund will not be issued on any account that has a current or outstanding balance.

The corporate finance department is located at Lumberton Children's Clinic and offers a collection specialist to gladly assist you with any billing needs. We also have two Medicaid and NCHealthChoice eligibility specialists, one located at Lumberton Children's Clinic and one at Pembroke Pediatrics.

Our corporation is committed to excellent physician/patient communication. If you have any questions regarding our financial policy please contact us at (910) 739-3318.

Thank you for choosing Children's Health of Carolina, PA for your child's healthcare needs.

I fully understand the Financial Policy and agree to abide by these rules.

_____ _____

Signature of Guarantor (Parent/Legal Guardian) Date

The mission of Children's Health of Carolina, PA
is to meet the medical needs and encourage overall
wellness of the children living in southeastern North Carolina.

For Office Use Only

MRN:_____

Children's Health of Carolina, PA

Patient Portal Registration Form and Disclosure Statement

Instructions: Please complete this form to request online access to your child's records. All fields are required.

FollowMyHealth Account Owner (Self/Parent/Guardian)	**First and Last Name:**	
	Email Address:	
	Phone Number:	
	Street Address:	
	City, State, Zip:	
	Last Four of SSN:	
	Relationship to Patient:	
Child/Dependent	**First and Last Name:**	
	Patient Date of Birth:	
Child/Dependent	**First and Last Name:**	
	Patient Date of Birth:	
Child/Dependent	**First and Last Name:**	
	Patient Date of Birth:	
Child/Dependent	**First and Last Name:**	
	Patient Date of Birth:	

DISCLOSURE STATEMENT:

By completing this form, I understand that the above listed email address will be used to log into the Children's Health of Carolina Patient Portal from FollowMyHealth and that anyone who has access to this email account may potentially receive access to my health records or correspondence from my healthcare team at Children's Health of Carolina. I also understand that, once any health information has been uploaded to my Portal account, it is my responsibility to keep it confidential.

_____ _____

FollowMyHealth Account Owner Signature Date