



ADULT DEMOGRAPHICS

Patient Name: _____
(LAST) (FIRST) (MIDDLE) (Suffix- Jr,III,etc)

Date of Birth: _____ Sex: Male FEMALE SS#: _____

Mailing Address: _____

Primary Phone: _____ Alternate Phone: _____

E-Mail Address: _____

Race: American Indian Asian Black/African American More than one race White Hispanic/Latino Prefer not to answer

Language Preference: English Spanish Other: _____ Ethnicity: Hispanic/Latino NOT Hispanic/Latino Prefer not to answer

Please choose your preferred methods of contact for appointment reminders, test results, etc

_____ Phone _____ Web Message (through Patient Portal) _____ Postal Mail

Please circle the **ONE** provider you prefer to see: (You are always free to see any of the providers and may have to see other providers at times)

- | | | | |
|-----------------|---------------------|--------------------|----------------|
| Dr Stephen Wall | Dr Steven Hammel | Dr Karin McLelland | Dr Sarah Evers |
| Dr Tyler Vereen | Anne Sarzynski, PNP | Karen Shaw, CPNP | |

Emergency Contact: _____ Relationship: _____ Phone: _____

MEDICAL CARE AGREEMENT FOR 18, 19 and 20 YEAR OLD PATIENTS

We are pleased to offer you the option to continue your medical care with us after becoming a legal adult. If you choose to continue your care at Haywood Pediatrics, the following guidelines will apply:

1. If you get married or become a parent, you will be terminated as a patient from the practice. Marriage and parenthood are "adult" issues and we will require you to find an adult doctor for your care.
2. If you will be attending a school away from home, please note that we cannot make new diagnoses or prescribe new medications unless you are seen in our office. We cannot address these issues over the phone. If your are on a routine medication, we will need to see you periodically to renew medications. If your condition requires close monitoring, we may ask you to see a physician in the area of your school.
3. After your 20th birthday, we will expect you to begin the search for an adult doctor. We have a Case Manager who can assist you with this process.

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have received a copy of Haywood Pediatric and Adolescent Medicine Group, P.A.'s Notice of Privacy Practices, version effective 8/1/2013. I consent to medical treatment and diagnostic procedures by Haywood Pediatrics healthcare providers. I have read the Consent to Use or Disclose Information for Treatment, Payment, or Healthcare Operations and do hereby authorize the release/transmission of pertinent medical information necessary for treatment, payment, or healthcare operations. I have also read the Authorization for Use and Disclosure of Individually Identifiable Health Information and understand that if I refuse to sign this authorization, the law may allow Haywood Pediatrics to refuse treatment. I consent to the uses and disclosures of my health information as outlined in the Notice.

I hereby authorize Haywood Pediatrics to furnish information concerning my care to my insurance carriers, to other medical persons to whom Haywood Pediatrics have referred me for treatment, and to the admitting hospital should I be admitted.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Insurance

As a courtesy, we will file claims for all visits. However, payment is expected at the time of service for co-pays, deductible amounts, etc. and it is the responsibility of the patient representative to verify with the insurance that we are participating with their policy and to know what benefits are covered under that policy. We participate with NC Medicaid/Health Choice, Aetna, BCBS, Cigna, Crescent, Medcost, Tricare, United Healthcare and several other plans.

Financial Policy

Haywood Pediatrics is committed to caring for the children and youth of Haywood County and providing excellent care to sick children regardless of their financial situation. To assist you, we have the following policy. If you have any questions, please speak with a member of the staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. We accept Cash and Credit/Debit Cards.

We expect timely payment for our services but are willing to discuss payment plans for the parents of sick children who are experiencing economic hardship.

Following are our financial policies:

- Payment is expected at the time services are rendered.**
- As an adult you are considered responsible for your bill regardless of who carries the insurance on you.**
- All insurance co-pays are to be paid at the time of service. Uninsured patients will be offered a discount for paying in full at time of service.**
- We expect regular payments (at least every 30 days) on outstanding balances and the patient representative is responsible for setting up payment arrangements with Haywood Pediatrics. Failure to do so may result in your account being referred to a collection agency and your family's termination from the practice.**
- Routine Care and Wellness visits will not be scheduled until outstanding balances are settled or adequate payment arrangements have been made.**

I understand I am responsible for all charges incurred at Haywood Pediatrics and authorize payment of insurance benefits directly to Haywood Pediatrics. I am responsible for payment of all charges not covered by insurance contracts - including co-payments, deductible, non-covered services, and those determined by the insurance company, where there is no contract with Haywood Pediatrics, to be above the insurance company's usual and customary fee. I confirm that all information given is true and correct to the best of my knowledge.

Name of Insurance Company: _____

Policyholder Name:_____ **Policyholder Date of Birth:**_____

Signature of Patient : _____ **Date:**_____ Page 2

HIPAA CONTACTS

Please list anyone **OVER 18 YEARS OLD** that we may speak to about your appointments, treatment and immunizations, pick up forms and prescriptions, and that we may contact in an emergency.

(IF you wish for us to be able to speak with your parents, they **MUST** be listed here)

WE CAN NO LONGER TAKE VERBAL CONSENTS!

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Name: _____ Relationship: _____ Phone: _____ Alt #: _____

Can confidential messages (including reminders, test results, etc) be left on answering machines/voicemails:

____ YES ____ NO

FOR OFFICE USE ONLY!: Reviewed by _____ on _____