HAYWOOD PEDIATRIC
&
ADOLESCENT MEDICINE GROUP, P.A.

NEW PATIENT DEMOGRAPHIC

Child's Name: _____

(LAST) (FIRST) (MIDDLE) (Suffix- Jr,III,etc)

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

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

Primarily resides with: _____ Mother & Father _____ Mother _____ Father _____ Other: _____

Maiden Name of Mother: _____

Parent/Guardian #1 (The person completing this form) : _____

Date of Birth: _____ SS#:_____

Mailing Address: _____

_____

Home Phone: _____ Cell Phone:_____ Alt Phone:_____

Email Address:_____ Relation to patient:_____

Parent/Guardian #2 (Do **NOT** list step-parents here!) :_____

Date of Birth: _____ SS#:_____

Mailing Address: _____

_____

Home Phone: _____ Cell Phone:_____ Alt Phone:_____

Email Address:_____ Relation to patient:_____

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

Please circle the ONE provider you prefer for your child 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**

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 child to my insurance carriers, to other medical persons to whom Haywood Pediatrics have referred my child for treatment, and to the admitting hospital should my child 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.**
- **The adult who brings the patient to the office is responsible for the bill. We cannot be responsible for arrangements between divorced parents and other custody arrangements.**
- **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.

Name of Insurance Company: _____

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

I, being the parent/legal guardian of the child listed, do hereby request and authorize Haywood Pediatric and Adolescent Medicine Group to perform necessary services for my child which are deemed advisable by the provider, whether or not I am present at the actual appointment. I swear that all the information provided is true and correct to the best of my knowledge:

Parent/Guardian Signature:_____ **Date:**_____

HIPAA CONTACTS

Please list anyone **OVER 18 YEARS OLD** that may bring your child to the doctor for diagnosis, treatment and immunizations, pick up forms and prescriptions, and that we may contact in an emergency. I understand that every effort will be made to contact me in case of accident, serious illness, or hospital admission. (If you wish for a Step-parent or grandparent to be able to bring they MUST be listed here)
WE CAN NO LONGER TAKE VERBAL CONSENTS!

Name: _____ **Relationship:**_____ **Phone:**_____

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Name: _____ **Relationship:**_____ **Phone:**_____

Name: _____ **Relationship:**_____ **Phone:**_____

16 AND 17 YEAR OLDS: I consent for my 16/17 year old to be seen by Haywood Pediatric and Adolescent Medicine Group and for the practice to perform necessary services for my child which are deemed advisable by the physician/provider, whether I am present at the actual appointment.

_____ YES _____ No Initials:_____

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

_____**YES** ____ **NO**

FOR OFFICE USE ONLY!: Reviewed by _____ **on** _____