

WINSTON-SALEM

PEDIATRICS

KERNERSVILLE

Today's Date _____ Referred by _____

Child's
Last Name _____ First _____ Middle _____

Nickname _____ Child's Social Security # _____

Date of Birth _____ Male Female (please circle)

Address _____

City _____ State _____ Zip Code _____

Billing Statements should be mailed to: Same as above address or write below

Address _____

City _____ State _____ Zip Code _____

Child Lives With: Parents _____ Mother _____ Father _____ Other _____

Race _____ Primary Language Spoken at Home _____ Ethnicity _____

Home Phone _____

Email Address _____

Father's Name _____

Mother's Name _____

Date of Birth _____

Date of Birth _____

Social Security # _____

Social Security # _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Work Phone _____

Work Phone _____

Cell Phone _____

Cell Phone _____

Emergency Contact if parent not available _____

Relationship to Child _____ Phone Number _____

PLEASE TURN THE PAGE OVER AND FILL OUT BACK SIDE

INSURANCE: PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

I authorize payment of medical benefits to Winston-Salem/Kernersville Pediatrics. I authorize the release of all medical information to other physicians and consultants in my child's care if needed and as necessary to process insurance claims, applications, and prescriptions.

Payment is required at the time of service unless you have made other arrangements. As a final courtesy, we will wait for payment from your insurance company; however, all applicable co-payments are due on the date of service.

SIGNATURE FOR INSURANCE FILE _____

HIPPA-A POLICY OF PROTECTED HEALTH RIGHTS AND INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I UNDERSTAND THAT AS A HEALTHCARE PROVIDER, MY PHYSICIAN OR THE PRACTICE'S STAFF MAY SHARE MY MEDICAL INFORMATION FOR TREATMENT, BILLING AND HEALTHCARE BUSINESS PURPOSES. I ACKNOWLEDGE THAT I HAVE BEEN GIVEN INFORMATION THAT DESCRIBES HOW MY MEDICAL INFORMATION IS USED. MY SIGNATURE CONSTITUTES MY ACKNOWLEDGEMENT THAT I HAVE BEEN PROVIDED WITH A COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES.

THE FOLLOWING INDIVIDUALS HAVE MY PERMISSION TO BRING MY CHILD TO PARTICIPATE IN TREATMENT AND FULL CONSULTATION WITH THE DOCTOR.

1. _____ RELATIONSHIP _____
2. _____ RELATIONSHIP _____
3. _____ RELATIONSHIP _____

SIGNATURE OF PATIENT'S PARENT OR LEGAL REPRESENTATIVE _____

Child's Family and Social History

Patient Name _____ Date of Birth _____ Male or Female

Child's Parents

Father	Age	Height	Weight	Health Problems? Y N	What Type?
Mother	Age	Height	Weight	Health Problems? Y N	What Type?

Child's Brothers

Names	Ages	General Health

Child's Sisters

Names	Ages	General Health

Family History: Check any problems that have occurred in your family

- Asthma _____
- Allergies _____
- ADHD _____
- Cancer _____
- Heart Disease _____
- Diabetes _____
- Hypertension _____
- High Cholesterol _____
- Seizures _____
- Learning Problems _____
- Eczema _____
- Thyroid Diseases _____
- Depression _____
- Sickle Cell _____
- Migraines _____
- Other _____

Please list people (adults and children) who live in your home:

When was your home built? _____ Well Water? Y N

Babysitter or Daycare (please circle)

Pets? Cat(s) _____ Dog(s) _____ Other _____

Child's Medical History

Birth History

Birth Weight _____ Where was child born? _____

Problems? Y N If yes, what were they? _____

Any Allergies?: _____

Surgeries (circle)

Tonsillectomy Adenoidectomy Ear Tubes Appendectomy

Other _____

Any Hospitalizations?

Child's Medical Problems: Check any problems child has had

Asthma _____

Allergies _____

Diabetes _____

Eczema _____

ADHD _____

Learning Problems _____

WINSTON-SALEM PEDIATRICS ~ KERNERSVILLE PEDIATRICS FINANCIAL POLICY

WELCOME TO OUR PRACTICE! Thank you for entrusting us with the care of your children. Our goal is to provide you quality care in a friendly, comfortable atmosphere in the most timely manner possible. Please read carefully and sign the bottom of the page indicating your understanding and acceptance of our policies and procedures. Please let us know if you have any questions or concerns.

We believe your time is as valuable as ours. We do not overbook patients except in cases of emergency and we do our best to stay on schedule. Please assist us in our efforts to stay on time by arriving a few minutes before your scheduled appointment. If you are more than 15 minutes late you may be asked to reschedule your appointment for a later date, or you may be seen as a work-in.

If you are a new patient, please arrive 15 minutes early to allow for time to complete the necessary medical and insurance information. If paperwork was mailed or faxed to you in advance, please bring the completed forms as well as your insurance card on the day of the appointment. Our receptionists are required to keep patient demographic information as up to date as possible. Please understand that we may ask you for any change of insurance company, home address or phone number on subsequent visits. This information helps us to better serve you.

On occasion you may not receive a reminder call, however, please realize it is each individual's responsibility to keep track of their appointments. If you need to cancel an appointment, please give us 24 hours advance notice so that we may schedule another patient in the time slot reserved for you. If you do not cancel your appointment 24 hours in advance, a \$25.00 fee may be charged (except in cases of emergencies) and is payable prior to future visits. After three repeated no-show visits with no prior call to cancel, your family may be dismissed from the practice.

While filing of insurance claims for our patients is a courtesy that we extend, ***ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.*** We will bill your insurance company if we are a participating provider. If we do not participate with your insurance plan, you will be responsible for the entire cost of the office visit and any procedures performed. ***PAYMENT AND COPAYS ARE DUE AT THE TIME OF SERVICE.*** *It is the ultimate responsibility of the patient to understand his/her insurance coverage.* Our staff cannot call your insurance company at the time of your appointment to obtain information about your benefits. Insurance policies may change and/or insurance company representatives do not always give us correct or consistent information. Your insurance is a contract between you, your employer, and the insurance company. *In the events of denials, errors, or non-covered services, the patient is responsible for all services rendered.* We will bill your secondary insurance, however, if that insurance company does not respond within 60 days, we will bill you directly and you are responsible for payment.

We do realize that there are times when a temporary financial problem may affect payment of your account. In that case, please contact us promptly for assistance so that we may be able to set up a payment agreement with you. In the event we are forced to submit a delinquent account to a collection agency, there will be a \$25.00 fee added to your account. There is also a \$ 25.00 charge for a Non Sufficient Funds check.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Parent (Legal Representative for Patient)

Date