

WINSTON-SALEM PEDIATRICS ~ KERNERSVILLE PEDIATRICS  
FINANCIAL POLICY

***WELCOME TO OUR PRACTICE!***

Thank you for entrusting us with taking care of your children! Our goal is to provide to 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.

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 to avoid delays. Please assist us in our efforts to stay on time by arriving on time for 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 walk-in.

1. 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 or if you printed it from the web site in advance, please bring the completed forms as well as your insurance card and drivers license 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.
2. On occasion you may not receive a reminder call, however, please realize it is each individual's responsibility to keep track of appointments made. 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.
3. 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**. As a courtesy to you, 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 is due at the time of service, and co-pays are due prior to seeing the doctor. 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 visit 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 event 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.
4. We do realize that there are times 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 for 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.

*Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.*

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.

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Parent (legal representative for patient)

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Date

WINSTON-SALEM

PEDIATRICS

KERNERSVILLE

Date \_\_\_\_\_

Referred by \_\_\_\_\_

Child's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Birth date \_\_\_\_\_  Male  Female (please check)

Address \_\_\_\_\_ Home phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Child's Social Security # \_\_\_\_\_

Child lives with:  Parents  Mother  Father  Other \_\_\_\_\_

Billing statements should be mailed to: \_\_\_\_\_

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Birth date \_\_\_\_\_

Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency contact if parent not available: \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Phone Number \_\_\_\_\_

**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 PURPOSED. 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 PARTICIPE IN TREATMENT AND FULL CONSULTATION WITH THE DOCTOR:

- 1. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
- 2. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
- 3. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**SIGNATURE OF PATIENT’S PARENT OR LEGAL REPRESENTATIVE** \_\_\_\_\_

**Winston-Salem Pediatrics  
Kernersville Pediatrics  
CHILD'S FAMILY AND SOCIAL HISTORY**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  Male  Female

**Child's parents:**

<b>FATHER</b>	<b>Age:</b>	<b>Height:</b>	<b>Weight:</b>	<b>Health Problems?</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>What type?</b>
<b>MOTHER</b>	<b>Age:</b>	<b>Height:</b>	<b>Weight:</b>	<b>Health Problems?</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>What type?</b>

**Child's brothers:**

<b>Names</b>	<b>Ages</b>	<b>General Health</b>

**Child's sisters:**

<b>Names</b>	<b>Ages</b>	<b>General Health</b>

**Check the following diseases or conditions this child's parents, grandparents, aunts, uncles, brothers, sisters have had:**

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizures/convulsions
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Inherited Diseases	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol			

- **Have any brothers or sisters died?**  Yes  No  
If yes, list age and cause of death: \_\_\_\_\_
- **List additional people that live in the house:**  
\_\_\_\_\_
- **What is the source of water at home?**  City/County  Well
- **Is this child left with a babysitter:**  Yes  No
- **Does child go to a day care center:**  Yes  No

**CHILD'S MEDICAL HISTORY**

***Pregnancy and Birth***

1. Did mother have any illness during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Did the baby have any trouble starting to breathe?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Was the baby born on time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Did the baby need oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. What was the birth weight?	___ lbs. ___ oz.	6. Did the baby have any problems while in the hospital nursery?	<input type="checkbox"/> Yes <input type="checkbox"/> No

***Feeding and Digestion***

1. Was there severe colic or any unusual feeding problem the first three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Is the child still on the bottle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do any foods disagree with the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is the baby's appetite usually good?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has constipation been a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Does the child take vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If still on formula, which one?		9. How much milk does the child drink in 24 hours?	_____ OZ.
5. Does the child have diarrhea often?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

***Infections, Illnesses, Miscellaneous Problems and Development – Has the child had any of the following:***

1. Three or more bouts with ear trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Trouble with the eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Difficulty urinating?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Problems with the teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Difficulty sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. What age did the child sit alone?	_____ months
5. Noisy breathing or heavy snoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. What age did the child walk alone?	_____ months
6. Usually more than three colds or throat infections with fever in a year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Did the child say any words by 12 and 18 months old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

***Allergies – Does the child have any of the following:***

1. Eczema or hives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Wheezing or asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Stuffy nose or constant cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Allergies or reactions to any medications or injections? If so, which ones?	<input type="checkbox"/> Yes <input type="checkbox"/> No

***Emotional Problems***

1. Is the child doing well in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Does the child get along well with other children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What grade is the child in?	Grade _____		

**Circle any of the following concerns you have about your child:**

nail biting	irritability	speech problems	thumb sucking	bedwetting
breath holding	nightmares	discipline problems	jealousy	temper problems
toilet training				
Other concerns?				

**Circle any of the following the child has had:**

chickenpox	pneumonia	serious accidents	broken bones	tonsils and adenoids removed	ear tubes
Other operations?					
Other diseases?					
Hospitalizations? For what?					

**Notes:**