Carmel Pediatrics, P.A.
Patient and Insurance Information

Patient Information

Patients Name_____

Sex: Male / Female Birth Date_____/_____/_____ SSN_____

Address_____

City_____ State_____ Zip_____

Parent /Guardian Information

Mother/ Guardian_____

Birth Date_____/_____/_____ SSN_____

Address_____

City_____ State_____ Zip_____

Home Phone #_____ Cell #_____

Work Phone #_____ Email_____

Employer_____

Address_____

City_____ State_____ Zip_____

Father/ Guardian_____

Birth Date_____/_____/_____ SSN_____

Address_____

City_____ State_____ Zip_____

Home Phone #_____ Cell #_____

Work Phone #_____ Email_____

Employer_____

Address_____

City_____ State_____ Zip_____

Patient Insurance Info

Insurance Company_____ Policy# _____ Group# _____

Authorization and Assignment: I hereby authorize and assign payment directly to Carmel Pediatrics, PA of any surgical and/or medical benefits otherwise payable to me for services rendered to the above identified patient. I further authorize Carmel Pediatrics, PA to releases any medical information necessary to facilitate payment of said services rendered in the course of treatment.

Signature:_____ Date:_____

Family History

Please select all that apply within the family

HIGH CHOLESTEROL	MENTAL RETARDATION	THYROID DISEASE
STROKES, HEART ATTACKS UNDER 55Y OLD	SEIZURES	INTESTINAL DISORDERS
HEART MURMURS OR DEFECTS	VISION DISORDER/BLINDNESS	SHORT STATURE
HIGH BLOOD PRESSURE	DEAFNESS	MISCARRIAGE/STILLBORN
ASTHMA	CANCER/ LEUKEMIA	STD'S
SEASONAL ALLERGIES	CHRONIC ANEMIA	HIV
TUBERCULOSIS	SICKEL CELL ANEMIA	PSYCHIATRIC DEPRESSION/ ANXIETY DISORDER
CYSTIC FIBROSIS	ABNORMAL BLEEDING (HEMOPHILIA)	ALCOHOLISM
RHEUMATIC FEVER	JOINT/BONE/SPINE DISEASE	TOBACCO USE
DIABETES	SCOLIOSIS	LIVER DISEASE/ HEPATITIS
DEATHS IN CHILDHOOD	MULTIPLE FRACTURES	
CHROMOSOMAL/ GENETICS	MUSCLE DISEASE	
DOWN'S SYNDROME	CHRONIC SKIN DISORDER	
CONGENITAL DEFECTS	KIDNEY/ URINARY DISORDER	

Siblings

Children's Names	Birthdate
1	
2	
3	
4	
5	

Emergency Contact

Contact Name:_____

Telephone #:_____

Relationship to Patient:_____

Carmel Pediatrics' Office Policy

Our goal is to provide and maintain a good physician-patient relationship. We let you know in advance our office policy which would allow a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, don not hesitate to ask a member of our staff.

Appointments

1. We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate a 24-hour notice. ***There is a charge of $25 for missed appointments.***
2. If you are late for your appointment (> 15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. 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.
5. The office calls a day in advance to remind you of your appointment. This is done as a courtesy. No reception of such call does not exempt you from a missed appointment.

Initial:_____

Insurance Plans

Please Understand

1. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current 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 healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. For children younger than 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:_____

Referrals

1. Advance notice is needed for 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. We cannot issue/approve a referral without an office visit for that specific reason.

Initial:_____

(Over)

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.
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 our visit. We will supply you an invoice that you can submit to your insurance for reimbursement.
5. Patient balances are billed immediately on receipt of your insurance pan'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 the office any account balance outstanding longer than 60 days will be forwarded to a collection agency.
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. For scheduled appointments, prior balances must be paid prior to the visit.
9. We accept cash, checks, Visa, MasterCard credit and debit.
10. A $25 fee will be charged for any checks returned for insufficient funds.

Initial:_____

Forms

1. There is no charge for any Physical form filled at the time of your child's visit. This is considered part of the visit. However, should you lose your form; there will be a $5 charge to replace them.
2. Family and medical Leave Act forms are $20. Payment is due when the forms are dropped off or at pick up. We require 3 to 5 day turnaround time.

Initial:_____

Transfer of Records

1. If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2. A copy of your complete record is available for a $0.75-per-page fee.
3. We provide records of your child for visits (including consultations from specialists) rendered here at Carmel Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Initial:_____

Prescription Refills

1. For monthly medication refills, we require 48 hours' notice, during regular business hours.
2. For controlled substances we require an office appointment for all refills. Please plan accordingly.

Initial:_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name_____

Responsible Party Member's Name _____Relationship _____

Responsible Party Member's Signature _____ Date _____

On completion we will provide you with a copy for your records.

Carmel Pediatrics PA; Phone: 704-752-2000, Fax: 704-752-1212

Carmel Pediatrics, PA

Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when I am unable to bring my child(ren) to the office for an appointment and need to rely on a family member. Please understand these circumstances; however, I'm aware that I must have a written authorization letter allowing this person to accompany my child(ren). The person bringing my child will present photo identification at time of service.

This authorization gives the person permission to bring my child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Carmel Pediatrics, PA and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the Carmel Pediatrics, PA provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) **Date**

Office Use Only:
Intergy Acct # _____
Patient Person # _____

Carmel Pediatrics, PA
7825 Ballantyne Commons Parkway, Suite 100
Charlotte, North Carolina 28227
Ph:704-752-2000 Fax:704-752-1212

Acknowledgement Form

Patient's Name:_____Date of Birth ___/___/___
Month Day Year

We are required by law to provide you with our notice of Privacy which explains how we use and disclose your health information. We are also required to obtain you signature acknowledging that this notice has been made available to you.

- Signature: _____ Date: _____
  (Patient or Authorized Representative)

Relationship to Patient:_____

Reason Patient Unable/Unwilling to sign: _____

_____

Acknowledgement Form
DOCUMENTO DE RECONOCIMENTO DE CARMEL PEDIATRICS, PA

Nombre del Paciente: _____ Fecha de Nacimiento: ___/___/___
Mes Dia Año

La ley nos require que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulger su informacion medica. La ley tambien nos require que obtengamos su firma reconociendo que est e aviso lo hemos hecho dispobile para used.

- Firma:_____ Fecha: _____
  (Paciente o Representatne Autorizado)

Relacion al Pacient: _____

Razon Por la Cual el Paciente No Puede/No Desea Firmar: _____

_____

Carmel Pediatrics, PA
7825 Ballantyne Commons Parkway, Suite 100
Charlotte, North Carolina 28227
Ph:704-752-2000 Fax:704-752-1212

Consent for Medical Services

I voluntarily consent for my child _____ to be examined and evaluated by Carmel Pediatrics. I also agree to any routine test to be administered as deemed necessary. Included in this agreement is permission for treatment as indicated and referral to other appropriate health facilities necessary.

X _____ _____
Signature of Parent/Legal Guardian Date

Vaccine Administration Consent Form

I _____ authorize Carmel Pediatrics to administer any
Please Print Name
Immunizations as recommended by the Academy of Pediatrics and North Carolina Department of Health Services Immunization Branch to my child.

_____
Please Print Child's Name

X _____ _____
Signature of Parent/Legal Guardian Date

CARMEL PEDIATRICS, PA
MEDICAL QUESTIONAIRE

BIRTH HISTORY

PATIENT NAME: _____ MED. RCD #_____ (OFFICE USE) BREASTFED / FORMULA

TERM / PRETERM (WEEKS GESTATION) _____ C-SECTION / VAGINAL

BIRTH WEIGHT: _____ LBS. _____ OZ. DISCHARGE WEIGHT _____ LBS. _____ OZ.

MATERNAL COMPLICATIONS: _____

NEWBORN COMPLICATIONS: *NONE / TRAUMA* _____

INFECTION _____ *JAUNDICE* _____ *COLIC* _____ *MILK ALLERGY* _____

DEVELOPMENTAL HISTORY (GIVE APPROXIMATE AGE / MILESTONE REACHED)

SMILE _____ *ROLL* _____ *SIT* _____ *WALK* _____ *MAMA/DADA* _____ *WORDS* _____ *SENTENCES* _____

USE CUP _____ *TOILET TRAINED* _____ *DRESS SELF* _____ *RIDE TRICYCLE* _____ *RIDE BIKE* _____

PAST MEDICAL HISTORY

MAJOR DISORDERS / DISEASES _____

FREQUENT MINOR ILLNESS(ES) _____

ACCIDENT(S) / INJURY(IES) _____

HOSPITALIZATIONS (DIAGNOSIS & DATES) _____

SURGERIES (AGE): *EAR TUBES* _____ *ADENOIDS / TONSILS* _____ *HERNIA* _____ *OTHER* _____

ALLERGIES: _____

MEDICATIONS: _____ MENSES (FEMALE PERIOD)? *YES / NO* AGE BEGAN _____

IMMUNIZATIONS UP TO DATE? *YES / NO / DON'T KNOW* CHICKEN POX? *YES / NO*

FAMILY HISTORY (CHECK ALL THAT APPLY TO IMMEDIATE FAMILY AND GRANDPARENTS)

ADOPTED _____/_____/_____ *DEPRESSION* _____ *MIGRAINE HEADACHES* _____ *ALLERGY* _____ *ECZEMA* _____

MENTAL ILLNESS _____ *ALCOHOLISM* _____ *EPILEPSY* _____ *MENTAL RETARDATION* _____ *ANEMIA* _____ *ASTHMA* _____

FEBRILE SEIZURES _____ *NEUROFIBROMATOSIS* _____ *HEART DISEASE* _____ *SICKLE CELL* _____ *ATTENTION DEFICIT* _____

HIGH BLOOD PRESSURE _____ *STROKE* _____ *CANCER* _____ *HIGH CHOLESTEROL* _____ *THYROID DISEASE* _____

CHROMOSAL _____ *KIDNEY DISEASE* _____ *DIABETES* _____ *LUNG DISEASE* _____ *OTHER* _____

SOCIAL HISTORY

NATURAL PARENTS: *MARRIED* *SEPERATED* *DIVORCED* *WIDOWED*

NAMES AND AGES OF SIBLINGS: _____

PATIENT LIVES WITH (ALL IN HOUSEHOLD) _____

PETS: _____ SMOKERS: _____ WATER: *CITY OR WELL*

DIET CONCERNS _____

DAYCARE/SCHOOL NAME _____

ACADEMICS: *POOR* *FAIR* *GOOD* *EXCELLENT* GRADE LEVEL: _____

BEHAVIORAL PROBLEMS _____

FAMILY STRESS (I.E. RECENT DEATH) _____

Carmel Pediatrics, PA
7825 Ballantyne Commons Parkway Suite 100
Charlotte, North Carolina 28277

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:_____ Date of Birth: _____

Carmel Pediatrics is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patients' instruction. **Person/Entity to Receive information (check each person/entity that you approve to receive information)**

- ☐ Provide name, relation and phone number _____
- ☐ Provide name, relation and phone number _____
- ☐ Provide name, relation and phone number _____

Consent for messages authorization

I authorize Carmel Pediatrics, its representative, physicians and staff to leave me a message if unable to reach me through the following methods:

- ☐ Voicemail Phone Number:_____

Description of information to be released:
(Check each that can be given to person/entity identified above)

Result of lab test/x-ray	Financial Statements	Medical records	Other_____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used as a result of this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient or primary guardian.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Description of personal representative's authority (attach necessary documentation) Date