Kids First Pediatrics OF RAEFORD

PATIENT MEDICAL HISTORY

Patient Name:	
Date of Birth:	

MEDICATION ALLERGIES/REACTION

Medication	Reaction

BIRTH HISTORY

Gestational Age (circle one)	Full term Premature	Number of weeks:
Type of delivery (circle one)	Vaginal C-section	Complications:
Birth weight		

PAST PERSONAL MEDICAL HISTORY

Problem	Check	
	Yes	No
ADHD		
Anemia		
Allergies		
Asthma		
Autism		
Bed wetting		
Constipation		
Diabetes		
Down's syndrome		
Ear infections (Recurrent)		
Eczema		
Fractures		
GERD (reflux)		
Heart Murmurs		
Learning Disability		
Migraines/Headaches		
Sickle Cell		
Sleep Apnea		
Seizures		
Strep Throat (Recurrent)		
Urinary Tract Infections		

SOCIAL HISTORY

Exposures	Yes	No
Daycare/School		
Smoking in household		
Travel outside country		
Specify country visited:		

HOSPITALIZATIONS

Hospitalizations	Year
1.	
2.	
3.	

SURGERIES

Type of Surgery	Year
1.	
2.	
3.	

FAMILY HISTORY

Problem	Check		Relationship (specify)
	Yes	No	
ADHD			
Anemia			
Anxiety			
Allergies			
Asthma			
Autism			
Arthritis			
Bed wetting			
Bipolar disorder			
Cancer			
Depression			
Diabetes			
Down's syndrome			
Ear infections			
Eczema			
GERD (reflux)			
Heart Attacks under age 50			
High Cholesterol			
Hypertension			
Learning Disability			
Migraines/Headaches			
Obesity			
Sudden Infant Death Syndrome (SIDS)			
Sickle Cell			
Sleep Apnea			
Seizures			
Stroke			
Thyroid disease			
UTIs			

Kids First Pediatrics OF RAEFORD

PATIENT REGISTRATION INFORMATION

Please note that insurance cannot be filed until ALL information is completed and a copy of your card is on file. Due to new requirements set by the insurance companies and to help protect your identity, you are required to present an ID and your insurance card at each visit. If insurance cannot be verified at the time of visit, you will be considered as self-paying patient and all balance must be paid at the time of the visit. Well child visits will be rescheduled for a more convenient time if the co-pay is not paid.

Patient Information

Child's (Legal) Name: First Name - MI - Last Name	**Nick Name**	**Birth Date**	**Sex**	**Social Security #**	**Ethnicity /Race**	**Language**
			M F			
			M F			
			M F			
			M F			

Home Address	**City**	**County**	**State**	**Zip**
Home Phone Number	**Cell Number**			

Mother (Circle One) Birth Stepmother Adoptive mother Foster mother **Any custody concerns?** Y / N

Full Name (First MI Last)	Social Security #		Date of Birth	
Home Address if different from Patient	City	County	State	Zip Code
Home Phone Number	Cell Phone Number		E-Mail Address	
Occupation	Employer		Business Phone Number	
Preferred Telephone contact is: (Circle One) Home / Cell / Business			Primary Language	

Father (Circle One) Birth Stepfather Adoptive father Foster father **Any custody concerns?** Y / N

Full Name (First MI Last)	Social Security #	Date of Birth	
Home Address if different from Patient	City	State	Zip Code
Home Phone Number	Cell Phone Number	E-Mail Address	
Occupation	Employer	Business Phone Number	
Preferred Telephone contact is: (Circle One) Home / Cell / Business		Primary Language	

Insurance Information

Primary Insurance Company Name	Employer
Telephone Number	Co-payment Amount
ID #	Group #
Owner of Policy (Parent's name)	Insured Date of Birth
Policy Owner's Social Security	Relationship to Patient
Do you have Secondary Insurance? Yes No	
Secondary Insurance Company Name	Employer
Telephone Number	Co-payment Amount
ID #	Group #
Owner of Policy (Parent's name)	Insured Date of Birth
Policy Owner's Social Security	Relationship to Patient

Emergency Contact/Additional Persons

Please list all Emergency Contacts/Persons who may have permission to bring the patient in for medical care and sign consent for any vaccine administration		
Name	**Phone Number**	**Relationship to Child**

Messages

May we leave detailed messages on an answering machine?(including messages related to a medical condition, reminders, recalls and billing statements)	**Yes** **No**	
If yes, please list all numbers where messages can be left	1.	3.
	2.	4.

I hereby authorize Kids First Pediatrics of Raeford and its physician(s) to furnish information to my insurance company and authorize my insurance benefits to be paid directly to Kids First Pediatrics of Raeford and its physician(s). In the event my account is placed in the hands of an attorney for collection, I agree to pay all cost and expenses including all attorney fees related to the collection thereof. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. This authorization shall be valid unless rescinded in writing by me at a later date.

Completed By:		**Received By: For internal use only**
Parent/Guardian Name		Employee Name
Parent/Guardian Signature		Employee Signature
Date		Date

Kids First Pediatrics
OF RAEFORD

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Child's(Legal) Name: First Name - MI – Last Name		**Birth Date**	**Social Security #**	
Home Address		City	State	Zip
Phone Number	Cell Number			

☐ **I authorize Kids First Pediatrics of Raeford to *release information to:***			OR	☐ **I authorize Kids First Pediatrics of Raeford to *obtain information from:***		
Name of Provider or Facility				Name of Provider or Facility		
Address				Address		
City	State	Zip Code		City	State	Zip Code
Phone Number	Fax Number			Phone Number	Fax Number	

PURPOSE FOR THIS REQUEST: (Check One) ☐ Relocation/leaving Practice ☐ Insurance Change
☐ Referral to Specialist ☐ Court Proceedings
☐ Personal ☐ Other _____

TYPE OF RECORDS REQUESTED: (Check One)
☐ ***Copy of Patient's Entire Medical record***
☐ Immunization history
☐ All medical records related to a specific illness or injury.

Specific illness/injury Date(s) of treatment

☐ Specific information (Select one or more, as applicable)
☐Procedure report ☐History & Physical ☐Laboratory Test results
☐X-ray reports ☐Other_____

This form authorizes the release of protected health information that may include diagnosis and treatment pertaining to psychiatric conditions, alcohol or substance abuse, sexual assault/victimization records, acquired immunodeficiency syndrome (AIDS) or test for infection with HIV.

I understand that:
- This authorization is valid for 12 months from the date of signature.
- I may cancel this authorization at any time by submitting a written notification but that it will not affect any information release prior to notification of cancellation.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.

Name _____ Signature _____ Date _____

FOR INTERNAL PURPOSES ONLY: Name and Title of Person Releasing records_____

Method Of Transfer ☐Mailed on (date) _____ Certified?(certification #)_____
☐Faxed to (number) _____ on (date) _____
☐Picked up by (name) _____ on (date) _____

Verification of Identification Performed? ☐Yes ☐No Form of Identification:

Kids First Pediatrics
OF RAEFORD

Date: _____

Child's Name: _____

Date of Birth: _____

As of today, I give Kids First Pediatrics of Raeford and their associates permission to immunize my child during the duration of care, or until my child turns 18.

These immunizations will be as recommended by the State of North Carolina, the American Academy of Pediatrics and ACIP.

I agree to maintain vaccination appointments in order to keep patients up to date on all immunizations.

_____

Parent/Guardian Name

_____

Parent/Guardian Signature

• KIDS FIRST PEDIATRICS OF RAEFORD • 4005 FAYETTEVILLE ROAD, RAEFORD, NC, 28376 •
• PHONE 910-848-KIDS (5437) • FAX 910-848-5439 • WWW.KIDSFIRSTPEDSRAEFORD.COM •

Kids First Pediatrics
OF RAEFORD

PEDIATRIC CONSENT FOR CARE

Authorization to Treat Minor Child When Not Accompanied BY Parent or Guardian

Kids First Pediatrics of Raeford must have permission from a child's parent or legal guardian before providing medical services when someone other than the parent or legal guardian accompanies the child. For the privacy and confidentiality of our patients, please list the names of individuals who have the right to bring your child/children into the clinic. This form will be included in your child's records.

Patient's Name: _____ Date of Birth: _____
Patient's Name: _____ Date of Birth: _____
Patient's Name: _____ Date of Birth: _____
Patient's Name: _____ Date of Birth: _____

On a new patient visit, the patient must be accompanied by a legal guardian. A picture ID will be checked at each appointment.

I, _____ give the following people permission to bring my
(Name of parent/guardian)
child/children **to Kids First Pediatrics of Raeford** to receive medical treatment and to make medical decisions and rights to confidential information during my absence (please include the name of the second parent):

The following persons have my permission to authorize medical care for my child and sign the encounter form signifying my responsibility for payment.

Name	Relationship

Signature of parent or guardian: _____ Date: _____
Print Name: _____ Relationship to patient: _____

This authorization will be in effect until changed by the parent or legal guardian signed above.

The above individuals will be asked to present their identification at the time of the visit. If someone other than these persons brings your child to us, we will contact parent or guardian for permission to treat or advice. In case of an emergency medical condition, we will treat and make every attempt to contact the parent or guardian. If permission is granted over a telephone call, it MUST be witnessed by two employees of Kids First Pediatrics of Raeford.

Kids First Pediatrics
OF RAEFORD

PEDIATRIC CONSENT FOR CARE
TELEPHONE AUTHORIZATION

Authorization to Treat Minor Child When Not Accompanied BY Parent or Guardian

Kids First Pediatrics of Raeford must have permission from a child's parent or legal guardian before providing medical services when someone other than the parent or legal guardian accompanies the child.

Patient's Name: _____ Date of Birth: _____

I, _____ give the following people permission to
(Name of parent/guardian)
bring my child/children to **Kids First Pediatrics of Raeford** today _____ to
(date)
receive medical treatment and to make medical decisions and rights to confidential information during my absence.

The following persons have my permission to authorize medical care for my child and sign the encounter form signifying my responsibility for payment.

Name	Relationship

Date: _____ Print Name: _____ Relationship to patient: _____

The above individuals will be asked to present their identification at the time of the visit. If permission is granted over a telephone call, it MUST be witnessed by two employees of Kids First Pediatrics of Raeford.

We certify that, _____, gave verbal permission for the providers
(Parent or Guardian's Printed Name)
at Kids First Pediatrics of Raeford to treat, _____, on _____.
(Child's Name and DOB) (Date)

_____ _____
Witness #1 Signature Witness #2 Signature

_____ _____
Date Date

Kids First Pediatrics OF RAEFORD

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective November 15, 2010

This notice describes how medical information about you and your child (as a patient of **Kids First Pediatrics of Raeford**) may be used and disclosed and how you can get access to this information. Please review it carefully.
If you have any questions about this notice, please contact:

Donna Carroll
Practice Administrator
Kids First Pediatrics of Raeford,
4005 Fayetteville Road,
Raeford, NC, 28376
Phone: 910-848-KIDS (5437)
Fax: 910-848-5439

We are required by law to:
- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the notice currently in effect.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. COMMITMENT TO YOUR PRIVACY:

Kids First Pediatrics of Raeford is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you.

The terms of this notice apply to all records containing your IIHI that are created or retained by **Kids First Pediatrics of Raeford.** We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. **Kids First Pediatrics of Raeford** will post a copy of our current Notice in our clinic in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. HOW WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Kids First Pediatrics of Raeford may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Kids First Pediatrics of Raeford may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other heath care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Kids First Pediatrics of Raeford may use and disclose your IIHI to operate our business. For example, we may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their healthcare operation activities

4. Appointment Reminders, Treatment Options and Health-Related Benefits and Services. Kids First Pediatrics of Raeford may use and disclose your IIHI to contact you and remind you of an appointment, inform you of potential treatment options or alternatives and inform you of health-related benefits and services that may be of interest to you.

5. Release of Information to Family/Friends. Kids First Pediatrics of Raeford may release your IIHI to a friend or family member that is involved in your care, or assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby-sitter may have access to this child's medical information.

6. Disclosures Required by Law. Kids First Pediatrics of Raeford will use and disclose your IIHI when we are required to do so by federal, state or local laws.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks. Kids First Pediatrics of Raeford** may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    - maintaining vital records, such as births and deaths
    - reporting child abuse or neglect
    - preventing or controlling disease, injury or disability
    - notifying a person regarding potential exposure to a communicable disease
    - notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - reporting reactions to drugs or problems with products or devices
    - notifying individuals if a product or device they may be using has been recalled
    - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities. Kids First Pediatrics of Raeford** may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings. Kids First Pediatrics of Raeford** may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement. Kids First Pediatrics of Raeford** may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime [including the location or victim(s) of the crime, or the description, identity or location of the perpetrator]

5. **Deceased Patients. Kids First Pediatrics of Raeford** may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation. Kids First Pediatrics of Raeford** may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research. Kids First Pediatrics of Raeford** may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determine that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health or Safety. Kids First Pediatrics of Raeford** may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military. Kids First Pediatrics of Raeford** may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security. Kids First Pediatrics of Raeford** may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal

officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates. Kids First Pediatrics of Raeford** may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary : (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation. Kids First Pediatrics of Raeford** may release your IIHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IIHI:

You have the following rights regarding the IIHI that we maintain about you:

1. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC, 28376** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

2. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC, 28376.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

3. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC, 28376,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

4. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC, 28376.** Your request must describe in a clear and concise fashion:
   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC, 28376.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Donna Carroll, Practice Administrator, Kids First Pediatrics of Raeford, 4005 Fayetteville Road, Raeford, NC.**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

   To file a complaint with our practice, contact:

   Donna Carroll
   Practice Administrator
   Kids First Pediatrics of Raeford
   4005 Fayetteville Road,
   Raeford, NC, 28376
   Phone: 910-848-KIDS (5437)
   Fax: 910-848-5439

   To file a complaint with the Secretary of the Department of Health and Human Services, contact:

   US Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, DC 20201

8. **Right to Provide an Authorization for Other Uses and Disclosures. Kids First Pediatrics of Raeford** will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Kids First Pediatrics
OF RAEFORD

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have been provided with a ***Notice of Privacy Practices from Kids First Pediatrics of Raeford*** that outlines a more complete description of the uses and disclosures of certain health information. I understand that Kids First Pediatrics of Raeford reserves the right to change their Notice of Privacy Practices and I may request a copy of the updated Notice of Privacy Practices by calling the office or requesting a copy in person.

_____ _____
Patient Name Date of Birth

_____ _____
Parent/Legal Guardian Signature Date

_____
Relationship to Patient

_____
Witness Signature

Kids First Pediatrics OF RAEFORD

FINANCIAL POLICY 2011

It is the policy of Kids First pediatrics of Raeford to outline clearly the respective financial responsibilities of our patients and our practice. We are committed to providing our patients with excellent patient care, while minimizing administrative costs. We have established this financial policy to accommodate both the patient and the Practice.

You need to understand your insurance coverage: not all services are covered by all plans and we do not know the details of all insurance plans. While filing of insurance claims to insurers that we participate with is a service that we extend to our patients, all fees ***ARE*** ultimately the patient's responsibility. We accept assignment from most major insurance carriers; which means covered charges will be paid directly to us. You will be held responsible for all services provided to your child, with or without insurance benefits. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.

If we do not participate with your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance company. However, payment is expected at the time service is rendered.

Due to current federal and insurance regulations, ***all co-payments, co-insurance and deductibles are collected at the time of service.*** We accept cash, checks, MasterCard and Visa. If these charges are paid by checks, and are returned unpaid by your financial institution, you will be subject to a fee of $25 on top of your co-payment, coinsurance or deductible owed. The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are no outstanding balances on the family's account.

It is the patient's responsibility to provide us with current insurance information and to present the insurance card and identification at each visit. If you do not have your insurance card, you will be considered a self-pay patient and payment is expected at the time service is rendered.

If your insurance requires you to designate a primary care physician (PCP), you are required to have authorization from us, your PCP, ***PRIOR*** to having a specialist appointment. We require 7-10 working days for routine referrals to be processed. Emergency referrals will be handled on a case to case basis. Do not call us from the specialists' office to request a referral. You may have to reschedule your appointment or self-refer, and pay the specialist's fees at the time of your visit. It is the parents' responsibility to be aware of the services needing insurance pre-authorization and requesting the same from Kids First Pediatrics of Raeford.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. If you have any questions regarding our financial arrangement, please feel free to call our office - ***910-848-KIDS (5437).***

Thank you for choosing ***Kids First Pediatrics of Raeford*** for your child's healthcare needs.

I fully understand the financial Policy and agree to abide by these rules.

Signature of Guarantor (Parent/Legal Guardian):_____

Date_____

• KIDS FIRST PEDIATRICS OF RAEFORD • 4005 FAYETTEVILLE ROAD, RAEFORD, NC, 28376 •
• PHONE 910-848-KIDS (5437) • FAX 910-848-5439 • WWW.KIDSFIRSTPEDSRAEFORD.COM •