Carolina Kids Pediatric Associates, PLLC

Patient Information: *Please list all children on this form to avoid having to complete a separate form for each child.*

Patient #1: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #2: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #3: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

If more than 3 children, ask for a second form and list names here:

Children's Primary Address ☐ Mom ☐ Dad ☐ Other (Name and relationship)

First Parent Contact: Relationship to patient Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Second Parent Contact: Relationship to patient Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Alternate or Emergency Contact: Name: Last First MI

DOB Relationship Phone Authorized to oversee pt care? ☐ Yes ☐ No

Primary Insurance Info: *Our office has contractual timely filing limits with insurance providers. Therefore, you may be responsible for claim balances if valid ins info is not provided within 75 days of service.* You **must** present the patient's valid insurance policy information **before** we can file your claims. *Remaining balance or non-covered charges are the responsibility of the responsible party indicated below.* **To prevent filing errors DO NOT provide secondary insurance info unless it is Medicaid.**

Primary Insurance Co Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Primary Provider: (circle one) Tanaka Willey Nechyba Emmet Helton

First Language Race Ethnicity (circle) Hispanic Non-Hispanic

How should we contact you for: **Well Check recalls** ☐ Call ☐ Text ☐ Email **Test Results**: ☐ Call ☐ Text ☐ Email

Appointment Reminders ☐ Call ☐ Text ☐ Email All emails and texts are generated by our EMR.

Responsible Party Info: ***You CANNOT delegate another person to be the responsible party.*** *Please complete this form in full today and request a blank form to take home if you plan to arrange for the responsible party to be changed.* ***Copays and balance payments are expected at time of service, regardless of custodial agreements.*** *I authorize Carolina Kids Pediatric Associates to file insurance claims for services provided and for payments of services to be made to same.*

Name: Last First Middle

DOB Relationship to patient Employer

Address Apt/Unit #

City State Zip Phone

Responsible Party Name: Print Signature Date

I have received a copy of Carolina Kids "Billing 101" ☐ YES ☐ NO, if no please request one and check yes.

I have received a copy of Carolina Kids "Privacy Practices" ☐ YES ☐ NO, if no please request one and check yes.

Person Completing Form: Print Name Signature Date

Carolina Kids Patient History Questionnaire

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

Birth History:

Prenatal health problems: _____ Place of birth: _____

Preterm birth: Y N If yes, how premature? _____

Problems identified in newborn period: _____

Past Medical History:

Has your child had any of the following? *(IF CHILD IS A NEWBORN, PLEASE SKIP THIS SECTION)*

Current medications	Y	N	_____
Medication allergies	Y	N	_____
Serious injuries or accidents	Y	N	_____
Surgeries	Y	N	_____
Hospitalizations	Y	N	_____
Chickenpox	Y	N	_____
Frequent ear/sinus infections	Y	N	_____
Frequent pharyngitis/tonsillitis	Y	N	_____
Other serious infections	Y	N	_____
Nasal allergies/food allergy	Y	N	_____
Environmental allergies	Y	N	_____
Asthma or chest infections	Y	N	_____
Heart problems	Y	N	_____
Abdominal problems	Y	N	_____
Urinary infections	Y	N	_____
Bedwetting (after 5 years)	Y	N	_____
Eye conditions/glasses	Y	N	_____
Ear/hearing problems	Y	N	_____
Skin problems	Y	N	_____
Anemia/bleeding problem	Y	N	_____
Blood transfusions	Y	N	_____
Frequent headaches	Y	N	_____
Seizures/neurologic problems	Y	N	_____

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

ADHD/developmental delay	Y	N	_____
Mental health concerns	Y	N	_____
Orthopedic problems	Y	N	_____
Diabetes	Y	N	_____
Thyroid problems	Y	N	_____
Girls: menstrual problems	Y	N	N/A _____
Adolescents: drug/alcohol use	Y	N	N/A _____
Emotional problems	Y	N	_____
Other problems	Y	N	_____

Family Medical History:

(Circle all that apply and include name of affected family member beside condition)

Nasal allergies : _____
Asthma/lung disease: _____
Heart disease: _____
High blood pressure: _____
High cholesterol: _____
Diabetes: _____
Cancer: _____
Anemia : _____
Hearing problem: _____
Immune problem: _____
Drug abuse: _____
Tuberculosis: _____

Bleeding problem: _____
Seizures/neurologic: _____
Developmental delay: _____
ADHD: _____
Liver problem: _____
Other GI problem: _____
Kidney disease : _____
Bedwetting (after 10):_____
Vision problem: _____
Alcohol problem: _____
Mental illness: _____
Other: _____

Social History:

Who lives at home? _____

Do any family members live outside the home? _____

Are there any custody arrangements we should be aware of? _____

Are there any animals in the house? _____

Are there any stressors in your home we should be aware of? _____

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

Carolina Kids Risk Assessment Questionnaire

Lead Risk Assessment:

1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing remodeling? YES NO

2. Has your family/child ever lived outside the U.S. or recently arrived from a foreign country? YES NO

   Where? _____

Tuberculosis Risk-Assessment:

1. Was your child born in a country other than the United States? YES NO

   If yes, where was he/she born? _____

2. Has your child traveled to another country? YES NO

   If yes, where did he/she travel and for how long? _____

3. Has your child been exposed to anyone with tuberculosis? YES NO

4. Does this child have close contact with anyone with a positive tuberculosis skin test? YES NO

5. Does this child spend time with anyone who has been in jail or a shelter, uses illegal drugs, or has HIV/AIDS? YES NO

7. Does any person live or work in this child's home who was born in a country other than the United States or has had significant foreign travel to high risk areas? YES NO

   If yes, what country or countries and for what time period? _____

Other Risk Assessment:

1. Does anyone in your home or in a home your child visits frequently use cigarettes or tobacco products? YES NO

2. Does your home have access to city water or a community well which has fluorinated water? YES NO

3. Do you have firearms in your home? YES NO

4. If yes, are firearms locked in a secure location? YES NO

5. In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food? YES NO

Carolina Kids Pediatrics Associates 2605 Blue Ridge Rd Ste 100 Raleigh NC 27607
Phone: (919) 881 9009 Fax: (919) 881 8463 www.carolinakidspediatrics.com

Newborn Insurance and Billing 101

Newborns:

- Be sure to add your newborn to your policy within 30 days.
- Follow up with the social security office if you do not receive a SS# promptly. Most insurance companies require a social security number to set up the policy.
- Many newborns require weight and feeding evaluation visits in addition to regularly scheduled well visits. Your plan will process these as problem-focused/sick visits. Co-pays apply to weight check visits. We follow the AAP guidelines for newborn evaluation and well care check ups. Well care check-ups are done at the first office visit (if indicated), and at 2wks, 2, 4, 6, 9, 12, 15, 18, and 24 months, and then yearly. Coding an "in-between" weight check as a well care visit does not follow the standards and could result in payment denials for future check-ups.
- Once your newborn has been added to your plan, you should receive an updated insurance card. You might receive a reminder bill if we have not received your insurance card in a timely manner.
- The 2 month well visit involves several vaccines. Vaccines are costly but are covered by MOST insurance plans. You will want to be certain to have valid insurance information on file with our office prior to the 2 month well visit.
- If you have attested that your child has been added to a private insurance policy we must provide private vaccines at the 2 month well visit. You will be responsible for the cost of the vaccines if your insurance claim is denied as not eligible on date of service.
- If you are unsure if you will have private insurance and plan to apply for Medicaid benefits please notify our office. It will be necessary for you to transfer to a practice currently accepting new Medicaid patients. Our office is not currently accepting new Medicaid patients (even if it will be your secondary plan), unless you have another child previously established with our practice for a minimum of 6 months.
- All insurance companies have timely filing limits, some as short as 90 days. Keep in mind that we require a 5-day allowance from the receipt of your card to file your claim. We do not file claims past the timely filing limits as contracted by the insurance company.

Do You Have More Than One Insurance Policy?

- The insurance companies determine the primary insurance plan. Neither you nor your provider is allowed to choose which policy you will use as primary or secondary. If you are unsure which policy is PRIMARY you must contact your insurance company or companies to clarify.
- Please provide your PRIMARY private insurance policy ONLY. We do not file SECONDARY private insurance. Providing incorrect insurance information could result in insurance processing errors that could delay or prevent future resubmission to the correct policy due to timely filing constraints.

Did our doctors see your newborn at the hospital?

- **IF OUR DOCTORS VISITED YOUR NEWBORN IN THE HOSPITAL**, you will receive a bill from our office for those services. Newborn hospital charges are to be filed under mother's policy (except if Medicaid**). Please provide our office with mother's insurance card** so that we can file the newborn hospital charges.
- Remember: **We will also need your baby's primary insurance card** when you receive it; the baby's primary policy is used to file office visits. (Mother's policy is for newborn hospital visits.)

Carolina Kids Pediatric Associates

Notice of Privacy Practices

Effective September 23, 2013

This notice describes how medical information about you may be used and disclosed, and how you may have access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment for health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses or disclosures of health information for treatment, payment and healthcare operations.
The following categories describe different ways that we use and disclose medical information. The information may be used in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: We may use and disclose medical information about you to determine eligibility for benefits and to facilitate payment for treatment and services you receive from health care providers.

Healthcare Operations: We may use or disclose your medical information in order to support the business activities of your physician's practice. We may use medical information in connection with quality assessment, submitting claims, for medical review, legal services, audit services and fraud and abuse programs.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or to recommend possible treatment options or alternatives that may be of interest to you.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. We may disclose information when required by a court order or subpoena.

No Other Uses or Disclosures without Your Written Authorization: Other disclosures will only be made with your consent, unless required by law. You may revoke this authorization at any time in writing.

Appointment Reminders: The practice may use and disclose medical information to contact you regarding a reminder of your appointment for treatment or medical care.

We participate in an Organized Health Care Arrangement with providers in the UNC Health Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate.

Your Rights Regarding Medical Information About You:

Your Right to Request Restrictions:
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy. You may request that we not use or disclose PHI for marketing or selling of PHI. You have the right to request that your PHI not be used for fundraising. Your request must state the restrictions and to whom the restrictions apply. This request must be in writing.

Your Physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

Your Right to Inspect and Copy: You have the right to inspect and copy medical information. To inspect and copy the medical information that may be used to make medical decisions about you, you must submit in writing a request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If applicable, copies can be requested in an electronic format.

Your Right to Amend: If you feel that the medical information about you is incorrect or not complete, you may ask the dentist to amend the information. To request an amendment your request must be in writing and you must provide a reason that supports your request. In addition, we may deny your request.

Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations. This request must be submitted in writing. Your request must state a time period of no longer than 6 (six) years.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters by alternative means or at an alternative location. This request must be in writing.

Your Right to be notified if Your PHI has been breached. You have the right to know if there has been a security breach of your unsecured Protected Health Information by us or a Business Associate.

Your Right to Request Restrictions on disclosures to Health Plans. You have a right to request restrictions to disclosures to health plans for payment or healthcare operations regarding services where the individual has paid for the service out of pocket and in full.

All Other Uses and Disclosures. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization. You may revoke your permission in writing at any time.

Your Right to a Copy of This Notice: You have the right to request a paper copy of this notice.

Changes: We reserve the right to change the terms of this notice at any time and to apply the revised notice to all individually identifiable health information that it maintains.

Complaints: If you believe your privacy rights have been violated, you may file a complaint to us or to the Secretary of the Department of Health and Human Services. All complaints must be in writing. **You will not be penalized for filing a complaint.** To file a complaint with the office, please contact the privacy officer at Carolina Kids Pediatric Associates, 2605 Blue Ridge Rd. Suite 100, Raleigh, NC 27607.

Our privacy officer is: ___Rebecca Eakes _____

Contact information :___(919) 881-9009_____

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Insurance and Billing 101

We have developed this informational sheet to help our families know what to expect at the time of your visit. We welcome questions and are happy to assist you as needed.

The providers of Carolina Kids Pediatrics follow the AAP recommendations for regularly scheduled checkups and up-to-date vaccine administration. These visits may include services such as, but not limited to; routine labs, hearing or vision screens, illness evaluation, or chronic condition follow-ups. These additional services may be subject to your insurance plan co-pays, deductibles, or co-insurances, even if you have 100% preventative care coverage.

Know your Insurance:

- KNOW YOUR PLAN. Be sure that we are a listed provider with your specific plan choice. For example, although we DO accept plans through most major insurance companies, **they may have some closed plans with further in network restrictions.** Your financial responsibility may be higher for out of network visits.
- KNOW YOUR CO-PAY and be aware of deductibles, co-insurances and the terms to which they apply.
- KNOW THE EFFECTIVE DATE of your current plan and BRING YOUR CARD EVERY TIME…(or send a copy if someone else is bringing your child), including children arriving on their own. (If under 18 yrs old and unaccompanied by an adult, also send a written signed note to evaluate and treat). Alternately, we accept faxed insurance card copies.
- If your insurance card is not available we may not have enough information to file your claim at time of service.
- Once we receive your card, you are responsible for notifying us if you need prior visits back-filed.
- All insurance companies have timely filing limits, some as short as 90 days. Keep in mind that we require a 5-day allowance from the receipt of your card to file your claim. We do not file claims past the timely filing limits as contracted by the insurance company.

Medicaid and NC Health Choice: We MUST be the assigned provider listed on your card or you may be asked to reschedule. Medicaid and NC Health Choice will not issue payment to unlisted providers.

Do You Have More Than One Insurance Policy?

- Insurance companies determine the primary insurance plan. Neither you nor your provider is allowed to choose which policy you will use as primary or secondary. If you are unsure which policy is PRIMARY you must contact your insurance company or companies to clarify.
- Please provide your PRIMARY private insurance policy only. We do not file SECONDARY insurance unless it is Medicaid. Providing incorrect insurance information could result in insurance processing errors that could delay or prevent future resubmission to the correct policy due to timely filing constraints.

Charges:

- On rare occasions, a telephone diagnosis may be made and you may be offered the option to have a prescription called-in to avoid an office visit. The fee for a telephone diagnosis with a prescription called-in is $20. This is NOT filed to your insurance and is NOT covered by insurance plans. You will be billed.
- We do not charge for missed appointments. However, if you have 3 or more missed appointments within your family, you may be discharged from the practice.
- Weekend visits include an additional weekend fee. (Initial newborn hospital visits are excluded from this)

Payments:

- Co-pays are DUE AT TIME OF SERVICE. If you are not accompanying your child, please send your co-pay with the person bringing the child. Payment may also be made by phone. We prefer not to “bill” for co-pays.
- One parent MUST accept responsibility for balances and co-pays and provide a street address and, if different, a billing address. You CANNOT sign for someone else to be responsible. In situations involving divorce or separation, court decisions are to be worked out between the private parties. We do not get involved in enforcing family legalities.
- A Short-Term Payment Plan is available on request for those who are unable to pay in full.