PATIENT INFORMATION

Child 1: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 2: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 3: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

Insurance Information:

Primary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Secondary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Mother/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Primary Phone (**Circle**: Home/Cell) _____ **Secondary Phone** (**Circl**e: Home/Cell/Work) _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

Father/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Primary Phone (**Circle**: Home/Cell) _____ **Secondary Phone** (**Circl**e: Home/Cell/Work) _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

Continued on Back

Responsible Party Information: The responsible party is the person that will be receiving the billing statements. This person is also financially responsible for the patient's medical bills. Copays and balance payments are expected at time of service, regardless of custodial agreements.

First Name: _____ Middle Name:_____ Last Name: _____ DOB: _____

Home Address: _____
Street City State Zip Code

Phone Number: _____ Relationship to Patient: _____

Alternate Contact Information: Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. Indicated below are the names of any person(s) to whom you allow disclosure of health information related to your child and authorize to oversee patient care.

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____

Phone Number: _____ Relationship to Patient: _____

Notify In Case Of Emergency (Not A Parent/Guardian)

Name_____Relationship_____ Phone_____

Name_____Relationship_____ Phone_____

Separated/Divorced Families

Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ Yes ☐ No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Authorization of Treatment and Assignment of Benefits

I authorize Northwest Pediatrics Inc., to treat my child. I have been presented with a copy of the Notice of Privacy Practice detailing how my child's health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my child's health information. I also acknowledge that I have been presented with a copy of Northwest Pediatrics Office Policies.

Signature of Parent or Legal Guardian_____

Relationship to Child_____ Date_____

Person Completing Form

Printed Name: _____ Signature: _____ Date: _____

Family History

You may use one form for all children that share the same biological family members listed below. For additional forms, please see the front desk.

Please check:

☐ *This family history applies to* ***all*** *children listed on reverse side*

or

☐ *This family history applies to the following children:* _____

Northwest Pediatrics

Please circle alive or deceased for each family member and check all		Asthma	Heart attack before age 50	Heart Disease	High Blood Pressure	High Cholesterol	Diabetes	Kidney Disease	Seizure Disorder	Thyroid Disease	Liver Disease	ADD/ ADHD	Cancer	Mental Illness	Substance Use
Father	alive deceased												Type _____	Type _____	Type _____
Mother	alive deceased												Type _____	Type _____	Type _____
Father's Father	alive deceased												Type _____	Type _____	Type _____
Father's Mother	alive deceased												Type _____	Type _____	Type _____
Mother's Father	alive deceased												Type _____	Type _____	Type _____
Mother's Mother	alive deceased												Type _____	Type _____	Type _____
Father's Brother(s)	alive deceased												Type _____	Type _____	Type _____
Father's Sister(s)	alive deceased												Type _____	Type _____	Type _____
Mother's Brother(s)	alive deceased												Type _____	Type _____	Type _____
Mother's Sister(s)	alive deceased												Type _____	Type _____	Type _____

Other: _____

Signature: _____ **Relationship To Child**: _____ **Date:** _____

Past Medical History

1) **Who lives in the house with the children listed below?** _____

2) **Are there smokers in the home?** ☐ **No** ☐ **Yes** **If yes, please circle: Inside Outside Car**

3) **Are there guns in the home?** ☐ **No** ☐ **Yes** **If yes, are they locked?** ☐ **No** ☐ **Yes**

4) **Within the last 12 months, have you worried whether food would run out before you got money to buy more?** ☐ **No** ☐ **Yes**

5) **Do you ever need help when reading instructions or other written material from your doctor or pharmacy?** ☐ **No** ☐ **Yes**

Child 1	**Child 2**	**Child 3**
Full Name: _____	**Full Name:** _____	**Full Name:** _____
☐ ADD/ADHD	☐ ADD/ADHD	☐ ADD/ADHD
☐ Abdominal Pain/GER	☐ Abdominal Pain/GER	☐ Abdominal Pain/GER
☐ Allergies	☐ Allergies	☐ Allergies
☐ Anemia or bleeding problem	☐ Anemia or bleeding problem	☐ Anemia or bleeding problem
☐ Anxiety	☐ Anxiety	☐ Anxiety
☐ Asthma	☐ Asthma	☐ Asthma
☐ Autism	☐ Autism	☐ Autism
☐ Bed-wetting (after 5 years of age)	☐ Bed-wetting (after 5 years of age)	☐ Bed-wetting (after 5 years of age)
☐ Bladder or kidney infection	☐ Bladder or kidney infection	☐ Bladder or kidney infection
☐ Blood Transfusion	☐ Blood Transfusion	☐ Blood Transfusion
☐ Cancer	☐ Cancer	☐ Cancer
☐ Concussion	☐ Concussion	☐ Concussion
☐ Constipation	☐ Constipation	☐ Constipation
☐ Chronic skin problems	☐ Chronic skin problems	☐ Chronic skin problems
☐ Developmental Delays	☐ Developmental Delays	☐ Developmental Delays
☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Eating Disorder	☐ Eating Disorder	☐ Eating Disorder
☐ Eye conditions	☐ Eye conditions	☐ Eye conditions
☐ Frequent ear infections	☐ Frequent ear infections	☐ Frequent ear infections
☐ Frequent headaches	☐ Frequent headaches	☐ Frequent headaches
☐ Hearing Impairment	☐ Hearing Impairment	☐ Hearing Impairment
☐ Heart problems or heart murmur	☐ Heart problems or heart murmur	☐ Heart problems or heart murmur
☐ Kidney Disease/Urologic Concerns	☐ Kidney Disease/Urologic concerns	☐ Kidney Disease/Urologic concerns
☐ Metabolic/Genetic disorder	☐ Metabolic/Genetic disorder	☐ Metabolic/Genetic disorder
☐ Orthopedic problems	☐ Orthopedic problems	☐ Orthopedic problems
☐ Pneumonia	☐ Pneumonia	☐ Pneumonia
☐ Recurrent urinary tract infections	☐ Recurrent urinary tract infections	☐ Recurrent urinary tract infections
☐ Serious injuries or accidents	☐ Serious injuries or accidents	☐ Serious injuries or accidents
☐ Seizures	☐ Seizures	☐ Seizures
☐ Thyroid problems	☐ Thyroid problems	☐ Thyroid problems
☐ Use of alcohol or drugs	☐ Use of alcohol or drugs	☐ Use of alcohol or drugs
☐ Visual Impairment	☐ Visual Impairment	☐ Visual Impairment
Other:	**Other:**	**Other:**
_____	_____	_____
Surgeries/Dates: ☐ **None**	**Surgeries/Dates:** ☐ **None**	**Surgeries/Dates:** ☐ **None**
_____	_____	_____
_____	_____	_____
Hospitalizations/Dates: ☐ **None**	**Hospitalizations/Dates:** ☐ **None**	**Hospitalizations/Dates:** ☐ **None**
_____	_____	_____
_____	_____	_____
Food/Medication Allergies: ☐ **None**	**Food/Medication Allergies:** ☐ **None**	**Food/Medication Allergies:** ☐ **None**
_____	_____	_____

4529 Jessup Grove Rd.
Greensboro, NC 27410
Phone: 336-605-0190
Fax: 336-605-0930

Authorization to Use/Release/Disclose Health Information

Section A: (Must be completed for all authorizations)

I,_____, understand that Northwest Pediatrics, Inc. is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy regulations.

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

RELEASE FROM:

Name:_____
Address:_____
_____
_____

RELEASE TO:

Name:_____
Address:_____
_____
_____

I authorize the following information to be sent to the above address: (Check all that apply)

- ○ Copies of Medical Records for the Period: / / to / / (Mo Day Year) (Mo Day Year)
- ○ Copies of information described below for the Period: / / to / / (Mo Day Year) (Mo Day Year)
- ○ History & Physical Examination
- ○ Reports from other physicians
- ○ Lab, X-Ray, etc. reports
- ○ Other (Please Specify): _____
- ○ The following information should **NOT** be released (Please specify):_____

Reason for transfer/disclosure: _____

By signing this release, I also understand that the policy of Northwest Pediatrics prohibits a transfer back to the practice from another local pediatrician.

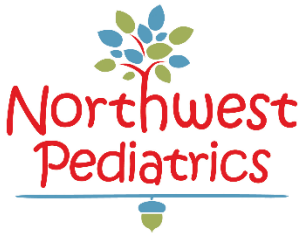
Section B: (Must be completed for ALL Authorizations)
I understand that:

- I may revoke this authorization at any time by notifying the Practice in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Northwest Pediatrics, Inc. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: _____ Date:_____

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS

Office use only: Patient Chart #_____ Date Information Disclosed: / / Initials:_____



Office Policies

Welcome to Northwest Pediatrics. Our purpose is to nurture the health of children. It is our desire to provide the most current, compassionate and comprehensive medical care.

Office Hours

Our office is open Monday, Tuesday, Thursday and Friday from 8:30-5pm. We are open from 9:30-5pm on Wednesday.

After Hours

We are always available to assist you during regular office hours. For questions that arise when our office is closed, we are pleased to provide you with access to our nurse triage after hours phone line. Please call 336-605-0190 and your call will be directed to our nurse triage line.

Vaccination Policy

Northwest Pediatrics follows the American Academy of Pediatrics guidelines for well care and immunizations. We believe strongly in immunizations and protecting infants and children. We do not support alternate vaccine schedules or not vaccinating children. If your philosophy differs from ours, we request that you find another pediatrician.

Late Arrival Policy

We value your time and will make every attempt to see your child in a timely fashion. Please extend us the same courtesy and be on time for your appointment. If you are running late for your appointment please notify our office and we will attempt to make accommodations within our schedule. Patients who are more than 15 minutes late for their appointment may be considered a “No-Show” and may be asked to reschedule their appointment.

No-Show Policy

We are sensitive to unexpected emergencies that may prevent you from keeping your appointment. However, we ask that you give us a 24 hour notice if you need to cancel an appointment. Appointments cancelled with less than 24-hour notice may be considered a “No-Show”. Three or more “No-Shows” in a 12 month period for a family may result in dismissal from the practice.

Medical Forms and Immunization Records

Request for medical records must be made in writing and contain the signature of a parent or guardian. Medical records requested for personal use will incur a charge of $15. There is no charge to send medical records to another physician. FMLA forms will be completed for a charge of $25. School and camp physical forms are completed free of charge at the well child visit. There is a $5 fee for forms completed any time other than at the well child exam as long as the patient has had a well child visit within the past 12 months. Please allow up to two weeks for medical records request.

School/Work Excuses

We are only able to provide school and work excuses for patients and/or parents who are seen within our office. At check-out you will be provided a note excusing the day that you were seen and the date deemed appropriate for you to return to work or school by the appointment provider.

Separated/Divorced Families

For families in which the parents are either separated or divorced, the parent bringing the child to the office is authorizing treatment and is, therefore, the parent responsible for co-payment or co-insurance on the date of service. We will not call or contact the other parent to obtain payment information. Please have the child's payment and insurance information with you when arriving for your office visit. All fees associated with the visit, including but not limited to, the co-pay of the child's insurance plan, are due at the time services are rendered. If there is a divorce decree requiring the other parent pay a portion, or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. Northwest Pediatrics will not make special provisions or act as a mediator in collection of payment.

Financial Policy

Welcome to Northwest Pediatrics. Thank you for choosing us as your Pediatrician. We welcome the opportunity to care for your child. We strive for excellence in delivering the most advanced services available, while also providing reliable confidential and compassionate patient care. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to contact our office.

Please present your current insurance ID card at your visit and, if any changes occur with your coverage, we ask that you contact us immediately. In the event that we do not participate with your insurance plan, you will be responsible for the entire bill.

As a service to you, our office makes effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. At all times, it is your responsibility to follow up on all requests from your insurance company regarding claims. Patients with a balance of $10 or less will not receive statements. Patients with a credit of $10 or less will not be issued a refund check; instead the balance/credit will remain on the patient's account and will be applied to future visits.

All co-payments and deductible amounts are due and should be paid at the time of service. If you are unable to pay your co-payment, you will need to reschedule your appointment. This policy is in accordance with legal requirements for collecting patient responsibility amounts. Unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, and collection agency fees. All fees will be owed in addition to the remaining balance. In the case of unpaid balance, you may be dismissed from our practice. As of May 1, 2013, NWPEDS no longer accepts new patients with Medicaid.

Additional services such as ear wax removal, wart removal, foreign body removal, etc. may or may not be covered by your insurance and therefore will be the financial responsibility of the patient. If there is an acute illness that is discussed and managed during your child's well visit, then two services may be billed, an age appropriate well exam and a problem focused exam. A co-pay/co-insurance may be due as a result.

If you do not have insurance and are considered self-pay, you are expected to pay in full at the time of service.

A $25.00 fee will be charged for all checks that are returned to us by your financial institution and will be payable immediately.

Our practice accepts Visa, MasterCard, Discover, American Express and debit cards. We also accept personal checks and cash.

Authorization: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company(s). If my account becomes delinquent, I agree to pay all costs incurred in collection of the account, including necessary collection fees.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

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.

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.

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 this 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 physician 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. This information can be released only upon your written authorization.

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. Please mail to Atlanta Federal Center, Suite 3870, 61 Forsyth Street, S.W. Atlanta, Georgia, 30309-8909, or email to OCRPrivacy@hhs.gov. You will not be penalized for filing a complaint. All complaints will be taken seriously and thoroughly investigated.

Our privacy officer is: Donna Kirkman

Contact information: 4529 Jessup Grove Road, Greensboro, NC 27410

Nondiscrimination statement: Northwest Pediatrics Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

Signature: _____ Date: _____