SouthPark Pediatrics, PA

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4601 Park Road, Suite 100, Charlotte, NC 28209

Phone 704-522-6656 Fax 704-522-6665

Consent for Release of Medical Records

From: *Patient's Name _____

*Patient's Address _____

*Patient's DOB/Social Security Number _____

To: _____

_____

_____

I do hereby consent and authorize you to release copies of the above named patient's medical records, including, as determined necessary by the physicians, current and previous medical records from other practices and practitioners, hospitals and/or clinics that are a part of the medical record.

PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please fax copies of all requested information as soon as possible to the address listed below:

FOR OFFICE COMPLETION ONLY:

Urgent Care visit_____Emergency Room visit_____Specialist evaluation_____

Newborn records including hearing screen and labs_____

Immunization record_____Medical Record Summary_____
Other_____Date_____

____ FAX RECORDS TO 704-522-6665-----Patient is in office now.

HIPAA form regarding exchange of private health information (PHI) for treatment, payment, and operations (TPO) has already been completed. This template is completed on date below to expedite record requests listed above.

***Patient, Parent, or Legal Guardian _____

Signature Date

SOUTHPARK PEDIATRICS, PA **Patient Registration Form**

DATE: Referring Doctor:			
Patient's Last Name	Pt's First Name/Middle Name /		Pt's Home Phone: ( )
Patient's Street Address	City/State/Zip		Pt's Date of Birth / /
Patient's School/Employer	Sex: ____M ____F	Age	Pt's Social Security - -
Responsible Party Full Name	Full Address (if different from pt)		Relationship
Responsible Party Employer	Home ( ) Other ( )	Resp Party DOB / /	Resp Party SS# - -
Emergency Contact Name	Contact Phone ( )		Relationship
INSURANCE INFORMATION (Copy of Insurance Card(s) and applicable Co-pay required at each visit)			
Primary Insurance Co. Name	Policyholder's Name		Policyholder's Date of Birth / /
Insurance Claims Address	City/State/Zip		Insurance Co. Phone ( )
Insurance ID Number	Group Name and/or Number		Employer Plan __Y __N
Secondary Insurance Co. Name	Policyholder's Name		Policyholder's Date of Birth / /
Insurance Claims Address	City/State/Zip		Insurance Co. Phone ( )
Insurance ID Number	Group Name and/or Number		Employer Plan __Y __N

Acknowledgement of Financial Responsibility: I understand that insurance will be filed for me and I authorize payments to be paid directly to SouthPark Pediatrics, P.A. (SPP). I understand that I am responsible for all Co-pays, Deductibles and/or Non-covered charges for services rendered according to the terms of my insurance policy. I also understand that I may be asked to assist in obtaining proper payment from my insurance company. I authorize SPP to disclose any health information necessary to my insurance carrier to obtain payment for services rendered. I understand that if I am not covered by health insurance, I am fully responsible for all charges incurred. ***Initials:*** _____ ***Date:*** _____

Consent for Treatment and Release of Information: I hereby voluntarily consent to treatment from SPP as ordered by its physicians and authorize necessary medical services including, but not limited to, examinations, lab testing, immunizations and medications. I fully understand that no guarantees have been made to me regarding the results of medical care rendered to me by SPP. I have been provided with a copy of SPP's "Notice of Privacy Practices" that provides a description of how my Protected Health Information (PHI) may be used and disclosed and I am aware that the Notice may be changed at anytime. ***Initials:*** _____ ***Date:*** _____

Consent for Email*:* I voluntarily consent to communication from SPP via email address provided by me for flu vaccine availability and non-specific referral updates. I understand that this information is not patient specific, therefore, not HIPAA protected. ***Initials:*** _____ ***Date:*** _____

_____ _____/_____

Signature of Parent/Guardian/Responsible Party **Date** **Time**

_____ _____/_____

Signature of Patient **Date** **Time**

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Treatment Authorization

Patient Name_____

DOB _____Chart Number_____

Please print below the names of any individuals to whom you grant permission to present your child to the doctor for medical care and to authorize treatment decisions. Please include child's name if they are permitted to be evaluated alone without the guardian present, and include a sibling's name if a sibling is allowed to bring the patient for evaluation without the legal guardian present.

Self – (Is patient permitted to bring himself without any other guardian?)_____

None_____

Please list all others below:

_____ _____ _____

Printed name of Parent/Legal Guardian **Signature of Parent/Legal Guardian**

Date

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When patient is 18 years old or older, patient should list below the names of individuals with whom SouthPark Pediatrics' is permitted to discuss all medical care information.

Parents-

None_____

_____ _____ _____

Signature of Patient **Date**

MISSED APPOINTMENT POLICY

Due to the unacceptable number of Missed Appointments for Check-Ups, Chronic Health Problem Management, Vaccine Administration and Follow-Up, patients will be responsible for payment of a **"Missed Appointment" fee of $35.**Dismissal from practice for failure to comply with recommendations may result if 3 "No Show" events occur.

We regret the need to implement this action; however, scheduled appointments disrupt the availability for same day visits and the subsequent impact of work-in "sick visits." When patients fail to keep appointments, the inconvenience is disrespectful to our patient families and to the staff and physician efforts towards providing timely customer service. We recognize that urgent and emergent medical circumstances are unpredictable on any given day. We also understand that the children often control the schedule as we work with them to cooperate for a less disturbing visit. At SouthPark Pediatrics, we strive to deliver "Quality Time With Families," as we remain flexible on a case by case basis.

At SouthPark Pediatrics, PA we feel that it is extremely important to follow the American Academy of Pediatrics recommendations. With these recommendations, there may be some services that, depending on your particular insurance plan, may not be covered and will fall under the guarantor's responsibility. Some of these services include the following:

- **Developmental Screenings** – The particular screenings we use are the Ages and Stages Questionnaire and the MCHAT (Modified Checklist for Autism in Toddlers). The Ages and Stages Questionnaire helps screen proper development of your child at different stages in their growth. The MCHAT is an autism screening tool that we use in the earlier well child visits.
- **BMI (Body Mass Index)** – Evaluating Body Mass Index has become an important initiative in pediatrics. With the population of adults suffering from obesity, the American Academy of Pediatrics has found that the sooner we start addressing risk factors including family history and causes of weight gain like hypothyroidism as well as complications such as diabetes and high cholesterol in children, the more of an impact we can have on their proper growth and development into adulthood. Insurance companies are now auditing us as well to make sure we are following this recommendation as it relates to our contracts with these particular insurance companies. If your child falls within a certain percentile that the physician feels more discussion and/or labs are to be done, these issues may or may not be covered by your particular plan and will be your responsibility to cover either by it being applied to your deductible, or an out of pocket expense.
- **30 month visit, 7 and 9 year visit** – These are additional well child visits that the American Academy of Pediatrics are recommending and may or may not be covered by your insurance plan. We are advising all parents to ask your insurance about your coverage of this visit prior to your appointment. If you go forward with this visit and your insurance does not cover, you will also be expected to pay for any balances not covered by your insurance company.
- **Lab handling fee** –This is a charge for preparing the throat swab, urine, blood specimen and paperwork for transport to lab and appropriate lab follow up.
- **Human Papilloma Virus (HPV) vaccine**- This is a 3 dose vaccine that should be started 9 months before the possibility of unprotected exposure to sexually transmitted disease. This vaccine may not be covered for boys so it is best to check with your insurance company so that you are aware of the financial responsibility that you incur when signing permission for this protection.

Due to advanced scheduling of well-child visits as well as making sure we keep your child up to date on yearly routine checkups, you will be asked to schedule your next appointment at check out. Please go ahead and reserve a spot on our calendar and we will give you a call prior to the appointment as a courtesy reminder. Many insurances require a 12 month interval and that is easiest met by scheduling you at check-out.

I have read and understand the above information and acknowledge that if I am billed for these services because my insurance did not cover, I am responsible for paying the balance to SouthPark Pediatrics for these services.

_____ _____ _____

Patient's Name Parent or Guardian Signature Date

Thank you for your cooperation and allowing us to provide the best care we can for your children!!

SouthPark Pediatrics

IMPORTANT INFORMATION REGARDING YOUR PHYSICAL CHECK UP EXAM

SouthPark Pediatrics practices comprehensive medical care focused on prevention as well as evaluation and management of identified disease, complaints and concerns.

There are two definitions that you need to be aware of that define office encounters.

A. Preventative Physical Exams (Well Child Checks): This visit is designed to educate you on changes you can make to live a healthier life and to identify new health problems. This encounter is NOT designed to address specific complaints or to manage known medical problems. This is usually an encounter to review preventative health issues such as:

- Past medical history
- Interim medical history since last physical exam
- Pertinent family history
- Review of systems
- Thorough physical exam
- Health habits
- Nutrition
- Exercise
- Sleep patterns
- Lifestyle choice

B. Office Visits (Evaluation and Management Encounters): This encounter is designed for the evaluation and management of single or multiple complaints or disease such as:

- Allergies/Asthma
- Eczema
- Headache
- Anemia
- Behavioral Health
- Weight Management and Associated Abnormal Labs- Ex: Cholesterol
- Constipation
- ADHD-Attention Deficit Hyperactivity Disorder

During your preventative physical exam, your physician will include management of your existing and/or any new medical problems. You will be charged for both the preventative physical exam and the office visit. The additional services may not be considered part of your preventive service benefit; therefore, these services may be non-covered by your insurance carrier or your carrier may apply the charges towards your deductible/coinsurance. You will be responsible for any services rendered today that are not covered by your insurance carrier. It is important for you to understand your individual insurance benefit coverage because each carrier processes claims differently.

Please refer to the following for examples of the definitions outlined above.

Example 1: A patient with no health problems presents for a preventative physical exam. Patient has no complaints and no problems are found. The charge to your insurance carrier would be for the preventative physical exam only.

Example 2: A patient presents for a preventative physical exam. The patient has no complaints and no known problems but is found to have eczema. This problem is addressed and treatment started. The charge to your insurance carrier would include the charge for the preventative physical exam plus a charge for an office visit.

Example 3: A patient with multiple known medical problems presents to discuss these problems as well as have a preventative physical exam. The multiple medical problems are addressed and treatment is delivered. The charge to your insurance carrier would include the charge for the preventative physical exam plus a charge for an office visit.

Your out-of-pocket expenses will be determined by your insurance carrier which determines your co-pay, deductible and individual insurance benefit coverage. Insurance companies create your coverage parameters as outlined by your employer. If you have questions, please contact our office at 704-522-6656 prior to your visit.

This acknowledgment remains in effect until retracted in writing. This document is found on our website, as are all forms that each patient is asked to sign and submit when the doctor-patient relationship is established.

I have read and understand the above information and acknowledge that if I am billed for these services because my insurance did not cover, I am responsible for paying the balance to SouthPark Pediatrics for these services.

Parent/Guardian Signature:_____Date:_____
Patient Name (print): _____Date of Birth_____

SouthPark Pediatrics, PA

Chart No._____

Patient name(last)_____(first)_____ _____(mid)_____ _____

Nickname_____DOB_____ Sex_____Age_____SSN_____-_____-_____
Mom's first last Dad's first last
Name_____Name_____single/married/separated/divorced
Mom's address_____
Dad's address_____
Mom's phone(H)_____(W)_____(Cell)_____
Dad's phone (H)_____(W)_____(Cell)_____
E-mail address_____Patient's cell_____
Emergency contact: Name/Number_____

Birth History: Vaginal ___ C-section___Weeks gestation___Pregnancy number___
Birth weight_____Birth Length_____Discharge weight_____APGAR_____
Complications/breech,etc._____

Past Medical History:Immunization reactions_____DRUG ALLERGIES_____
Developmental concerns_____
Recurrent/Chronic medical problems_____
Allergies__Asthma/bronchitis__Infections-ear__urinary tract__lung__Seizures_____
Specialist referrals_____
Hospitalizations_____
Surgeries_____

Family History:Mom:Ethnic origin_____Religion_____Language_____
Dad:Ethnic origin_____Religion_____Language_____
Mother's DOB_____Occupation_____Health problems_____
Father's DOB_____Occupation_____ Health problems_____
Siblings 1. Name_____DOB_____Health problems_____
2. Name_____ DOB_____Health problems_____
3. Name_____ DOB_____Health problems_____
4. Name_____ DOB_____Health problems_____

Family History-Patient's siblings, parents, grandparents with the following? Yes/No

AIDS/HIV/Sexually transmitted disease	Y/N	Crohn's Disease/Inflammatory Bowel Disease	Y/N	Migraine	Y/N
Allergies	Y/N	CysticFibrosis	Y/N	Muscular dystrophy	Y/N
Anemia	Y/N	Diabetes	Y/N	Obesity	Y/N
Asthma	Y/N	Depression	Y/N	Pregnancy loss	Y/N
Attention Deficit Disorder	Y/N	Eating disorder	Y/N	Speech Delays	Y/N
Autsim	Y/N	Eczema	Y/N	Seizures	Y/N
Birth defects/genetic disorder	Y/N	Heart disease/(<55 yrs old)	Y/N	Scoliosis	Y/N
Bleeding/blood problems	Y/N	Hi blood pressure	Y/N	Sickle cell disease	Y/N
Cancer/Type_____	Y/N	High cholesterol	Y/N	Stroke(<55yrs old)	Y/N
Childhood arthritis	Y/N	Kidney disease	Y/N	Vision Problems	Y/N
Childhood deaths	Y/N	Learning disorder	Y/N		
Congenital hip disease	Y/N	Mental retardation	Y/N		

Social History-Exposure: Day care Y/N Smoke Y/N Pets _____Y/N

Completed by_____Date_____

Referred by_____

Reviewed by_____Date_____