

Chapel Hill Pediatrics and Adolescents, PA

New Family Demographics Sheet

Please print clearly.

Date ____/____/____ Form Completed By _____

Address _____

Street

City

State

Zip

***Best contact phone# (____) ____ - ____ home cell work Whose _____

Alternate # (____) ____ - ____ home cell work Whose _____

Alternate # (____) ____ - ____ home cell work Whose _____

Alternate # (____) ____ - ____ home cell work Whose _____

Preferred Email Address: _____

Preferred method of communication: Text E-mail Phone

How did you hear about Chapel Hill Pediatrics? _____

Child's Name _____ Nickname _____

M () F () Birth Date (DOB): ____/____/____ Child's SS# ____ - ____ - ____

Race _____ Ethnicity: Hispanic Non Hispanic Primary Language _____

Child's Name _____ Nickname _____

M () F () Birth Date (DOB): ____/____/____ Child's SS# ____ - ____ - ____

Race _____ Ethnicity: Hispanic Non Hispanic Primary Language _____

Child's Name _____ Nickname _____

M () F () Birth Date (DOB): ____/____/____ Child's SS# ____ - ____ - ____

Race _____ Ethnicity: Hispanic Non Hispanic Primary Language _____

Family Information

Parent's Name _____ SS# ____ - ____ - ____ DOB ____/____/____

Occupation _____ Employer _____

Parent's Name _____ SS# ____ - ____ - ____ DOB ____/____/____

Occupation _____ Employer _____

Emergency Contact (other than parent) _____ Relation to child(ren) _____

Home # (____) ____ - ____ Work# (____) ____ - ____ Cell # (____) ____ - ____

Are there siblings not listed above? If so, please list their name(s), date(s) of birth, and where they live:

Family History

Patient Name(s): _____

Directions:

If you answer yes to any of the following questions, please provide more details under "comments."

	Biological Father	Biological Mother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other relatives (list)	
Have any biological family members had...?								Comments
Childhood hearing loss								
Nasal allergies/ hay fever								
Asthma								
Food Allergies								
Cystic Fibrosis								
Tuberculosis/ positive PPD								
Stroke (before 55 years old)								
Heart disease (before 55 years old)								
High cholesterol/takes cholesterol medication								
Anemia								
Bleeding disorder/hemophilia								
Dental decay								
Cancer (before 55 years old)								
Liver disease								
Kidney disease								
Diabetes (before 55 years old)								
Bed wetting (after 10 years old)								
Obesity								
Epilepsy/convulsions/seizures								
Alcohol abuse								
Drug abuse								
Tobacco abuse								
ADHD								
Anxiety								
Depression								
Mental health problems								
Autism								
Developmental disability or delay								
Birth defects/chromosomal abnormalities								
Immune problems, HIV, or AIDS								
Migraine headaches								
Lazy eye								
Vision problems								
Hip dysplasia or hip problems								
Any other significant problem								

Chapel Hill Pediatrics and Adolescents, PA

Patient Payment Policy

Revised: October 2016

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients.

Insurance

- Please provide a copy of your insurance card at each visit.
- We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Each plan has different benefits as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits.
- We are required to file with your primary carrier only. It is your responsibility to file charges with any secondary insurance carriers for reimbursement.
- **If you have insurance coverage under a plan with which we do not have a contract**, you will be treated as a “self-pay” patient and will be provided documentation to assist you in filing your own claim. We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service. You will be asked to sign a waiver stating that you have no health insurance and will not be filing with any health insurance carriers. Failure to sign this waiver may result in cancellation of your appointment.
- We cannot extend professional courtesy discounts.

Payment

Payment is expected at the time of service. This includes co-pays, co-insurance, balances, and deductibles. Failure to produce payment at check-in may result in your appointment being rescheduled.

- As a courtesy to our patients we gladly accept cash, check, money order, Visa, Master Card, and Discover.
- Co-pays not received within 24 hours of service will be subject to a \$15 administration fee.
- **Yearly deductible plans: Families who must meet yearly deductibles will be required to pay \$75.00 at the time of service. A claim will be generated to your insurance company so that this amount will be credited to your deductible. In addition, we require a copy of your health savings account debit/credit card or a personal debit or credit card to remain on file in our office. Your card will be charged and a receipt generated once your insurance company sends us your explanation of benefits for the claim. If there has been an overpayment, we will issue you a refund check the following business day. If you do not place a credit card on file, payment in full is required on the date of service and a refund will be issued once your insurance company processes the claim.**
- In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. **We do not bill another individual or estranged spouse for payment.**
- A service charge of \$35 will be added for:
 - Returned checks
 - Re-filing of insurance due to incomplete or incorrect information given at the time of service.
 - Administrative fee associated with accounts turned over to collection agencies.
- A fee of \$10 will be assessed for each patient financial history request.

Appointments and Cancelling Services

- An appointment written in our schedule with your child’s name on it is a bond of trust that we will be here to serve you and you will be present for that appointment. The appointment is made with your approval and is considered confirmed whether or not you receive a reminder e-mail, call, or postcard. On the occasion that we might run late, it is due to attending to unanticipated needs of other patients, just as your unanticipated needs might require attention.
- We require 24 hours’ notice to cancel prescheduled appointments and 2 hours’ notice to cancel a same day appointment. We charge a \$35 no-show fee for missed appointments, pre-scheduled appointments that are canceled with less than 24 hours’ notice and same day appointments canceled with less than 2 hours’ notice. We cannot accept cancellations of appointments left online.

Balances

- Any amount not covered by the insured/patient’s insurance is due within 30 days of the time of service. Late payments will incur an additional \$10 per month billing fee.
- Balances on account must be paid prior to receiving additional services.
- **No balance over \$300.00 can be carried on a family account.**
- Accounts will be turned over to a collection agency if past due 60 days or more. I understand that I am responsible for all collection costs involved with the collection of this account including court cost, reasonable attorney fees and all other expenses incurred with collection if I default on any unpaid balance.
- Failure to pay balance may result in discharge from the practice.
- **Should you have extraordinary financial pressures, we will assist you with a payment plan, agreed to in writing with our billing department prior to services being rendered.**

Form Fees

- A fee of \$10 will be assessed for each **camp** form.
- A fee of \$30 will be assessed for any form requiring completion in less than 5 business days.

After Hours Nurse/Triage Calls

- For all callers within North Carolina, a fee of \$16 will be assessed for each after hours/weekend triage call and a fee of \$38 will be assessed for each triage call received on a holiday for patients over 2 months of age.
- For all callers out of state, a fee of \$38 will be assessed for each after hours/weekend triage call and a fee of \$45 will be assessed for each triage call received on a holiday.

Urgent Care Hours/Holidays

- Appointments Monday – Friday before 8am and 5pm or later, appointments during our weekend hours, and same day appointments during a holiday are considered to be “urgent care.”
- There is a fee of \$45 for each urgent care visit and a fee of \$45 for each urgent care visit on a holiday. This fee will be billed to the insurance we have on file, but if it is denied this fee will become your responsibility.

Important note about Billing:

Insurance companies have very specific regulations about billing for health care services. As your health care providers, we are required to follow those regulations in how we report services provided to you. All physicians/providers must report to the insurance company in a universal code system linked to the service, treatment or procedure provided. **It is not uncommon for a patient to receive a regular check-up and an evaluation of an acute or chronic illness (ex: ADD/ADHD, asthma, ear aches, and sore throats). In these cases your insurance may be billed for a well child exam and an additional office visit.**

For example:

- Your child is evaluated and treated for an ear infection as well as examined for his well child exam. Both services must be reported to the insurance company.
- A child with asthma may have his/her asthma evaluated at the same time as the well child exam. Again, both services must be reported to the insurance company.

Insurance companies handle these reported codes differently. **Some insurance companies may require an additional co-pay to cover the charge and/or the charge may go towards your co-insurance or deductible; this is determined entirely by your insurance company.** If you have questions, please check with your insurance carrier.

We appreciate the opportunity to participate in your family’s healthcare. As always, we are dedicated to providing the best possible care for your family. If our billing office can help, please contact them at 919-942-4173 extension 811.

I have read both pages of the above financial policy and understand and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian



Chapel Hill Pediatrics and Adolescents, PA

Acknowledgment of Receipt of Notice of Privacy Practices

Please print clearly.

Patient Name(s):

Address:

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

Printed Name

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

An emergency existed & a signature was not possible at the time.

The individual refused to sign.

A copy was mailed with a request for signature by return mail.

Unable to communicate with the parent for the following reason:

Other: _____

Prepared by _____

Signature _____

Date _____

Chapel Hill Pediatrics and Adolescents

Notice of Privacy Policies

This notice describes how medical information about you 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 the Privacy Officer.

Effective Date: April 14, 2003 Revised: March 23, 2017

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.chapelhillpeds.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practices that may provide medical care for you such as home health agencies.

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.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or to improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal Proceedings: To assist in any legal proceedings or in response to court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical Research: We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional Institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by use as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosure of your health information:

- Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other health care providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object:

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share this information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about privacy practices you can contact:

Mary Sheppard, Practice Administrator, 919-942-4173 x 199 or mwsheppard@chapelhillpeds.com

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective 4/2003, revised 9/2013.

Patient Past History

Patient Name: _____ Date of Birth (DOB): ____ / ____ / ____

General	YES	NO	Explanation	
Is your child in good health?				
Does your child have any serious illnesses?				
Has your child has any surgery? What/when?				
Has your child been hospitalized? When?				
Has your child ever been to the emergency room (ER)? When?				
Has your child ever seen a specialist? Whom?				
Does your child take any medications regularly?				
Is your child allergic to medicine or drugs? Which ones?				
Does your child have or has your child ever had:	YES	NO	WHEN?	Explanation
Chicken pox				
Frequent ear infections				
Hearing loss or problems with ears or hearing				
Nasal allergies/hay fever				
Problems with eyes or vision				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Any heart problem or heart murmur				
Anemia or bleeding problem				
Blood transfusion				
Immune problems, HIV, or AIDs				
Frequent abdominal pain or constipation				
Urinary tract infections or problems				
Bed wetting (after 5 years old)				
Metabolic/genetic/chromosomal disorders				
Cancer				
Sleep problems or snoring				
Chronic or recurrent skin problems (acne/eczema)				
Frequent headaches				
Convulsions/seizures or other neurologic problems				
Obesity				
Diabetes				
Thyroid or other endocrine problems				
High blood pressure				
History of serious injuries/fractures/concussions				
Use of alcohol, tobacco, or drugs				
Smoke exposure in the home (even outside)				
ADHD				
Anxiety, depression, or mood problems (specify)				
Autism or developmental delay/difference				
Dental decay				
History of family violence				
Sexually transmitted infections				
Pregnancy				
(for girls) Problems with periods				
Any other significant problem (specify)				

Patient Past History (continued)

Patient Name: _____ Date of Birth (DOB): ____ / ____ / ____

Please list all those living in the child's home:

Name	Date of Birth (DOB)	Relationship to child	Health problems	Occupation (adults)

What is the child's living situation, if not with both biological parents?

Adoptive Parents Joint Custody Other
 Foster Family Single Custody

Please explain: _____

Birth History

I don't know birth history

Birth weight: _____ lbs _____ oz

Was the baby born:
 At term (38 – 41 weeks) Early; ____ weeks Late; ____ weeks

Where there any complications with pregnancy, delivery, or immediately after birth?
 No Yes, please explain: _____

Was a NICU (neonatal intensive care unit) stay required?
 No Yes, please explain: _____

During pregnancy, did mother:
 Use tobacco Use Drugs or Medications (what, when) _____
 Drink alcohol Use Prenatal Vitamins

Was the delivery:
 Vaginal Cesarean: Why? _____

Was baby's initial feeding:
 Formula Breast milk: How long breastfed _____

Was the baby discharged from the hospital at the same time as the mother?
 Yes No, please explain _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print Patient's Full Name)

(Birth Date: m/d/y)

(Street Address)

(Home Phone Number)

(City, State, Zip Code)

(Cell Number)

At the request of the individual, I _____, do hereby authorize:
(Parent/Child if over 12)

(Name of Facility/Previous Doctor's Office)

(Address of Facility/Previous Doctor's Office)

(Phone/Fax Number of Facility/Previous Doctor's Office)

To release:

___Progress notes___ Pathology Reports___ Other Doctor Notes ___ Lab Reports___ OB/GYN Notes ___ All Records
___RadiologyReports___ HospitalNotes___ ECG/EEG/Cardio___ Other: _____

I do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To:

**Chapel Hill Pediatrics and Adolescents, P.A.
205 Sage Road, Suite 100**

Please contact Carlena at ext 109
with any questions or concerns.

**Chapel Hill, NC 27514
(P) 919-942-4173 (F) 919-933-3473 / 919-968-4216**

Purpose of disclosure: ___Referral to Specialist ___ Insurance ___ Worker's Comp___ Legal Investigation
___ Disability ___ Personal ___ Relocated___ Other (specify): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring: _____

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these records.

Patient signature if over 12 yrs.

Date:

Signature of individual or guardian or personal representative of
patient's estate.

Relationship to patient

Date: