Haywood Pediatric & Adolescent Associates, P.A.

DATE: _____ **ACCOUNT # _____**

Please Fill Out Completely!

Child's Name*:* _____
(Last Name*)* (First Name*)* (Middle Name*)*

Date of Birth*:* _____ **SS#:** _____ **Sex:** Male Female

Race : ☐ American Indian ☐ Asian ☐ Black or African American ☐ More than one race ☐ White ☐ Hispanic or Latino ☐ Prefer not to answer ☐ Other: _____

Ethnicity/Etnicidad: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer **Language Preference** (circle one): English Spanish

Primarily Resides with: _____ Mother & Father _____Mother _____Father _____Other: _____

Mother's or Guardian's Full Name: _____

Maiden Name _____ SS# _____ Date of Birth _____

Address _____ Home Phone _____
(Mailing Address) (City) (State, ZIP)

Cell Phone _____ Employer _____ Work Phone: _____

Relationship to patient: ☐ Mother ☐ Other: _____

Email _____

Father's or Guardian's Full Name: _____

SS# _____ Date of Birth _____

Address _____ Home Phone _____
(Mailing Address) (City) (State, ZIP)

Cell Phone _____ Employer _____ Work Phone: _____

Relationship to patient: ☐ Father ☐ Other:_____

Email _____

Emergency Contact: (Check One) ☐ Mother ☐ Father ☐ Other: _____ Phone: _____

Preferred method of communication: appointment reminders, immunization reminders, etc…
(Please # (1,2, etc) preferred order, leave blank if you do not wish to be contacted in this method)

_____ Postal Mail

_____ Phone

_____ Web Message through our Patient Portal

_____ Text Message

MORE ON THE NEXT PAGE →

Please fill out completely!

Preferred Provider: (please check ONLY one) ☐ Dr. Stephen Wall ☐ Dr. Steven Hammel ☐ Dr. Karin McLelland
☐ Dr. Sarah Evers Dr. Tyler Vereen Anne Sarzynski, PNP ☐ Lillian Norris, PNP Lena Fagadore, PNP

INSURANCE INFORMATION

Name of Primary Insurance: _____

Subscriber Name: _____ **DOB**: _____ **SS#**: _____

Name of Secondary Insurance: _____

Subscriber Name: _____ **DOB**: _____ **SS#**: _____

How did you learn about Haywood Pediatric and Adolescent Medicine Group, PA?

_____ Friend/ Family Member _____ Hospital or Health Care Provider _____Website _____ Facebook _____Parent a former patient

_____Advertising? Where did you see it? _____ Other...please explain_____

I, being the parent or guardian of the above named child/children, do hereby request and authorize Haywood Pediatric and Adolescent Medicine Group to perform necessary services for my child which are deemed advisable by the physician/provider, whether or not I am present at the actual appointment.

ONLY PARENT OR LEGAL GUARDIAN CAN SIGN THIS FORM (Step-parents, grandparents, foster parents or anyone else that is NOT the legal guardian CANNOT sign. You may take this home and have the parent or legal guardian sign and either drop off at one of our offices or mail back to us). Thank you.

I swear that all the information provided is correct to the best of my knowledge:

Signature of Patient or Responsible Party: _____(SEAL) Date: _____

MORE ON THE NEXT PAGE →

PATIENT ACKNOWLEDGMENT AND CONSENT

I have received a copy of Haywood Pediatric and Adolescent Medicine Group, P.A.'s Notice of Privacy Practices, version effective 8/1/2013. I consent to medical treatment and diagnostic procedures by Haywood Pediatrics healthcare providers. I have read the Consent to Use or Disclose Information for Treatment, Payment, or Healthcare Operations and do hereby authorize the release/transmission of pertinent medical information necessary for treatment, payment, or healthcare operations. I have also read the Authorization for Use and Disclosure of Individually Identifiable Health Information and understand that if I refuse to sign this authorization, the law may allow Haywood Pediatrics to refuse treatment. I consent to the uses and disclosures of my health information as outlined in the Notice.

I hereby authorize Haywood Pediatrics to furnish information concerning my child to my insurance carriers, to other medical persons to whom physicians of Haywood Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Can confidential messages, including reminders, lab and x-ray results or other healthcare information be left on answering machines, cell phone, or work voice mail?

(Circle One) YES NO

16 AND 17 YEAR OLDS: I consent for my 16/17 year old to be seen by Haywood Pediatric and Adolescent Medicine Group and for the practice to perform necessary services for my child which are deemed advisable by the physician/provider, whether or not I am present at the actual appointment. ☐Yes ☐No initials_____

Please, list anyone **over the age of 18** that may bring your child to the doctor for diagnosis, treatment and immunizations. I understand that every effort will be made to contact me in case of accident, serious illness, or hospital admission. **WE CAN NO LONGER TAKE VERBAL CONSENTS.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____

Patient Name *(please print)* Date of Birth

_____ _____

Printed Name of Patient or Responsible Party Signature of Patient or Responsible Party

_____ _____

Relationship to Patient Date

MORE ON THE NEXT PAGE →

Financial Policy

Haywood Pediatrics is committed to caring for the children and youth of Haywood County and providing excellent care to sick children regardless of their financial situation. To assist you, we have the following policy. If you have any questions, please speak with a member of the staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. We accept Cash and Credit/Debit Cards.

We expect timely payment for our services but are willing to discuss payment plans for the parents of sick children who are experiencing economic hardship.

Following are our financial policies:

- Payment is expected at the time services are rendered.
- The adult (parent/legal guardian) who signs the demographics will be considered the guarantor and will be responsible for all balances not covered by insurance, including vaccinations, even if that adult is not present at the time of service. We do NOT honor custody agreements nor court orders.
- All insurance co-pays are to be paid upon check-in.
- We expect regular payments (at least every 30 days) on outstanding balances and the patient representative is responsible for setting up payment arrangements with Haywood Pediatrics. Failure to do so may result in your account being referred to a collection agency and your family may be terminated from the practice.
- Routine Care and Wellness visits will not be scheduled until outstanding balances are settled or adequate payment arrangements have been made.

Insurance
(Please present patient's insurance card at each visit)

As a courtesy, we will file claims for all visits. However, payment is expected at the time of service for co-pays, deductible amounts, etc. and it is the responsibility of the patient representative to verify with the insurance that we are participating with their policy and to know what benefits are covered. We participate with NC Medicaid/Health Choice, Aetna, BCBS, Cigna, Crescent, Tricare, Medcost, United Healthcare and many other plans.

I am responsible for all charges incurred at Haywood Pediatrics and authorize payment of insurance benefits directly to Haywood Pediatrics. I am responsible for payment of all charges not covered by insurance contracts – including co-payments, deductible, non-covered services, and those determined by the insurance company, where there is no contract with Haywood Pediatrics, to be above the insurance company's usual and customary fee.

Signature of Patient or Responsible Party: _____(SEAL) Date: _____

MORE ON THE NEXT PAGE →

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

MEDICAL HISTORY

BIRTH
Length of pregnancy: _____

Illnesses mother had during pregnancy:

a. Severe vomiting _____
b. Increased blood pressure _____
c. Viruses(flu, colds, etc.) _____
d. Kidney infections _____
e. Depression _____
f. Swelling _____
g. Vaginal bleeding _____
h. Rashes_____
i. Hospitalizations _____
j. Other _____

Labor:
Spontaneous_____ Induced_____
Length of labor (in hours) _____

Delivery:
Type: Vaginal _____ C-Section _____
Presentation: Vertex (head first) _____ Breech (buttocks first) _____

Newborn:
Birth weight: _____
Problems in hospital nursery (respiratory difficulties, jaundice, blueness, convulsions, bleeding, feeding difficulties, deformities, others): If yes, please explain: _____
_____
_____

Feeding:
Breast _____ Formula (what kind) _____
Any feeding problems? _____

DEVELOPMENT (age child first performed the following):

a. Rolled over: _____
b. Sat without support: _____
c. Stood unassisted: _____
d. Acquired first tooth: _____
e. Walked alone (more than 4 steps): _____
f. Said first word (other than mama, dada): _____
g. Put two words together (other than bye-bye):_____
h. Bladder control most of the time: _____
i. Bowel control most of the time: _____

ALLERGIES

Allergic to:
_____
_____
_____

Type of Reaction (ex. rash, difficulty breathing, etc):
_____
_____
_____

MEDICATIONS & REASON THEY ARE BEING TAKEN:
(please include all prescriptions, over-the-counter, herbal remedies & vitamins):

MEDICATION	REASON

MORE ON THE NEXT PAGE →

MEDICAL HISTORY (continued)

SPEECH, HEARING OR VISION PROBLEMS? If yes, please specify: _____

_____

INJURIES:

Type	Age	Long-Term Effects

SURGERY:

Type	Age	Complications

HOSPITAL VISITS, URGENT CARE VISITS & SPECIALISTS WITHIN LAST 6 MONTHS:

Reason	Name of Facility	Date

FAMILY HISTORY

Is there any family history of the following (include parents, grandparents, siblings, aunts, & uncles)

1. Asthma
2. Serious allergies
3. Diabetes
4. Seizures
5. Mental retardation
6. Blood disorders
7. Bleeding tendencies
8. Thyroid diseases
9. Liver diseases
10. Kidney disease
11. Rheumatic fever
12. Childhood heart disease
13. Birth defects
14. Death in first year of life
15. Tuberculosis
16. Cancer
17. Obesity
18. High blood pressure
19. Heart attacks before age 50
20. Strokes before age 60
21. Any other condition occurring in 2 or more family members

If yes, list disease or condition below; give relationship of family member to child and give specific diagnoses and circumstances (if known).

_____
_____
_____
_____

Is there any family history of substance abuse (such as drugs or alcohol)? If yes, please describe circumstances (if known):

_____
_____
_____

IMMUNIZATIONS

Please, provide us with a copy of past immunizations from health clinics, schools, or other physicians.

MEDICAL RECORDS

Please, ask for & sign release of records; so we may obtain records from other health clinics, hospitals, or other physicians.

THANK YOU!