Lake Norman Pediatrics

Patient Information Sheet

Patient's Name: ____

(First) (Middle) (Last)

Date of Birth: ____________________ SS#____________________ **Gender:** ☐ Male ☐ Female

Address: ______________________________ City: ______________ State: _______ Zip: _______

Sibling(s) Names	DOB

Race (check one)
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than 1 race
- ☐ American Indian/ Alaska Native
- ☐ Declines to respond

Ethnicity (check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Email Address______________________________ ______________________________

Preferred Notification Method: ☐ Phone ____________________ ☐ Mail

☐ Mother ☐ Stepmother ☐ Legal Guardian

Name ______________________________

DOB__________ Maiden Name__________

SS#____________________

Mailing Address: ______________________________

____

City State Zip

Home Phone: ______________________________

Cell Phone______________________________

Employer______________________________

Work Phone______________________________

Occupation______________________________

Former Patient of Lake Norman Pediatrics? ☐ Yes ☐ No

☐ Father ☐ Stepfather ☐ Legal Guardian

Name ______________________________

DOB__________ SS#__________

Mailing Address: ______________________________

____

City State Zip

Home Phone: ______________________________

Cell Phone______________________________

Employer______________________________

Work Phone ______________________________

Occupation______________________________

Former Patient of Lake Norman Pediatrics? ☐ Yes ☐ No

******Please note: Your current insurance card is required at EVERY visit ******

☐ Private Insurance ☐ Market Place ☐ Self Pay ☐ Medicaid ☐ NC Health Choice

______________________________ ______________

Parent/Legal Guardian Signature Date

Lake Norman Pediatrics

Medical History

Patient's Name: ____
(First) (Middle) (Last)

Drug Allergies	Reaction

Food Allergies	Reaction

☐ **No Known Allergies – Date** ____________________

Does anyone smoke in the household? ☐ Yes/Inside ☐ Yes/Outside only ☐ No

Patient History

☐ Adoption
☐ Anemia
☐ Anxiety/Depression
☐ Asthma
☐ Cancer
☐ Chicken Pox
☐ Delayed Development
☐ Diabetes
☐ Ear Infections
☐ Ear Tubes
☐ Feeding Problems
☐ Heart Condition
☐ Kidney Condition
☐ Prematurity
☐ Speech Impairment
☐ Strep Throat
☐ Surgery: __________________
☐ Tonsillitis
☐ Wheezing

☐ Other:

Family History

☐ Allergies _____________
☐ Anemia ______________
☐ Asthma ______________
☐ Cancer _______________
☐ Diabetes ______________
☐ Heart Condition _____________
☐ High Blood Pressure______________
☐ High Cholesterol______________
☐ Kidney Problems ______________
☐ Lung Problems______________
☐ Mental Health _______________

☐ Other:

BIRTH HISTORY

City/Hospital: ____

Birth Weight _____________________ Oxygen Required ☐ Yes ☐ No

Complications: ____

Family Status

***Please note: Legal Documentation will be required for any custody arrangements ***

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Re-Married ☐ Widowed

Legal Guardian: ____ Relationship: _____________________________________

If divorced or separated, primary caregiver: ☐ Mother ☐ Father ☐ Guardian ☐ Foster Care

Lake Norman Pediatrics

Financial Policy

We are committed to providing your child the best possible medical care. Part of that care involves working with you to insure you are aware of our financial policies and your payment responsibilities. The following is a statement of our Financial Policy.

Insurance

Your insurance policy is a contract between you and your insurance company. Lake Norman Pediatrics is not a party to that contract. It is the parent's responsibility to know your benefits, coverage, and copay/deductible prior to the visit. Parents should make this information available to whomever is present with child/children at time of visit. As a courtesy, we will file claims to your primary insurance company. Lake Norman Pediatrics will not become involved in disputes regarding your co-pays, deductibles or non-covered services.

Your current insurance card is required at each visit. Please be advised, if your insurance changes, it is your responsibility to provide us with updated insurance information. **You will be responsible for all charges filed with incorrect insurance or outside of the time filing limit.** All insurance carriers have a claim filing time limit (90 days).

Co-Pays/Deductibles

As stated in the contract between you and your insurance carrier, co-pays/deductibles are required to be paid at time of service. A portion of your deductible will be collected at time of service. We accept all major credit cards, checks, cash and CareCredit.

Self-pay Patients

Self-pay patients are responsible for 100% of all charges incurred and expected to make full payment at time of service.

Collections

We use an outside collection agency to handle all past due balances. We make several attempts to collect or make payment arrangements prior to sending an account to collections. The patient is subject to termination from the practice when an account in placed in collections. Parent/Legal Guardians are responsible for all collection fees.

Transfer of Records

Our office will charge a reasonable fee to cover cost incurred in searching, handling, copying and mailing medical records to the patient or patient designated representative as allowed by the NC General Statutes (§ 90-411) and covered under HIPAA. Please call the office should you require an initial estimate of service fees.

PLEASE NOTE: Only records initiated and completed by our staff in our office can or will be copied. Allow a maximum of 30 days for transfer of records to be completed.

Parent/Legal Guardian:____

Date:______________________

656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133
FAX 704-660-0406

PRIVACY FORMS
***H**ealth*
***I**nsurance*
Portability and
***A**ccountability*
***A**ct of 1996*
(HIPAA)

Providing Comprehensive Pediatric Care for Your Children from Birth through Adolescence Since 1987

April 2003

Acknowledgement of Receipt of the Notice of Privacy Practices F-2000

____ ______________________

Name of Patient (*Please Print or Type)* Patient Date of Birth

I acknowledge I was provided the Notice of Privacy Practices of Lake Norman Pediatrics. The Notice of Privacy Practices provides information about how Lake Norman Pediatrics may use and disclose protected health information on the patient listed. I was given the opportunity and encouraged to read it in full.

Lake Norman Pediatrics reserves the right to revise its Notice of Privacy Practices. If the notice is modified, a copy of the revised notice may be obtained by:

- requesting a copy in person
- accessing the Lake Norman Pediatrics web site at http://www.lakenormanpediatrics.com
- requesting a copy be mailed

If you have any questions about the Lake Norman Pediatrics Notice of Privacy Practices, please contact:

Lake Norman Pediatrics
Attn: Privacy Administrator
656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133

Required Signature:

____

Signature of Patient or Patient Representative

____ ______________________

Name of Patient Representative and Relationship (*Please Print or Type)* Date

Inability to obtain acknowledgement

A good faith effort was made to obtain an acknowledgement that the Lake Norman Pediatrics Notice of Privacy Practices was provided to the patient listed above or their representative. The acknowledgement was not obtained because:

- ❑ The patient was undergoing emergency treatment
- ❑ The patient or patient representative declined to sign the acknowledgement
- ❑ Other: ________________________________

Required Signature

____

Name of Staff Member *(Please Print or Type*)

____ ______________________

Signature Date

Lake Norman Pediatrics

Consent for Treatment

Patient's Name: _________________________________ Date of Birth: _________________

This authorization is for patients under 18 years of age.

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship	Phone Number

Vaccine/Injectable Medication Administration:

Lake Norman Pediatrics has my permission to administer Well Child Immunizations or Injectable Medications.

____ ____________________

Signature of Parent or Legal Guardian Date

For patients 16 years and older ONLY:

Patient listed above may present and be treated unaccompanied by an adult. ☐Yes ☐ No

____ ____________________

Signature of Parent or Legal Guardian Date

Lake Norman Pediatrics

Vaccine/Lab Billing

*Lake Norman Pediatrics would like you to be aware that any **vaccines** given or **labs** performed in our office or sent to an outside lab may be subject to a deductible or non-covered service by your insurance carrier. Your insurance policy/company determines how charges are processed and applied. Please understand **vaccines/labs** are expensive and you may be responsible for the deductible/co-payment due by your insurance.*

You have the option to contact your insurance company to verify your coverage prior to vaccines given or labs performed. Please discuss this with the office staff or physician at the time of visit.

Thank you,

Lake Norman Pediatrics

I have read the information provided and understand I will be responsible for any deductible/non covered service required by my insurance.

*Patient's Name*_________________________________ *Date of Birth*__________________

____

Parent/Legal Guardian Signature

656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133
FAX 704-660-0406

Amy P. Ferguson, MD
Gianna D. Madrid, MD
Karen S. Mayhew, PA-C
Laura O'Donnell, MD
Robin C. Ray, MD
Kevin D. Wellbaum, MD

Authorization to Release Protected Health Information

I hereby authorize Lake Norman Pediatrics to obtain medical records on the patient listed below through the release of PHI as described below. I understand the information disclosed, pursuant to this Authorization, may be subject to disclosure by the recipient, and no longer protected by the privacy regulations.

Patient's Name:____ **Date of Birth:** _________________________

Release From:		Release To:
Practice		Practice: **Lake Norman Pediatrics**
Address:		Address: **656 Carpenter Ave.**
		Mooresville, NC 28115
Phone:		Phone: **704-664-5133**
Fax:		Fax: **704-660-0406**

This authorization permits Lake Norman Pediatrics to use or disclose the following PHI (Protective Health Information). Check the appropriate box or describe the information to be released.

☐ Entire record ☐ Immunization Record ☐ Pathology Reports ☐ Laboratory Reports

☐ Copy of Medical Records for the period ____/_____/_____ to _____/_____/_____

☐ Other (Please Specify) ____

☐ **I do** ☐ **I do not** authorize release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for drug and/or alcohol abuse.

PURPOSE OF DISCLOSURE:

☐ Transferring Physicians ☐ Insurance ☐ Moving ☐ Legal Purpose ☐ Patient Request-No Reason ☐ Personal

☐ Other____

I understand that I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer 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.
- Lake Norman Pediatrics assumes no responsibility for the use or misuse by others of my (child's) health information disclosed under this authorization.
- This release form is valid 12 months from the date below.

Patient/Parent/Guardian Signature:____**Date:** ___________