



Lake Norman Pediatrics

Chart#

PATIENT INFORMATION

Patient Name – First, Middle, Last _____ Sex: M F
Name Called _____

Street Address or PO Box: _____ City _____ State _____ ZIP Code _____

Date of Birth _____ Patient SS# _____ Home Phone Number _____

Primary Contact: _____
Name _____ Cell# _____ Work# _____ Home# _____

****Primary contact will be used for Appointment scheduling, cancellations, lab results, etc.****

CONTACT INFORMATION OR LEGAL GUARDIAN

Mother Father Stepmother Stepfather Legal Guardian- Relationship _____

First, Middle Init, Last _____ Date of Birth _____

SS# _____ Home Phone# _____ Cell # _____

Street Address or PO Box: _____ City _____ State _____ ZIP Code _____

Place of Employment: _____ Work Phone # _____ Parent/Guardian E-Mail Address _____

Mother Father Stepmother Stepfather Legal Guardian- Relationship _____

First, Middle Init, Last _____ Date of Birth _____

SS# _____ Home Phone# _____ Cell # _____

Street Address or PO Box: _____ City _____ State _____ ZIP Code _____

Place of Employment: _____ Work Phone # _____ Parent/Guardian E-Mail Address _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy Holders Name _____ SS# _____

We file all Primary Insurances
We file Secondary insurance only with BC/BS, Tricare and Medicaid
A copy of insurance cards are required to file insurance
Copay is required at time of service

Signature of Parent/Legal Guardian _____ Date _____



Lake Norman Pediatrics

Chart# _____

PATIENT HISTORY FORM

Patients Name – First _____ Middle _____ Last _____ Date of Birth _____

Sex: M F

Allergies:

Drug _____ Reaction _____

Food _____ Reaction _____

Environmental Allergies _____ Reaction _____

No Known Allergies – Date _____

Does anyone smoke in the household? Yes Outside Only No

OTHER CHILDREN IN FAMILY

Name: _____ Name: _____ Name: _____

Name: _____ Name: _____ Name: _____

PLEASE CHECK – PATIENT HISTORY

- | | | | |
|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech Impairment | |

List Surgeries/Hospitalizations: _____

IMMUNIZATIONS- A copy of your child's immunization record is required

PLEASE CHECK – FAMILY HISTORY /RELATIONSHIP TO PATIENT

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Kidney Problems _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Heart Condition _____ | <input type="checkbox"/> Lung Problems _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Cholesterol _____ | |

BIRTH HISTORY

Location: _____ Pediatrician: _____

Birth Weight: _____ Length _____ Breastfed Formula _____ Oxygen Required Yes

Complications: _____

SOCIAL HISTORY

Parent Marital Status: Married Divorced Single Separated

Who has legal custody of child? Mom Dad Grandparents Other _____

Who will bring child to the office? (Check all that apply) Mom Dad Grandparents Stepmom

Stepfather Other _____

Lake Norman Pediatrics

Financial Policy

We are committed to providing your child the best possible 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 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. Please become familiar with the terms and benefits of your insurance plan. As a courtesy, we will file all claims to your primary insurance company. Lake Norman Pediatrics will not become involved in disputes regarding co-pays or deductibles.

We expect a current copy of your insurance card. Please be advised that if your insurance changes, it is your responsibility to provide us with updated insurance information. **If you supply us with incorrect information or out of the time filing limit, we will hold you responsible for any unpaid charges.** All insurance carriers have a claims filing time limit.

Co-pays

As stated in the contract between you and your insurance carrier, all co-pays are to be paid at time of service. Co-pays will be collected prior to your appointment.

Self-Pay Patients

Self-pay patients are 100% responsible for all charges incurred and expected to make full payment at the time services are rendered. Should you need to make payment arrangements, please call and ask to speak with one of our Billing Associates. We will make every effort to reach a mutually agreeable budget plan.

Collections

We use an outside collection agency to collect on patient balances after they become past due over 120 days. We make several attempts to make payment arrangements prior to sending an account to collections. Once the account is sent to collections, the patient is subject to termination from the practice.

Labs & Procedures

Labs and procedures may be subject to deductibles. It is your responsibility to be familiar with your plan and benefits.

Transfer of Records

Lake Norman Pediatrics may use an outside company for copying and the transferring of records unless otherwise requested. This company is responsible for all copying fees and will bill you directly. Lake Norman Pediatrics is not responsible for this billing nor receives compensation for this service. Currently, the charge for this service is per page plus postage.

I hereby acknowledge that I have read and agree to abide by Lake Norman Pediatrics Financial Policy.

Signature of Responsible Party

Date



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

Health
 Insurance
 Portability and
 Accountability
 Act of 1996
 (HIPAA)

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

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 of 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

Child's Legal Name-Last, First, Middle)

(Date of Birth)

Child's Legal Name-Last, First, Middle)

(Date of Birth)

Child's Legal Name-Last, First, Middle)

(Date of Birth)

Child's Legal Name-Last, First, Middle)

(Date of Birth)

I authorize the medical personnel of Lake Norman Pediatrics to treat my child if illness or injury occurs during my absence.

Signature of Parent/Legal Guardian _____ Date _____

I give my consent for Lake Norman Pediatrics to administer Well Child immunizations or injectable medications.

Signature of Parent/Legal Guardian _____ Date _____

I give the following people authority to bring my child in for Sick or Well Child appointments during my absence, including authorization to administer Well Child immunizations or injectable medications.

1. _____
(Name) (Telephone Number) (Relationship)

2. _____
(Name) (Telephone Number) (Relationship)

3. _____
(Name) (Telephone Number) (Relationship)

Signature of Parent/Legal Guardian _____ Date _____

This authorization for treatment is valid until revoked in writing by Parent /Legal Guardian.

(Witness Signature)

(Date)