400 Athletic Club Blvd Unit 101
Clayton, NC 27527
Phone : (919) 267-1499
Fax : (919) 250-6272

4109 Wake Forest Rd. STE 300
Raleigh, NC 27609
Phone : (919) 250-3478
Fax : (919) 250-6272

Patient Registration Form

Date:_____

Patient Information

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: ____/____/____ Age: _____ Sex: _____

Race: ☐ African-American ☐ Asian ☐ Native American ☐ White ☐ Other ☐ Decline to Respond

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Respond

Insurance Information

Primary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____

Mother/Legal Guardian

Name: _____

DOB: ____/____/____

Address:_____

_____

City State Zip Code

Home Phone: _____

Cell Phone: _____

Email: _____

Marital Status (Check One)

☐Single ☐Married ☐Divorced ☐Widowed

Father/Legal Guardian

Name: _____

DOB: ____/____/____

Address:_____

_____

City State Zip Code

Home Phone: _____

Cell Phone: _____

Email: _____

Marital Status (Check One)

☐Single ☐Married ☐Divorced ☐Widowed

Who is the primary care giver? ☐Both ☐Mother ☐Father ☐Other

If applicable, who has primary custody? ☐Both ☐Mother ☐Father ☐Other** _____

(**Please provide legal documents for any alternative custody arrangements.)

Emergency Contact (Other than Parent)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PLEASE LIST ALL PERSONS WHO MAY SCHEDULE APPOINTMENTS, CALL FOR MEDICAL ADVICE OR BRING YOUR CHILD TO THE OFFICE FOR TREATMENT (I.E GRANDPARENTS, BABYSITTER, AUNT). THESE INDIVIDUALS WILL BE ASKED TO PRESENT IDENTIFICATION AT THE TIME OF THE VISIT. IF SOMEONE OTHER THAN THESE PERSONS CONTACTS US RELATIVE TO YOUR CHILD, WE WILL CONTACT THE PARENT OR GUARDIAN FOR PERMISSION TO TREAT OR ADVISE. IN THE EVENT OF AN EMERGENCY, WE WILL TREAT AND MAKE EVERY ATTEMPT TO CONTACT THE PARENT OR GUARDIAN.

NAME	RELATIONSHIP	PHONE NUMBER

Additional Information

Preferred Language : _____

Preferred Provider: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Authorization

As a courtesy, Kids First Pediatrics will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Kids First Pediatrics and/or the rendering physician(s) to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Kids First Pediatrics of Raleigh.

Uses of Protected Health Information to Contact You

We may use your protected health information to contact you by phone or via e-mail at home or any other location that you may specify and leave a message regarding appointment reminders, insurance items and any calls pertaining to your child's clinical care, including lab and x-ray results with information about treatment alternatives or other health related benefits and services that in our opinion may be of interest to you.

This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original.

Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to you in the posted Notice of Privacy Policies and Consent to Treat Forms.

_____ _____

Parent/Guardian Signature Date

Medical History Form

General Questions:

How did you hear about us? (Please Check One)

☐	Family Member	☐	Advertisements
☐	Friend	☐	Hospital Referred
☐	Internet	☐	Other

Are you the child's…….? (Please Circle One)

☐	Mother	☐	Other Relative
☐	Father	☐	Other
☐	Grandparent	☐	Self (Are you the patient?)
☐	Foster Parent		

	Yes	No	I Don't Know	Explanation
Do you consider your child to be in good health?	☐	☐	☐	
Does your child have any serious illnesses or medical conditions?	☐	☐	☐	
Do you have any concerns about your child's behavior or development?	☐	☐	☐	
Is your child in daycare?	☐	☐	☐	
Is your child in school?	☐	☐	☐	***What type?***
Do you feel your family has enough to eat?	☐	☐	☐	

Birth History:

	Yes	No	I Don't Know	Explanation
Were there any prenatal or neonatal complications?	☐	☐	☐	
Was a NICU stay required?	☐	☐	☐	
During pregnancy, did mother use tobacco?	☐	☐	☐	
During pregnancy, did mother drink alcohol?	☐	☐	☐	
During Pregnancy, did mother use drugs or medications?	☐	☐	☐	
During pregnancy, did mother take prenatal vitamins?	☐	☐	☐	

Social History:

Where is your child currently living? (Please Check One)

- ☐ In a house or apartment with family
- ☐ In a house or apartment with relatives or friends
- ☐ In a house or apartment with foster family
- ☐ Shelter
- ☐ Other : _____

How many times have you moved in the past year? (Please Check One)

- ☐ 0
- ☐ 1 - 2
- ☐ 3 - 4
- ☐ 5 or more

	Yes	No	I Don't Know
Does your child live with both of his/her parents?	☐	☐	☐
Do you feel your child lives in a safe place?	☐	☐	☐
Are there pets in the child's home?	☐	☐	☐
Are there smoke alarms in the child's home?	☐	☐	☐
Are there any guns in the child's home?	☐	☐	☐
Does anyone in your household smoke? Cigarettes, E-cigarettes, or other?	☐	☐	☐

	Always	Often	Sometimes	Rarely	Never	Not Applicable
How often does your child wear a helmet when riding a bicycle?	☐	☐	☐	☐	☐	☐
How often does your child wear a seatbelt (carseat)?	☐	☐	☐	☐	☐	☐
How often does your family eat meals together?	☐	☐	☐	☐	☐	☐
How often do you read bedtime stories to your child?	☐	☐	☐	☐	☐	☐

Biological Family History:

Please place an **X** in the box if the listed relative has ever been diagnosed with the following medical conditions.

	Mother	Father	Siblings	Grandparents	Other Relatives
Asthma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Learning Problems	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Other Concerns	☐	☐	☐	☐	☐

Past Medical History:

☐	Asthma	☐	Other Heart Problems
☐	Reactive Airway Disease	☐	Obesity
☐	Wheezing	☐	Diabetes
☐	Bronchitis	☐	Frequent Abdominal Pain
☐	Bronchiolitis	☐	Constipation requiring doctor's visits
☐	Pneumonia	☐	Kidney Infection
☐	Other Breathing Problems	☐	Bed-wetting (after 5 years old)
☐	Seasonal Allergies	☐	Recurrent Urinary Tract Infections
☐	Eczema	☐	Urologic Malformation
☐	Chronic Skin Problems	☐	Other kidney or urologic problems
☐	Allergy to bees	☐	Metabolic or Genetic Disorder
☐	Allergy to peanuts	☐	Cystic Fibrosis
☐	Other Allergy Problems	☐	Anemia
☐	Broken Bones	☐	Bleeding Problem
☐	Concussion	☐	Blood Transfusion

☐	Needed Stitches	☐	Cancer
☐	In a Car Accident	☐	Tumors
☐	Other Injury	☐	Bone Marrow Transplant
☐	Dental Decay	☐	Chemotherapy
☐	Problems with eyes or vision	☐	Snoring
☐	Wears Glasses	☐	Sleep Apnea
☐	Wears Contact Lenses	☐	Other Sleeping Problems
☐	Frequent Ear Infections	☐	ADHD
☐	Hearing Loss	☐	Mood Problems
☐	Other Problems with ears/hearing	☐	Anxiety
☐	Frequent Headaches	☐	Depression
☐	Seizures	☐	Other Behavioral Problems
☐	Cerebral Palsy	☐	Speech Delay
☐	Other Neurologic Problems	☐	Developmental Delay
☐	Heart Murmur	☐	Uses Alcohol/Drugs
☐	High Blood Pressure	☐	Uses Tobacco Products

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AUTHORIZATION OF RELEASE OF HEALTH INFORMATION

Patient Name: _____ **DOB:** / /

Address: _____ **Telephone:** _____-_____-_____

_____

1. I authorize the use or disclosure of the named individual's health information as described below:
2. The following individual(s) or organization(s) is authorized to make the disclosure

CHECK ONE : ◯ Send TO ◯ Request FROM

Provider Name: _____ **Telephone:** _____-_____-_____

Address: _____ **Fax Number:** _____-_____-_____

_____

3. The type of information to be used or disclosed is as follows (check and /or include description):
   - ☐ Immunization Record & Medical Summary
   - ☐ Records only from (date) _____ to (date) _____
   - ☐ Records pertaining to (please describe) _____
4. I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS-related syndrome or HIV testing. It may also include information about behavior or mental health services, alcohol, drug, psychiatric and psychological information.
5. Release records for use by or disclose to the provided:

Kids First Pediatrics of Raleigh
4109 Wake Forest Rd. STE 300 Raleigh, NC 27609
Telephone: *919.250.3478* ***Fax:*** *919.250.6272*

6. Disclosed information will be used for the following purposes:
   - ☐ My personal records
   - ☐ Transfer of care, due to dissatisfaction with the practice
   - ☐ Transfer of care due to relocation
   - ☐ Other (please specify) _____
7. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
8. I understand that I have the right to revoke this authorization at any time, by presenting a written revocation to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. This authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in ninety (90) days.
10. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form to assure healthcare or treatment.

Signature _____ _____ **Date** ____/____/____

Patient or Legal Representative Relationship to patient

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Office Policy

***Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office and financial policies allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully*; your clear understanding of the policies is important to our professional relationship. If you have any questions, do not hesitate to ask a member of our staff.**

Vaccine Policy

Kids First Pediatrics provides a safe and healthy environment for ALL children. We follow the vaccine schedule recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) for all patients. For the safety of our patients, we do not treat patients not following the vaccination schedule.

Appointments

We value the time we have set aside to see and treat your child. If you are running late please call our office as soon as possible. If you are unable to make it to your scheduled visit, please notify our office within 24 hours of your child's appointment. If you miss 3 appointments within a year, we reserve the right to discharge you from the practice. A charge of $25.00 will be applied toward each additional missed or "no-show" appointment. Patients are encouraged to register online and complete any assigned questionnaires prior to arriving for their visit. This helps to reduce wait time and allows for a more informed healthcare experience. A photo ID of the individual accompanying the child to the appointment is required along with the patient's insurance card at time of visit for each appointment.

Current Information

As a patient at Kids First Pediatrics, you are required to notify our staff of any changes in your following demographic information:

- Insurance
- Benefits
- Patient Name
- Home Address
- E-mail
- Authorized individuals
- and/or Contact numbers

Last reviewed - March 2023

Financial Responsibility

Your insurance policy is a contract between you and your insurance company. In order to avoid unexpected costs, it is your responsibility to make sure that we are ***IN NETWORK*** with your particular plan by contacting your health plan directly.

We accept cash, checks, Visa, and MasterCard credit and debit cards. A $30.00 fee will be charged for any checks returned for insufficient funds. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances. Co-payments, co-insurances and deductibles are due at the time of service.

Self-Pay patients are required to pay for services in ***FULL*** at the time of the visit. If your insurance is out of network you are required to pay for services in full at the time of the visit. $50 is required at time of service for all patients with high deductible insurance plans. All lab work is billed by the reference laboratory. Refer to your invoice to obtain their contact information.

Outstanding patient balances are due in full within 30 days of your appointment. Any account balance outstanding longer than 30 days will be charged a $10.00 collection fee and will be forwarded to a collection agency.

Forms

There is no charge for a routine form given at the time of your child's appointment. However, should you lose your forms, there will be a $5.00 charge per form to replace them. Family and Medical Leave Acts require a $20.00 payment when the forms are dropped off and a 7-day turnaround time for the form.

Prescription Refills

All prescription refills should be requested through your pharmacy. The pharmacy will send a request for refill to the practice electronically for doctor review. If there is an issue with the pharmacy's request, refills can be requested through Patient Portal or the Healow app. A 48 hour notice during regular business hours is required for all medication refills. Please plan accordingly.

Referrals

Advance notice is needed for all non-emergent referrals, typically 10 business days. Remember, we must approve referrals before they are issued. Once referred, it can take up to 14 business days for the referred practice/service to contact you for scheduling. It is the responsibility of the parent/guardian to follow up with Kids First if you have not been contacted by the referred practice after this time frame.

Transfer of Records

If you transfer to another physician, a 30 day notice is required to provide a copy of your immunization record and medical summary for your new physician. If you wish to have this process expedited, immunizations and medical summaries performed at Kids First Pediatrics are available on Patient Portal. We provide records of your child for visits rendered here at Kids First Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

We must emphasize that as pediatric providers, our relationship is with you and your child, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients. All charges are strictly your responsibility from *THE DATE SERVICES ARE RENDERED*. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

By signing below, I acknowledge that I have read, accepted, and fully understand the office and financial policies set forth by Kids First Pediatrics of Raleigh & Clayton. I agree to comply with and accept the responsibility for any payment that becomes due, as outlined in the office and financial policies. I understand and agree that Kids First Pediatrics may amend the terms of these policies at any time, without prior notification to the guarantor.

Patient Name(s)_____

Parent OR Guardian Name_____ **Relationship**_____

Parent OR Guardian Signature _____ **Date**_____

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Consent to Treat

1. I _____ **(*parent/guardian name*)** give permission for **KIDS FIRST PEDIATRICS** to give _____ **(*patient name*)** medical treatment.
2. I allow **KIDS FIRST PEDIATRICS** to file for insurance benefits to pay for the care the patient receives.

   I understand that:
   - **KIDS FIRST PEDIATRICS** will have to send the patient's medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with a clinician.

Patient Name _____

Parent/Guardian Name_____ **Relationship**_____

Parent/Guardian Signature _____ **Date**_____

Consent to Treat Form.
Content last reviewed September 2020.
Agency for Healthcare Research and Quality, Rockville, MD.
https://www.ahrq.gov/health-literacy/improve/precautions/tool11d.html

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Privacy Policy

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition.
- Provide disaster relief.
- Include you in a hospital directory.
- Provide mental health care.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for our services.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- Say yes to all reasonable requests.

Last reviewed - June 2023

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

***** For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our website.

For any questions regarding the privacy policy please contact us !

As a practice, we value privacy and never market or sell personal information.

By signing below I am acknowledging that I have read, accepted and fully understand the privacy policy set forth by Kids First Pediatrics of Raleigh & Clayton.

Patient Name(s)_____

Parent OR Guardian Name_____ **Relationship**_____

Parent OR Guardian Signature _____ **Date**_____

Last reviewed - June 2023