Sandhills pediatrics

Welcome and thank you for choosing Sandhills Pediatrics! We want to let you know what to expect as you prepare for your upcoming visit. Enclosed is our new patient welcome packet. Please complete the included documents and bring them on the day of your appointment.

Your visit will begin with the clinic registration and check-in staff. If you did not complete the forms in the welcome packet, you will need to do so at the visit. You may also be provided with additional paperwork to complete as requested by the provider. Clinical staff will collect vital signs and ask a series of questions to update the patient medical record. This is important to your child's provider and will help him or her have the information needed to ensure we provide you and your child with the highest quality of care.

***Patients under the age of 18 should be accompanied by someone with legal authority to consent to treatment.** If the person accompanying the patient has legal authority to consent to treatment on behalf of the patient, but is not the patient's parent, the person needs to bring the appropriate paperwork (i.e. legal guardianship documents) to the appointment.

If the patient is being accompanied by a foster parent, DSS case managers must be available by phone during the appointment in order to consent to treatment as necessary. If the patient will be accompanied by someone who does not have legal authority to consent to treatment on behalf of the patient, the parent will need to send, in writing, a statement that the person accompanying the patient may consent for treatment if needed.

If we do not have appropriate legal documents, your appointment may be rescheduled.

We are dedicated to our patients and providing quality medical care to your child(ren). Families where the parents are divorced or separated sometimes present our practice with unique challenges (who communicates with who, who pays the bill?). Please ask about our policy for divorced or separated parents if this applies to you.

If you cannot keep your appointment, please call as soon as possible at 910 692-2444. Please have the following documents on the day of your appointment:

- The completed welcome packet
- Copy of insurance card and photo ID
- Updated shot record
- All medications your child is taking in original container(s)

For your convenience we have on call service available after hours through HealthLink at 1-888-267-3675.

Please visit our website at www.sandhillspeds.com for additional information or call us at 910-692-2444

We look forward to seeing you and thank you for choosing Sandhills Pediatrics for your child's care.

Southern Pines	Seven Lakes/West End	Raeford
195 West Illinois Ave Southern Pines,NC 28387	155 Grant Street West End, Nc 27376	116 Campus Ave Raeford, NC 28376

Sandhills pediatrics

Patient Registration Form

First Name _____ MI _____ Last Name_____ Suffix_____

DOB_______________ Gender (**circle one**): Male Female Gender Diverse

Race (circle one): American Indian/Alaskan Native; Asian; Black/African American; Native Hawaiian/Pacific Islander; White; Other

Ethnic Group (circle one): Hispanic OR Non-Hispanic Preferred Language:_____

Primary Account Holder Name:_____

Primary Account Holder Address (mailing): _____

Primary Account Holder Address (physical): _____

Communication Preference: [ ] Call [ ] Text [ ] Email (via secure patient portal)
Preferred Phone #: ( ) _____
Family Email: _____

Parent/ Guardian Info: (*date of birth of parents required for insurance billing due to federal rules)*

Parent/Guardian #1: (**circle one**) Mom or Dad - Last name_____First Name_____

MI _____ Maiden Name _____ DOB _____________ SSN:_____-_____-_____

Work # ( ) _____ Cell # ( ) _____

Parent/Guardian #2: (**circle one**) Mom or Dad - Last name _____ First Name_____

MI _____ Maiden Name _____ DOB _______________ SSN: _____-_____-_____

Work# ( ) _____ Cell # ( ) _____

Insurance Info:

Primary Insurance Name _____

Employer Name of Insurance Carrier _____

Secondary Insurance Name _____

Employer Name of Insurance Carrier _____

Do you have any children that have been seen by one of our providers prior to today's visit?

YES NO Name _____ DOB __________ _____
Name _____ DOB _____ __________
Name _____ DOB _______________

Emergency Contact other than Parent/ Guardian

Contact Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Do we have permission to contact them in an emergency and leave messages if necessary? YES NO

Signature _____ **Date** _____

Revised 04/20

Sandhills pediatrics

Incoming Authorization to Release and Disclose Patient Information

Patient Information	Name: _____ Date Of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Releasing Information FROM	Name: _____ Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Releasing Information TO	**Sandhills Pediatrics** **Phone: 910-692-2444** **195 W. Illinois Avenue** **Fax: 910-692-3651** **Southern Pines, NC 28387**
Information to be Released	I understand this information may include any history of HIV, AIDS, sexually transmitted diseases, pregnancy, behavioral health/psychiatric care, alcohol and/or drug related information ___ Immunization Record ___ Last Physical Exam ___ Medical Summary ___ Entire Chart ___ Specific Info/Dates: _____

- This authorization is valid for 12 months from the date of the signature
- Sandhills Pediatrics, Inc. will not restrict or condition my treatment if I choose not to sign this form.
- I may revoke this authorization at any time by submitting a written notification, but I understand that revoking this authorization will not affect any information released prior to revocation.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Print Name: _____ Signature:_____

Relationship to Patient: Self Parent/Guardian Other: _____ Date: _____

FOR INTERNAL PURPOSES ONLY: Name and title of person completing records release _____
Method of Transfer: __ **Mailed on:** _____ __ **Faxed on:** _____

Sandhills pediatrics

Parental Designation to Permit Consent to Treatment

Patient's Name _____ DOB _____

Patient Address _____

_____

I, being the parent or legal guardian of _____, do hereby request and authorize Providers/staff of Sandhills Pediatrics to perform the necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment. Treatment may include examinations, immunizations/procedures, and other interventions.

Below is a list of individuals who have permission to bring my child to the office for treatment:

_____

_____

_____

_____

_____

_____

_____

_____ ***Check here*** if unaccompanied minor (16 years or older) has permission to be treated without a parent or adult present.

By signing below, I indicate that I understand the scope and importance of this grant of powers to Sandhills Pediatrics. This consent shall be effective from the date it is executed until updated by the practice or parent or until the patient turns 18 or is deemed an adult.

_____ _____

Signature of Parents or Legal Guardian Date

_____ _____

Witness Date

Reviewed 04/2020

Sandhills pediatrics

Patient Acknowledgement of Receipt of Privacy Notice

Patient Name _____ DOB _____

Sandhills Pediatrics, Inc. is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. This policy is posted in the lobby area and is provided to patients at the time of their registration.

I acknowledge that I have received a copy of this noticed regarding the use and disclosure of the patient's health information.

_____ _____

Signature Date

_____ _____

Printed name Relationship to patient

I authorize Sandhills Pediatrics to leave messages regarding my child on my voicemail or answering machines at the phone numbers I supply (**circle one**) YES NO

I specifically authorize Sandhills Pediatrics to release medical information to the following individuals:

_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #

I understand I may change this consent at any time. I release Sandhills Pediatrics, its employees and physicians for any legal responsibilities or liabilities for disclosure of my child's medical information to the extent authorized here.

_____	_____	_____
Parent/Guardian Signature	Date	Relationship to patient

_____

Witness

Revised 03/2019

Sandhills pediatrics

Financial Policy

The physicians of Sandhills Pediatrics, Inc. are dedicated to providing the very best health for your child/children. Our mission is always for the children, however, in order to assure the financial stability of our practice, we have adopted the following financial policy.

We participate with the majority of insurance carriers. To guarantee the accuracy of claims processing, you may be asked to present a valid insurance card at every visit.

Your agreement with your insurance carrier is a private one, although, we do staff our business office with professional account representatives who perform insurance follow up, if an insurance carrier has not paid within 60 days of billing, the balance may be transferred to patient responsibility. Any outstanding balances, co-payments, and deductibles are due prior to checking in/out for your child's appointments.

Medicaid:
Our office is a Medicaid-participating provider and we will bill Medicaid for you. It is the parent's responsibility to bring the **annual** Medicaid card at each visit. Failure to bring a card may result in you being asked to sign a form stating if current eligibility cannot be obtained at the time of check-in the parent may be liable for payment. We are always willing to work out payment arrangements if necessary.

Managed Care:
Currently we participate with several managed care networks such as Blue Cross Blue Shield,
First Carolina Care, Medcost, Aetna, Cigna, and United Health Care and Tricare.

Tricare:
We are Out-of-Network Participating Providers for Tricare Select and Tricare Prime, however, we will agree to file your claim. Once payment has been received from Tricare you will be billed for any additional balance applied to your Out-of-Network deductible and cost-share balance. If your child is covered by Tricare Prime, please note we are unable to act as PCM (Primary Care Manager) therefore we are unable to refer your child to a specialist if needed.

HSA's, HRA's High Deductible Plans:
HSA's and HRA's generally have a high deductible. We will submit the claim directly to your insurance company. Upon receipt of the explanation of benefits (EOB), advising us these charges have been applied toward your family's deductible, we will then bill you for the balance.

Weekend Clinic/Holidays:
An acute care walk in clinic is available every Saturday and Sunday, and on most holidays from 8-1130AM. There is an additional ***$55 Weekend/Holiday charge*** on these days which is covered by most insurance companies.

Payment Methods:
Our office accepts the following payment methods: Cash, Personal Check, Visa, MasterCard, and Discover. For returned checks, we assess a ***$25.00 NSF charge***. Per your contract with your insurance company, copays are due at the time of service. Patients with unpaid delinquent accounts may be turned over to collections and/or discharged from the practice. The parent is ultimately responsible for all fees for services.

I have read, understood, and agree to the above financial policy.

Signature: _____ Date: _____

Sandhills pediatrics

Patient Portal

Thank you for signing up for our patient portal, My Kid's Chart.

You will be able to access and print your child's immunization record, view upcoming appointment times and locations, and send non-urgent secure messages to our staff.

Please fill out the information below and we will have your portal up and running within one week or so. You will receive an email when your account is ready. The email will contain a link to the portal and a temporary password. You can access your portal through the link by clicking My Chart at the top of our website, www.sandhillspeds.com.

*If your child is 18 years of age or older, his or her chart is considered private. A parent or guardian will be able to access the portal to send secure messages, but no other information will display. We can set up a young adult to access his or her account through his or her own email address.

Child's Name	Date of Birth

I,_____, am the parent/legal guardian of child/children listed above and I acknowledge that there are no court orders or restraining orders in effect limiting my access to medical information for the child/children listed above.

Parent/Guardian Signature:_____Date _____

Email Address: _____

I as the parent/legal guardian for the child/children listed above, authorize the following individuals to have access to the patient portal:

Name:_____Email:_____

Name:_____Email:_____

_____ (staff initial) Parent/Guardian identify verified.

_____ (staff initial) legal documents verified for guardianship, if applicable.

Sandhills pediatrics

New Patient Questionnaire

Patient Name _____ DOB _____

My name (adult completing form) _____

Birth Weight _____
Was the baby full term? (**circle**) YES NO Did mom use alcohol/drugs during pregnancy? YES NO
How many weeks early/late? _____ if yes, please list _____
Vaginal or C-Section
Did the baby stay in the NICU? YES NO Did the baby go home with mom? YES NO
if yes, for how long? _____
Did mom have problems during pregnancy? YES NO
if yes, please list _____
Is your child up to date on their vaccines? YES NO NOT SURE
Where has your child received vaccines? _____
Has your child been diagnosed with any medical problems? YES NO
If yes, please list _____

Has your child been hospitalized since birth?	YES	NO	List _____
Has your child had surgery?	YES	NO	List _____
Has your child had any serious accidents?	YES	NO	List _____
Is your child allergic to any medications?	YES	NO	List _____
Is your child allergic to bee stings or foods?	YES	NO	List _____
Does your child take any medications regularly?	YES	NO	List _____
Does your child see any special doctors?	YES	NO	List _____

Does your child have any of the following:

Developmental problems?	YES	NO	_____
Asthma?	YES	NO	_____
Seasonal allergies?	YES	NO	_____
Diabetes?	YES	NO	_____
Problems seeing?	YES	NO	_____
Problems hearing?	YES	NO	_____
Heart murmur/problem?	YES	NO	_____
Bladder/kidney infections?	YES	NO	_____
Epilepsy/seizures?	YES	NO	_____
(Girls) Started periods?	YES	NO	When_____
(Girls) Period problems?	YES	NO	Describe _____

Do you have any concerns about how your child is doing in school? YES NO
if yes, please describe _____

Family History

Do any family members (blood relatives) have: (list relative and medical problem)

Asthma?	YES	NO	_____
Tuberculosis?	YES	NO	_____

Revised 04/2020

Patient Name _____ DOB _____

Sickle cell?	YES	NO	_____
Cystic fibrosis?	YES	NO	_____
Seasonal allergies?	YES	NO	_____
Cancer?	YES	NO	_____
Heart disease (<50yo)?	YES	NO	_____
Heart arrythmia?	YES	NO	_____
High blood pressure?	YES	NO	_____
High cholesterol?	YES	NO	_____
Diabetes (<50yo)?	YES	NO	_____
Seizures/Epilepsy?	YES	NO	_____
Kidney Disease?	YES	NO	_____
Liver Disease?	YES	NO	_____
Depression?	YES	NO	_____
Anxiety?	YES	NO	_____
Bipolar?	YES	NO	_____
ADHD?	YES	NO	_____
Mental Retardation?	YES	NO	_____
Thyroid Problems?	YES	NO	_____
Deafness?	YES	NO	_____
Anemia?	YES	NO	_____
Bleeding problems?	YES	NO	_____
Alcohol abuse?	YES	NO	_____
Drug abuse?	YES	NO	_____
Immune problems?	YES	NO	_____
HIV/AIDS?	YES	NO	_____
Unexplained death?	YES	NO	_____

Any other family history you would like us to know?

_____

_____

Please list those who live in the same home as the child

Name	Relationship	Age	Health Problems

If the child's mom and dad do not live together, what is the custody status?

_____

_____

Does anyone in the household smoke tobacco? YES NO List _____

Occupation: Mom _____

Dad _____

Guardian _____

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