Patient Registration Information

Patient Name: First _____ Middle_____ Last_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Cell Phone: ( )_____

Patient DOB: _____ Patient Age: _____ Gender: ☐ M ☐ F

Parent/Guardian Name (if applicable): _____

Mother's DOB: _____ Father's DOB: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Mother's Employer: _____ Occupation: _____

Address: _____

Work Phone: ( )_____ Email:_____

Father's Employer: _____ Occupation: _____

Address: _____

Work Phone: ( )_____ Email:_____

Sponsor SS # _____

Emergency Contacts

Name: _____Relationship:_____

Day Phone: ( )_____ Cell: ( )_____

Name: _____Relationship:_____

Day Phone: ( )_____ Cell: ( )_____

Name: _____Relationship:_____

Day Phone: ( )_____ Cell: ( )_____

Pediatric Partners
"A Therapeutic Learning Center"

Patient Registration Information

Is the patient currently taking any medications? If so, please list.

_____

_____

_____

Is the patient allergic to any drugs/medications? If so, please list.

_____

_____

_____

Please check any of the following that the patient now has or that may be related to their current condition:

Allergies ☐
Anemia ☐
Any Pins or Metal Implants ☐
Arthritis/Swollen Joints ☐
Asthma/Bronchitis ☐
Back Injury/Surgery ☐
Blood Clots ☐
Bowel/Bladder Problems ☐
Cancer/Chemo/Radiation ☐
Coronary/Heart Disease/Angina ☐
Diabetes ☐
Dizziness/Fainting ☐
Elbow Injury/Surgery ☐
Emotional/Psychological Problems ☐
Epilepsy/Seizures ☐
Foot/Ankle Inury/Surgery ☐
Gout ☐
Heart Surgery ☐
Hernia ☐
High Blood Pressure ☐
Hip Injury/Surgery ☐
Infectious Diseases ☐
Joint Replacement ☐
Knee Injury/Surgery ☐
Neck Injury/Surgery ☐
Numbness/Tingling ☐
Osteoporosis ☐
Pacemaker ☐
Severe Headaches ☐
Shortness of Breath ☐
Shoulder Surgery ☐
Sleeping Problems ☐
Stroke/TIA ☐
Thyroid Issues/Goiter ☐
Varicose Veins ☐
Vision/Hearing Loss ☐
Weakness/Fatigue ☐
Weight Loss ☐

Surgery in the last 12 months? If so, please give details.

_____

_____

_____

_____

Physician/Pediatric Information

Today's Date: _____

Practice Name: _____

Physician/Pediatrician Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: ( )_____ Office Fax: ( )_____

Physician Email Address: _____

Insurance/Billing Information

Primary Insurance: _____ Phone: ( )_____

Member ID #: _____ Group ID #:_____

Insured: _____

Secondary Insurance: _____ Phone: ( )_____

Member ID #: _____Group ID #:_____

Insured: _____

Medicaid Number: _____

Notice of Patient Information Practice

This notice describes how your medical records may be used or disclosed and how you can access your records. Please review it carefully.

Pediatric Partners of NC, Inc. Legal Duty is that we are required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Pediatric Partners of NC, Inc. uses your personal health information (PHI) primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Pediatric Partners of NC, Inc. may use your PHI to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits/offers that could be of interest to you.

Pediatric Partners of NC, Inc. may also use or disclose your PHI without prior authorization for public health purposes, for auditing purposes, for research and studies, and for emergencies. We also provide information when required by law.

In any other situation, Pediatric Partners of NC, Inc. policy is to obtain your written authorization before disclosing your PHI. If you provide us with written authorization to release your information for any reason, you may later reevoke that authorization to stop future disclosures at any time.

Pediatric Partners of NC, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient treatment areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENTS INDIVIDUAL RIGHT

You have the right to review or obtain a copy of your PHI at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your PHI for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your PHI for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Pediatric Partners of NC, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Pediatric Partners of NC, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our administrator at the address listed below. For further information on Pediatric Partners of NC, Inc. health information practices or if you have a complaint, please contact the follow person:

Pediatric Partners of NC, Inc.
Lisa Whittenton- Owner
325 Alexander Street
Fayetteville, NC 28301

Patient Information Consent Form

I have read and fully understand Pediatric Partners of NC, Inc.'s Notice of Information Practices. I understand that Pediatric Partners of NC, Inc. may use or disclose my personal health information for the purpose of:

- Carrying out treatment
- Evaluating the quality of services provided
- Any administrative operations related to treatment or payment
- Appointment reminders
- Information about treatment alternatives
- Other health related benefits/offers

I understand that I have the right to restrict my personal health information when used and disclosed for treatment, payment, and administrative operations. I also understand that Pediatric Partners of NC, Inc. will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Pediatric Partners of NC, Inc.'s Notice of Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name (Please Print)

_____

Signature

_____

Date

Policies of Pediatric Partners of NC, Inc.

TREATMENT CONSENT
I consent to therapy considered necessary in diagnosing and/or treating my condition.

AUTHORIZATION AND RELEASE
I authorize Pediatric Partners of NC, Inc. to bill and receive payments from my insurance company. I also permit the release of necessary information, including medical records, to my insurance company.

FINANCIAL POLICY
Payment of all co-pays, deductibles and any portion not covered by my insurance company is due at time of service. Pediatric Partners of NC, Inc. will bill my insurance carrier as a courtesy to me. Pediatric Partners of NC, Inc. CANNOT guarantee insurance benefits given by the insurance company to be 100% accurate. The information Pediatric Partners of NC, Inc. receives IS NOT A GUARANTEE of payment from the insurance company. It is recommended that I call and verify benefits prior to my scheduled appointment. I understand that I am responsible for any portion not covered by my insurance company and prompt payment is required. An 8% interest fee will incur on any balance greater than 30 days. Accounts sent to collection will incur additional fees.

I have read, understood, and accepted the above policies as indicated by my signature below.

_____

Patient Name (Please Print) Date

_____

Signature Date

_____

Witness Date

PARENTS AND CAREGIVERS PLEASE READ IN ITS ENTIRETY

NO-SHOW POLICY REMINDER

In your original enrollment package, you initialed and signed a page that described our "No-Show Policy." As a reminder here is our current "No-Show Policy":

> "*It is important that I keep all scheduled appointments to obtain maximum benefit from my child's therapy program. Being* ***on time*** *for these appointments is* ***imperative!*** *The therapist has blocked this time especially for me. Not showing or giving less than 24 hours to cancel, takes time away from other patients who would have benefited from this appointment. A $50.00 fee will be charged to my account for a no-show or late cancellation."* **This fee is not covered by insurance and must be paid prior to your next visit.**

DISMISSAL FROM THERAPY

Please be advised that three (3) "no-shows" or "late cancellations" is **grounds for dismissal from therapy services.** We have an extensive wait list of children whose parents are desperate for their children to begin therapies and we continue to receive calls daily.

LATE CANCELLATIONS

Regarding illnesses, we understand that children get sick, and you may not be able to provide the 24 hour notice requested. Please let us know that you will be canceling immediately. We make every attempt to fill open slots that occur throughout the week; however, we do need adequate notification so that this can happen. Generally, we are not able to fill the spot when we have been given less than a couple hours notice. A ten- or 30-minute notice is not sufficient and is equivalent to a "no-show." If we are holding an appointment slot open for your child, then another child who may have been able to make that appointment did not have the opportunity to come.

Abuse of this cannot be tolerated. If your child has excessive cancellations "due to illness" you and your family may better benefit from a company that provides Home Services. **If your child had multiple therapies that occur successively and one of the therapist cancels, you are still expected to attend the other scheduled session.** Therapy sessions are scheduled back-to-back as a convenience to the family. If you cancel the other therapy, it will count as a "no-show" and your account will be charged.

ATTENDANCE

In addition, frequent absences from therapy is counter-productive. If you regularly scheduled appointment is no longer convenient, please discuss this with your therapist. Motivation, a belief that change can occur and carryover from both the parents and the client are necessary for a successful intervention/rehabilitation program. It is essential that you attend all your therapy appointments. If you have questions or concerns regarding the recommended frequency or duration of therapy, please speak with your therapist.

TO CANCEL

To cancel your appointment, please call Marty or Taylor at 910-920-3838, and inform them of which therapies you need to cancel. At that time, please also let her know if you wish to be rescheduled for that week, as we will make every attempt to do so.

Thank you for understanding our position on these policies. **When children do not show for appointments, and another child was not given the opportunity to attend, no one is being helped by our therapists.** We thank you for allowing us in your lives and to work with your children. We look forward to celebrating their successes with you.

Parent/Caregiver Signature_____Date: _____

PRIVACY POLICY STATEMENT
We understand that information about you is personal. We are committed to protecting your health information. We will create a record for the care you receive at the facility and billing offices of Pediatric Partners of NC, Inc. We need this record to provide quality care and to comply with certain legal requirements. This notice tells you about the ways we may use and disclose your health information. We are required by law to make sure your health information that identifies you is kept private; give you this notice of affect. Any healthcare professional of Pediatric Partners of NC, Inc. is authorized to enter your information into your medical record including any employee, staff, volunteer, director, occupational, speech, or physical therapist of assistant that are employed or contracted by Pediatric Partners of NC, Inc.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:
We may use your health information to provide you with treatment or services. We may disclose your health information to staff of Pediatric Partners of NC, Inc. to provide services that are part of your care. We may use and disclose your health information so that your therapy and services provided by Pediatric Partners of NC, Inc. may be billed, and payment collected from you, an insurance company, or a third party.

There are some services provided in Pediatric Partners of NC, Inc. through contacts with business associated. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job that we've asked them to do and bill you, or your insurance company, for the treatment of therapy services rendered. To protect your health information, we require the business associate to appropriately safeguard your health information. We may disclose your health information to a foundation or association that is related to the treatment and/or services you are receiving. We would only release contact information such as your name, address, and phone number. We may release your health information to a family member, other relative, close personal friend, or any other person who is involved in your care or payment to your care. We may release your health information to an entity assisting in a disaster relief effort so that your family can be notified about your conditions, status, and location. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may release your information to worker's compensation of similar programs. These programs provide benefits for work-related injuries or illnesses. We may disclose your health information to a health oversight agency for activities authorized by the government to monitor the healthcare system, government programs, and compliance with civil rights laws. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may disclose your information in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute. We may release health information if asked to do so by a law enforcement official 1) in response to a court order, subpoena, warrant, summons, or similar process, 2) to identify or locate a suspect, fugitive, material witness, or missing person, 3) about a death we believe may be a result of a criminal act, 4) about criminal conduct at Pediatric Partners of NC, Inc., and 5) in emergency circumstances to report a crime, the location of a crime or victims, or the identify, description of the person who committed the crime.

If you provide use with permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke that permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission. We are required to retain records of the care we provide to you. In the event that North Carolina Law requires us to give more protection to your health information than stated in this notice or required by Federal Law, we will give that additional protection to your health information. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy health information that may be used to make decisions about you. You must submit your request in writing to the Administrator of Pediatric Partners of NC, Inc. We will respond within 60 days of receiving your written request.

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. To request restrictions, you must make your request in writing. In your request, you must tell us 1) what information you want to limit, 2) whether you want to limit our use, disclosure, or both, and 3) to whom you want the limits to apply. We are not required to agree to your request. If we do not agree, we will comply with your request unless the information is needed to provide you emergency treatment. You may not limit uses and disclosures that we are legally required or allowed to make. You have the right to request that we communicate with you about medical matters in a certain way or location. For example, you can ask that we only contact you at work or home. To request confidential communications, you must make your request to the Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. You have the right to a paper copy of this notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you, as well as any information we receive about you in the future. The notice will contain an effective date on the first page. If you believe your privacy rights have been violated, you may file your complaint with Pediatric Partners of NC, Inc. If you have any questions or complaints about your privacy practices or would like to know how to file a complaint, please contact the Administrator at (910) 920-3838. You will not be penalized for filing a complaint.

Consent for Exchange of Client Information

I hereby authorize representatives from Pediatric Partners of NC, Inc. to exchange specified information in my child's records with the following agencies:

- Your child's medical provider(s)
- Children's Developmental Services Agency (CDSA)
- Department of Social Services (DSS)
- School District and the Department of Public Instruction
- Family Support Network of Cumberland County
- Cumberland County Mental Health
- Medicaid/Private Insurance Provider
- Other: _____

This information could include, but is not limited to the following:

- Physician's Orders
- Occupational Therapy Evaluations and Progress Notes
- Speech-Language Therapy Evaluations and Progress Notes
- Physical Therapy Evaluations and Progress Notes
- Medical Records
- Individualized Education Plan (IEP)
- Individualized Family Service Plan (IFSP)
- Discharge Summary
- Other: _____

I understand that this information will be used *only* for the development of appropriate educational and therapeutic planning.

This content shall be valid for a period of one year from the date of signature.

NOTICE OF RIGHTS AND OTHER INFORMATION

It is my right to refuse to sign this authorization. I _____ may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the clinic. My revocation will be effective upon receipt; however, will not be effective to the extent that the requestor or others that have acted in reliance upon this authorization. I have the right to receive a copy of this authorization. Treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality law (HIPPA). I have the right to inspect or obtain a copy of the information that I am being asked to disclose at any time.

_____

Parent/Guardian Signature Date

_____

Child's Name DOB:

Patient Registration Information

In an efforts to contact parents for appointment reminders, changes in schedules, etc., we are considering a new program that would allow us to send you an e-mail that would go directly to your cell phone as a text message, and then you could text or call us in return.

For future convenience, please give us your current email address and best cell number to send you a text, along with your cell carrier (ex: AT&T, Verizon) and permission to contact you that way.

_____

Email

_____

Cell Number Carrier

Pediatric Partners of NC, Inc. has permission to text me or email me with information and/or questions.

_____

Name (Please Print)

_____

Signature

_____

Date

I prefer that Pediatric Partners of NC, Inc. not contact me by text or email.

_____

Name (Please Print)

_____

Signature

_____

Date

Photo/Video Release Form

AUTHORIZATION TO USE PHOTOGRAPHS AND/OR AUDIO-VISUAL

I, _____, hereby authorize Pediatric Partners of NC, Inc. to use, reproduce, and/or publish photographs and/or video that may pertain to _____(minor's name)—including images, likeness and/or voice without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSAs) or for other related endeavors. This material may also appear on the Corporation's Internet Web Page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, the Corporation may publish materials, photograph, and/or make reference to me in any manner that the Corporation deems appropriate in order to promote/publicize service opportunities.

Description of Material (Photos/Audio-Visual):

_____

_____

_____

_____

Name (Please Print)

_____

Signature

_____

Date