Patient History

Name: _____ DOB: _____

Birth History:

Birth Weight _____ lbs _____ oz

C-Section ☐ Vaginal Delivery ☐ Full Term ☐ Pre-Term ☐ Weeks _____

Complications ☐ No Complications ☐

Explain _____

Hospitalizations:

No ☐ Yes ☐ Date _____ Reason _____

Surgeries

No ☐ Ear Tubes ☐ Tonsillectomy/Adenoidectomy ☐ Hernia ☐

Appendectomy ☐ Cardiac Surgery _____

Other Surgery _____

Chronic History (recurring frequently; 6 or more times a year or 3 in three months)

None ☐ Murmur ☐ Ear Infections ☐ Sinusitis ☐ Asthma ☐ Strep ☐

Allergies:

Medicines _____

Environmental _____

Foods _____

Significant History

Fracture (body part) _____ ADHD/ADD ☐

Anxiety/Depression ☐ Constipation ☐ Reflux ☐

Medications:

Daily _____

As Needed _____

Family Medical History: (S=Sibling P=Parent E=Extended)

Murmur N/A Heart Disease/High Blood Pressure N/A ADHD N/A

Kidney Disease N/A Diabetes/Thyroid Disorder N/A Cancer N/A

Other _____

Social:

Parents:

Single ☐ Married ☐ Divorced ☐ Custody _____

Siblings: Name Age

_____

_____

_____

_____

_____

GROWING UP PEDIATRICS

Growing Up Pediatrics
Patient Registration Form

Patient

Date of Birth: _____ Today's Date: _____

Name: _____
First Middle Last Nickname

Address: _____
Street City State Zip

Primary Insurance: _____ Secondary Insurance: _____

Please present your insurance card(s) to our staff.

Parent #1

Name: _____

DOB: _____

Mobile #: _____

Email: _____

Parent #2

Name: _____

DOB: _____

Mobile #: _____

Email: _____

Current Living Situation: Married☐ Single☐ Divorced☐ Other ☐

If Custodial Living: Parent 1____ % Parent 2 ____ % Other_____

Other Child in Home: _____ Relationship: _____

Other Child in Home: _____ Relationship: _____

Other Adults in Home: _____ Relationship: _____

Emergency Contact (if parent cannot be reached): _____

Emergency Contact Address: _____ Phone: _____

Preferred Pharmacy: _____ Address:_____

How were you referred to our office: Website☐ Friend☐ Other☐

Initials: _____ **Financial Consent:** I authorize Growing Up Pediatrics, P.A. to release any medical information necessary to my insurance carrier an effort to obtain reimbursement for services rendered to my child/dependent and hereby authorize direct payment of benefits payable for these services to Growing Up Pediatrics, P.A.

Initials: _____ **Consent to Treat:** I authorize Growing Up Pediatrics, P.A. to provided medical care to my child/dependent that Is necessary and appropriate.

Initials: _____ **Consent for Email:** I hereby authorize Growing Up Pediatrics, P.A. to communicate with me via email.

Initials: _____ **Consent for Texts:** I hereby authorize Growing Up Pediatrics, P.A. to communicate with me via text.

Initials: _____ **Medicaid Attestation:** I attest that my child/children are not applicants or beneficiaries of Medicaid or Medicare for their primary health insurance coverage, and that it is not our intent to apply for these services in the next 12 months.

_____ _____

Signature of Parent/Guardian/Legal Representative **Date**

Growing Up Pediatrics
Financial and Practice Policies

I have read the information below carefully and agree to abide by Growing Up Pediatrics Financial and Practice Policies.

_____ _____

Patient Name DOB

_____ _____

Guarantor Signature Date

Thank you for choosing Growing Up Pediatrics, PA as your Pediatric Provider: We are committed to working with you to provide the best medical care for your child with the goal of good physical, emotional and mental health. In order to continue to provide this care, we must receive payment for our services. Please read the detailed financial policy below, let us know if we can answer any questions, and sign in the space provided. A copy will be provided to you upon request.

Well-Child Checkups: Growing Up Pediatrics requires its patients to have regular well-child checkups at age appropriate intervals. A consistent history of well visits gives providers critical baseline information should your child become ill, experience developmental irregularities, or encounter complexities in their healthcare. Well-child checkups should occur at 5 days (weight and color), 2 weeks (growth and evaluation), 4 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months. From 24 months to 18 years well visits should be scheduled annually. Our policy is consistent with the American Academy of Pediatrics' recommendations which can be found on their website, www.aap.org. Medical advice cannot be delivered over the telephone if a patient is not up to date with well checks. We reserve the right to terminate care of your family if regular well-child checks are not maintained.

Vaccines: Our goal is to promote child wellness and health. We offer pediatric vaccines according to the Center for Disease Control schedule. If you choose not to vaccinate your child on the CDC schedule, we require you to sign our Vaccine Refusal Form at each Well-Child Checkup.

Insurance: It is essential that you provide us with complete, accurate information so that we may properly submit billing information to your insurance company. We make every effort to submit insurance claims quickly and provide you with our statements. By signing this document, you authorize and direct your insurance carrier(s) to issue payment directly to Growing Up Pediatrics, PA for services rendered to your dependents.

Your insurance policy is a contract between you and your insurance company. Please review your policy and become familiar with the terms and benefits of your plan. Our relationship is with you and your dependents. The obligation to ensure payment in a timely manner lies with you. Your signature above guarantees prompt payment for all services that are provided to your dependents for any and all costs that are not paid by your insurance company. We are not responsible for delays, misplaced claims, or the need of the insurance company for additional information from you.

Claims Filing: We will file claims for those insurances with which we are contracted, as well as secondary insurance. We accept the contractual write-off based on your primary insurance. Once we have received instructions from your insurance company, you will receive a bill for any outstanding balance. You will then be responsible for that balance.

Co-Payment, Deductibles and Co-Insurance: All copays, as well as outstanding balances, will be collected at appointment check-in. We are bound by our contracts with insurance companies to collect co-pays the day of your appointment. All outstanding co-insurance and deductible balances deemed patient responsibility are due within 45 days from the date of service. These amounts are calculated based on a negotiated fee schedule with the insurance company.

Self-Pay Patients: We offer a self-pay discount if you do not have insurance. Payment in full is expected at the time service is rendered.

Payment Options: We accept cash, credit cards, and check as payment for services. You will be charged a fee of $45.00 for all returned checks.

(Please Turn Over)

Keep Us Informed: Most often errors in billing and claims payments are related to incorrect information. Please update us with name, address, email address, phone number and insurance information as it changes.

Collections: We will make several attempts to work with you to keep your account in good standing. If your account remains unpaid for a period of 90 days or more, we may discharge your child/ children from the practice and retain the services of a collection company to collect outstanding the balance on your account. You will receive at least one letter regarding your account status prior to GUP considering termination.

After Hours Phone Calls: Please be aware that telephone calls managed by our after-hours service may be subject to a charge billed directly to you, not your insurance company. Be sure to visit our website for answers to commonly asked questions and over-the-counter medication dosages.

Extended Hours Appointments: Sick visits scheduled during extended office hours (Monday - Friday after 4:45pm, Saturday mornings and Holidays) will be billed with an additional charge to your insurance company. Your insurance may or may not cover this charge. If they do not, it will become your responsibility.

Forms/Records: Please allow 3 business days for the completion of forms requiring a physician's signature. Forms can be completed in less than 3 days for an expediting fee of $25.00. If you choose to transfer from Growing Up Pediatrics to another medical practice, we will provide a copy of the patient's vaccine record and growth chart at no charge. There may be a fee for any other medical records. GUP staff will advise you of this fee prior to your transfer. Release of medical records requires a signed Authorization to Release Medical Information form.

No-Shows, Cancellations & Late Appointments: Please give our office 24 hours advanced notice of cancellation so that we may offer that appointment to another patient. If you are more than 15 minutes late for your appointment you may be required to reschedule to a later date. If your family members have more than two (2) no-shows or dayof cancellations, we have the right to terminate care to your family.

Termination of Care: While we make every effort to partner with our patient families, there are unfortunate times when we must terminate care of your child or children. If this happens, you will be notified in writing with a termination date. We would continue to provide medical care for sick appointments only for 30 days, providing you time to locate another primary care physician. All medical records will be made available to you upon the completion of a medical records release form that can be downloaded from our website.

Custody Payment Issues: Due to the many complicated issues that arise due to custody and payment issues, it is our office policy that payment is expected by whichever parent is bringing their child to the appointment. Parents are responsible for updating Growing Up Pediatrics with custody arrangements. Failure to do so may result in termination of care for your family.

Feedback: We love to hear good news about our service but want to do better. If at any time you have a complaint regarding our office or employees, we do want to hear about it. Please speak directly to our Practice Manager. We strive to improve our patient experience and take respectful, constructive input seriously.

Inappropriate Behavior: Growing Up Pediatrics strictly prohibits verbal or physical abuse or threats of any kind to our physicians, nursing staff or office staff. We will not tolerate any negative comments about our office, physicians or staff members to be posted on any form of social media. If you are witnessed displaying these types of behavior in our office or on social media, you will be dismissed from our practice and will need to find medical care elsewhere. For the health of our patients and staff, tobacco products may not be used in office at any time. This includes but is not limited to cigarettes, chewing tobacco and e-cigarettes.

GROWING UP
PEDIATRICS
growinguppeds.com

Wendy G. Talley, MD, FAAP
Christina A. Wescott, MD, FAAP
Carrie K. Gregory, MD, FAAP
Valorie S. Byrd, FNP-C

8301 Magnolia Estates Drive
Suite 17
Cornelius NC 28031

704 895 9060 phone
704 895 6494 fax

Consent for Treatment of Minor Child

I, being the parent or guardian of _____

do hereby request and authorize any provider at Growing Up Pediatrics and the staff to perform the following services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment. Please check all that apply:

- ☐ Non-Emergent, Acute Care
- ☐ Well Checks
- ☐ Administration of Vaccines
- ☐ Other: _____

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

_____

_____

_____

_____

_____ _____

Signature of Parent or Guardian Date and Time

_____ _____

Witness Date and Time

Acknowledgement of Receipt of Notice of Privacy Practices

Patients (please list all children in family)

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

_____
Relationship to Patients

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

_____

- ☐ Other:_____

_____

Prepared By: _____

Signature: _____

Date: _____

Wendy G. Talley, MD, FAAP
Christina A. Wescott, MD, FAAP
Carrie K. Gregory, MD, FAAP
Valorie S. Byrd, FNP-C

Growing Up Pediatrics, PA
8301 Magnolia Estates Drive, Ste. 17
Cornelius NC 28031
704 895 9060 phone
704 895 6494 fax

Authorization for Release of Medical Records

Patient Full Name _____

Birth Date (Mo/Day/Year) _____

Street Address _____

Phone (Cell) _____

City, State, Zip Code _____

Phone (Other) _____

Release Information From:

Name of Facility, Person, Company _____

Street Address, City, Zip _____

Phone _____

Release Information To:

Growing Up Pediatrics, PA
Name of Facility, Person, Company

8301 Magnolia Estates Dr., Suite 17
Street Address, City, Zip

704-895-9060 (p) 704-895-6494 (f)
Phone

Dates of Information to be Disclosed: From _____ to _____ (or) All _____

Type of Information to be Disclosed (circle all that apply):

History & Physical ☐ Pathology Reports ☐ Emergency Reports ☐
Vaccine Records ☐ Laboratory Reports ☐ Discharge Summary ☐
Progress Notes ☐ Radiology Reports ☐ Other :_____

I do ☐ or I do NOT ☐ authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol.

Purpose of Disclosure (circle one)

Referral to Specialist ☐ Legal Investigation ☐ Personal/Moving ☐ Change of Doctor ☐

Format (only check one)

Paper ☐ CD ☐ Fax ☐

Delivery Method: (only select one)

Regular U.S. Mail ☐ Pick-Up ☐ Fax to _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization.

_____
Signature of Individual or Guardian or Personal Representative of Patient's Estate

_____ _____
Print Name of Individual or Guardian or Personal Representative Date