HANOVER pediatrics

Child's Name:_____
First Middle Last

DOB:_____ Gender: ☐Male ☐Female

Primary Language: ☐English ☐Spanish

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: (Check all that apply) ☐American Indian or Alaska Native ☐Asian ☐Black
☐Hawaiian Native/Pacific Islander ☐White

Child's Name:_____
First Middle Last

DOB:_____ Gender: ☐Male ☐Female

Primary Language: ☐English ☐Spanish

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: (Check all that apply) ☐American Indian or Alaska Native ☐Asian ☐Black
☐Hawaiian Native/Pacific Islander ☐White

Primary Insurance Information:

Primary Insurance Company Name: _____ **Group No:** _____ **ID/Certificate No:** _____

Policy Holder's Name _____ **DOB:** _____ **Policy holder's Social Security No.** _____

Secondary Insurance Company Name _____ **Group No:** _____ **ID/Certificate No:** _____

Policy Holder's Name _____

Parent and Guardian Information

Guardian/Parent/Patient _____

First MI Last
Relationship to Patient: _____
Guardian/Parent DOB_____/SS#_____
Lives with Patient ☐Yes ☐ No

_____
Street Address

_____
City, State, Zip
Employer Name: _____
Contact Info-Please complete and **CIRCLE** one preferred method:
Home Phone: _____ Work Phone:_____
Cell Phone: _____
Email : _____

Guardian/Parent/Patient _____

First MI Last
Relationship to Patient: _____
Guardian /Parent DOB_____/SS#_____
Lives with Patient ☐ Yes ☐No

_____
Street Address

_____
City, State, Zip
Employer Name: _____
Contact Info- Please Complete and **CIRCLE** one preferred method:
Home Phone: _____ Work Phone:_____
Cell Phone: _____
Email:_____

Emergency Contact:
Please List one other individual we may contact in an emergency (other than parents listed on front.)

Name	Phone	Relationship to Patient
_____	_____	_____

Other Contacts
I hereby authorize the following individual(s) to bring my children to Hanover Pediatrics for medical attention in my absence. This authorization will remain in effect until Hanover Pediatrics is notified in writing of any changes or deletions.

	Name	Phone	Relationship to Patient
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Pharmacy Information: (What pharmacy do you routinely use where we may process prescriptions and refills, name and phone number)_____

_____

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Insurance Policy

While changes to health insurance are a common occurrence, there are insurance carriers with which we are not accredited or from which we are no longer accepting new patients. If you experience a change in insurance status, please update our staff immediately so we can help direct your child's care most appropriately.

Your child's health and well-being are foremost in importance. If a change of insurance is required for any reason and we are not accepting new patients with that insurance, we will be happy to continue seeing your child for acute sick visits for up to 30 days and will arrange for transfer of records to any office you deem appropriate.

I acknowledge that I have read and understand the information above.

Child/Children's Name_____

_____

_____
Print Name

_____
Signature

_____
Date

Privacy Notice Acknowledgement Form

The Federal Privacy Regulations require that we have a written acknowledgement that you have received our Notice of Privacy Practices.

Name of Patient: _____ DOB: _____
(Please Print)

Your signature indicates that you have received the Notice of Privacy Practices

Signature of Parent/Legal Guardian/Custodian:

_____ _____
Signature Date

Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the notice of Privacy Practices on _____. The acknowledgment was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other

Name of Staff Member: _____ Date: _____

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

We may charge an upfront **$35.00 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a **$35.00 service fee** in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Hanover Pediatrics also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is $25.00** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES.
I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Rights Regarding Medical Records**
- **Patient Financial Responsibility including collections, no-show policy**
- **Confidentiality and Privacy of Medical Records**

_____ _____

Guardian Signature if patient under 18 years of age Date

_____

Guardian's Printed Name

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Scheduled Appointment Agreement

Your health care is important. WE ARE NOT AWARE of how your insurance company determines which services/labs are paid and which services/labs are not paid or which are subject to coinsurance or deductible. Some pay only for illness codes, and some only for prevention codes, and some do not pay for a myriad of other factors. Our responsibility to the patient is to provide care and order labs based on your individual medical needs and current prevention guidelines and the standard of medical care. There are no medical guidelines to support "routine labs" ordered without a medical evaluation whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about coverage. There are many plans and their benefits change often we have no way of knowing what is current for you.

You may schedule an appointment as a WELL EXAM, PREVENTIVE CARE or ROUTINE EXAM. It will be billed as such to your insurance plan. Due to coding laws, we MUST bill your exam as Preventive Care. If during your visit you have ADDITIONAL CONCERNS or PROBLEMS that require a diagnosis and/or other treatment it would be considered a Problem Oriented Exam and you may incur additional office or lab charges. These charges and any from your Preventive Care Exam will be billed to your insurance company. You may want to keep your Well Exam separate from your Problem-Oriented Exam and we would be happy to schedule it that way for you.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate is "patient responsibility". Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

Laboratory services are provided by Laboratory Corporation of America (Labcorp), Sonora Quest Laboratories, ProPath, Medical Diagnostic Laboratories and Mercy Diagnostics and have no direct financial or other affiliation with Hanover Pediatrics. This means the laboratory work done is billed entirely by those individual companies. The services and billing remains the same regardless of whether you had those laboratory services done at Hanover Pediatrics or at an outside laboratory. The laboratory service, therefore, is offered as a convenience to our patients. If a billing question about laboratory service occurs, it is the responsibility of the patient to direct those questions to the laboratory billing department and please note that we will not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility".

_____
Guardian Printed Name

_____
Signature

_____
Date

Patient Medical History Form

NAME:_____ AGE: _____ DATE: _____

PHYSICIAN your child was seeing previously :_____

MEDICAL PROBLEMS (Past or present): _____

_____

_____

List all CURRENT **PRESCRIPTION MEDICINES** (include dosage, reason for taking it, who prescribed it):

_____

_____

_____

OVER-THE-COUNTER MEDICINES, (including vitamins, and food supplements that you take): _____

_____

ALLERGIES to medications or food (including reaction): _____

_____

SURGERIES (include year, surgeon, and hospital):

_____

_____

HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

_____

FRACTURES OR BROKEN BONES (include the bone injured and the year): _____

_____

Has your child had (circle):	feeding problems	jaundice	asthma	anemia
bleeding problems	blood clots	head injury	acid reflux	colic
constipation	major infections	seizures	pneumonia	eczema
strep throat	heart murmur	lead poisoning	seasonal allergies	chicken pox
lactose intolerance	depression	mental illness	hearing trouble	vision trouble
mono	ear infections, how many _____		other_____	

Immunizations (check one): up to date _____ delayed _____ I have elected not to immunize my child _____

Reason for delay or not being immunized:_____

BIRTH HISTORY

Pregnancy or birth complications? _____Full term or preterm? _____ Was this child a twin? _____

How many weeks/months? _____ Type of Delivery (circle): vaginal or caesarean Birth weight? _____

Breast fed or bottle fed (circle one), until what age? _____

Medical History

Please list family member and specify maternal or paternal side Ex: Maternal grandmother, paternal aunt
(circle if cause of death and write age of death)

heart disease _____ genetic disorder _____

diabetes _____ cancer (**what type**?)_____

thyroid disease _____ high blood pressure _____

mental illness _____ arthritis _____

glaucoma _____ asthma _____

allergies _____ tuberculosis_____

seizures _____ substance abuse/addiction _____

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Patient Medical History Form

Patient Name:_____ DOB:_____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

_____

Social History

Who lives in your household? _____

Who is the primary caregiver for your child most days? _____ Who else watches your child? _____

Primary languages spoken in the home:_____ Does anyone in your home smoke?_____

Ethnicity (circle): Hispanic or Non-Hispanic Race:_____

Does your child go to (check all that apply)? daycare_____ preschool _____ school _____ home school_____

Name of school:_____ Grade:_____

Any sports or organized activities your child participates in:_____

Approximately how many hours per day does your child spend watching T.V. or on the computer? _____

Does your child use (circle one): seat belt car seat none Are there guns/firearms in the home? _____

Does your child ride a bicycle? _____ If yes, does he or she wear a helmet? _____

Household Pets(inside/outside)_____

Does your child wear sunscreen? _____ Do you have a swimming pool? _____ Pool fence or alarm?_____

Concerns

Do you have any concerns about your child's diet. _____

_____

Do you have any concerns about your child's weight? _____

Do you have any concerns with your child's school performance or ability to learn? _____

_____

_____

Do you have any concerns about the safety of your child? _____

Do you have any concerns about your child's breathing? _____

Do you have any concerns about your child's toileting? _____

Anything else you would like us to know? _____

_____

Authorization to Release Medical Information

****Please mail any records over 50 pages****

Release To:
Hanover Pediatrics
3505 Converse Drive, Suite 200
Wilmington NC, 28403
Phone: 910- 769-4994
Fax: 910-769-9254

Release From (Previous Pediatrician)
Name:_____
Address_____
_____
Phone:_____
Fax:_____

Patient Name:_____ **DOB:**_____

1. Information to be released:

☐ **ALL** information ☐ **ALL** Progress notes ☐ Lab Reports ☐ X-ray Report
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:_____

Special Authorization: Check applicable box(es) and sign immediately below:
By signing below, I authorize the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

NOTE: This release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentially rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse by patient.

Patient's/ Guardian Signature_____ Date_____

2. **RECORDS FROM THE TIME PERIOD:** / / through / /
3. **PURPOSE OF DISCLOSURE:(** Check applicable purpose)

☐ Transfer of Medical Care ☐ Payment of insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other_____

4. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent anytime except to the extent that action has already been taken.

5. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

6. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature:_____ Date:_____
For office use only:
MR#_____ Date:_____ Initials of Staff Member Sending:_____

Patient Rights Regarding Medical Records

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: 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. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member. **Changes to This Notice**

We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission for any health information that has not yet been shared.

Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.