COPY

Dr. Marie Edith Calixte, M.D FAAP

NEW PATIENT INTAKE FORM

Full Name: _____ SSN: _____

(Nombre Completo) (# de seguro social)

Date of Birth: _____ Gender: M F

(Fecha de Nacimiento) (Genero Masculino Femenino)

Guardian Name:_____ DOB: _____

(Nombre del Guardian Legal) (Fecha de Nacimiento)

Address: _____

(Direccion)

City: _____ State: _____ Zip: _____

(ciudad) (Estado) (Codigo Postal)

Home Phone #: _____ Cell Phone#: _____

(Telefono de Casa) (Telefono Celular)

Language: English Spanish Other: _____

Insurance type: _____

(Tipo de Seguro)

Insurance ID#: _____

(Numero de Aseguransa)

Emergency contact: _____ Tele:_____ Rela:_____

(Contacto de Emergencia) (Telefono) (relacion)

How did you hear about our Clinic? (Como se entero de nuestra clinica?)

CHILD CURRENT LIVING SITUATION

With whom does the child currently reside? (Please mark all that apply)

□ Biological Mother □ Step-mother □ Adoptive Mother □ Foster Mother
□ Biological Father □ Step-father □ Adoptive Father □ Foster Father
Other (explain: _____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of our knowledge even if you are not the child's biological parent.

BIOLOGICAL MOTHER'S INFORMATION

Name: _____ Age: _____ Birth date: _____

Occupation: _____ Ethnic/Cultural Background: _____

Mobile Phone: _____ Home Phone: _____

Employer: _____ Telephone Number: _____

Address: _____

City/State/Zip Code _____

BIOLOGICAL FATHER INFORMATION

Name: _____ Age: _____ Birth date: _____

Occupation: _____ Ethnic/Cultural Background: _____

Mobile Phone: _____ Home Phone: _____

Employer: _____ Telephone Number: _____

Address: _____

City/State/Zip Code _____

If the child currently resides with parents OTHER than biological parents, please describe them here:

PARENT ONE

Name: _____ Age: _____ Birth date: _____

Relationship to child: □ Adoptive Parent □ Step-Parent □ Foster Parent □ Other: _____

Occupation: _____ Ethnic/Cultural Background: _____

Mobile Phone: _____ Home Phone: _____

Employer: _____ Telephone Number: _____

Address: _____

City/State/Zip Code _____

PARENT TWO

Name: _____ Age: _____ Birth date: _____

Relationship to child: □ Adoptive Parent □ Step-Parent □ Foster Parent □ Other: _____

Occupation: _____ Ethnic/Cultural Background: _____

Mobile Phone: _____ Home Phone: _____

Employer: _____ Telephone Number: _____

Address: _____

City/State/Zip Code _____

If child does not live with BOTH biological parents, who has legal custody of the child?

_____

Additional Comments: _____

_____

PLEASE LIST ANY PERSON OTHER THAN PARENTS WHO ARE ALLOWED TO BRING YOUR CHILD TO THE PHYSICIAN VISIT AND WHOM YOU GIVE PERMISSION TO SPEAK TO THE PHYSICIAN REGARDING YOUR CHILD'S HEALTH

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

GUARANTOR/PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

(Example: Automated Appointment reminder or Payment Reminder)

Circle One/or All TEXT EMAIL TELEPHONE CALL

List the number and/or email _____

58 BEAR DRIVE GREENVILLE SC 29605
TELE # 864-243-8916 FAX # 864-243-8938

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO KIDS CHOICE PEDIATRICS, PA

Autorizacion para enviar informacion medica a Kids Choice Pediatrics, PA

Patient's Information (Informacion del Paciente)

Patient's Full Name(please print)-(nombre)	Birth Date MM/DD/YYYY(Fecha de Nacimiento)
Street Address(direccion)	City(ciudad) State(Estado) Zip(codigo Posta)
Social Security No(N.Seguro Social)	Cell Phone(Celular) Work Phone(Trabajo)

All the request of the Individual, I_____ do I hereby authorize.
(A peticion del paciente, yo **(Print Name)-(Nombre)** legalmente autorizo

Name of the institution(Nombre de la institucin)	
Street Adress(Direccion)	City(ciudad) State(Estado) Zip(codigo Postal)
Phone(Telefono)	Fax

To Release of my Medical Records as Indicated below:
Enviar copia de los archivos medicos del paciente arriba mencionado

(All Dates) Date From: _____ Date To:_____(Todos los archives) (Fecha desde) MM/DD/YYYY(-M/D/A) Fecha Hasta:MM/DD/YYYY(M/D/A)

Please check the boxes of items you are requesting
Por favor marque la informacion que esta solicitando

I do / I do not authorize release of information related to AIDS (Acquired Immune Syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychiatric care and/or Psychological Assessment and/or Alcohol and Drug Abuse.

☐ Yo autorizo ☐ No autorizo enviar la informacion relacionada con el inmunodeficiencia adquerida SIDA o VIH virus de inmunodeficiencia humana, cuidado psiquiatrico o psicologico y abuso de drogas y alcohol.

(Please Circle)

*ENTIRE MEDICAL RECORD
Archive medico complete

*EMERGENCY
reporte de Emergencia

*IMMUNIZATIONS
Vacunas

*ECG/EEG

*HISTORY&PHYSICAL
Historia & Fisicos

*LABORATORY REPORT
Reporte de Laboratorio

*RADIOLOGY REPORT
reporte de Radiologia

*OTHER:_____
Otros

PURPOSE OF DISCLOSURE (Circle all that apply)
Proposito de la solicitud

*Change of Doctor Leaving the Practice
(Cambiar de Doctor)

*Referral to Specialist
(referido a un especialista)

*Personal

*Continuing Care
(Cuidado Continuo)

*Insurance
(Seguro)

*Other:_____
(Otros)

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 a 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 facility receiving it and would then no longer be protected by federal regulation. I understand that the medical provider whom this s furnished may not condition its treatment of me on whether or not I sign the authorization.
Please note: There may be charges for personal copy.
Yo autorizo enviar la informacion medica del paciente arriba mencionada. Esta autorizacion es valida por 12 meses desde la fecha que fue firmada. Yo entiendo que informacion usada o revelada puede ser objeto de una divulgacion y podria no estar protegida por las regulaciones federales por la persona que esta recibiendo. Yo entiendo que el proveedor medico a quien es dirigida podria no tener las condiciones para tratarme de todas formas yo firmo esta authorization.
Nota: Podria haber cargos por copias para archivo personal

X_____Date:_____
Signature of Individual or Legal Guardian or Personal Representative of Patient's Estate
(Firma del individuo o Representante Legal del Paciente)

Kids Choice Pediatrics, PA

Notice of Privacy and Disclosure

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, that may identify you and that relate to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The changes will apply to all protected health information we already hold, as well as new information after the changing occurs. Before we make a significant change in our policies, we will change our notices and post new notices in the waiting area and exam rooms.

Our Notice of Privacy Practice **(NPP)** provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

☐ Patient refuse to sign **Privacy and Disclosure** portion of form.

Reason: _____

_____

AUTHORIZATION FOR TREATMENT

- I hereby authorize medical treatment by the physician, Advanced practice clinician, and other clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology test, or any other services or treatments deemed necessary for my care and safety.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare providers and to ask and have answered to my satisfaction any question or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by law.
- I understand that Kids Choice Pediatrics, PA utilizes and electronic medical record system.
- I understand that Kids Choice Pediatrics, PA utilizes an electronic prescribing mechanism for electronic transmission of prescription and that any medications my healthcare provider prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to my Kids Choice Pediatrics, PA provider from any pharmacy or drug monitoring agency.
- I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me/ the patient, treatment and health care operations consistent with the Bon Secours Notice of Privacy Practices.
- I understand that by providing my email address to Kids Choice Pediatrics, PA, I am authorizing Kids Choice Pediatrics, PA directly or through its contractors and agents, to contact me via unsecured email to provide me with:
- Information to remind me of appointment:
- Information letting me know a lab result is available to view in MyChart
- Information letting me know how to participate in a patient satisfaction survey; and
- Information about other reminders that may be helpful in coordinating my care.
- Kids Choice Pediatrics, PA will use reasonable safeguards to protect my privacy by limiting the amount or type of information disclosed through the unencrypted e-mail. Detailed information, such as specific lab results, test results and other detailed clinical that Kids Choice Pediatrics, PA may use my e-mail address to communicate with me in the manner described above. I understand that I have the right to request that my e-mail address be removed from my medical record at any time.

✖ _____ _____

SIGNATURE **DATE**

CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Kids Choice Pediatrics is to provide you and your child with convenient, accessible, high-quality medical care. In order for us to assure high quality and accessibility to all of our patients, it is important that patients arrive in a timely manner for all scheduled appointments or cancel the appointment **24 hours** in advance. This policy allows us to make better use of our available appointments for those patients in need of medical care.

Missed Appointment Policy

A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the schedule date and time. If you do not show up for your appointment and do not cancel the appointment **24 hours** in advance, we will record this in the medical records a "missed appointment".

Each time you miss your appointment, you will be notified by telephone, and you will be asked to re-schedule.

Fees for Appointments

Kids Choice Pediatrics will begin to charge patients when do not attend to their appointments or call 24 hours in advance to reschedule.

As a courtesy to our patients, we will not charge for two (2) missed appointments. We understand that emergencies do arise.

The fee for missed appointments is **$20** for all types of appointments including Well Care Exams, Follow-up Exams, Sick Exams, Vaccination Appointment or Sub-Specialty Care. This fee WILL NOT be submitted to the health plan; it will be charged directly to the patient prior to their appointment.

Authorizations

I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments. I may contact our Medical Billing Manager at 864.666.1960 for additional information.

Signature_____ **Date**_____

KIDS CHOICE PEDIATRICS

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing us as your pediatrician care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read agree to any treatment.

Payment for services: Please understand that payment of your bill is considered part of your treatment. Our office staff will notify you of on any co-payments at the time of service. All co-payments are due prior to your appointment.

Balances: All outstanding balances are due prior to your next appointment. If you are unable to pay your balance in full, under special circumstances we will accept a minimum 50% of the total balance.

Benefits: It is your responsibility to know your own insurance benefits, deductible, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

Insurances: If we have a contract with your insurance company, we will bill your insurance company first, less any co-payments. If you have not met your deductible, we will send you a statement and this is your responsibility. This process generally takes 45-60 days from the time is received by the insurance company.

Please understand some insurance coverages are Out-of-Network that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of network benefit, your portion of financial responsibility may be higher than the In-Network rate.

Information Update: We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage.

YOU WILL NEED TO BRING YOUR CURRENT INSURANCE CARD AND PHOTO ID AT EACH VISIT.

Self-Pay Patients: If we do not contract with your insurance company or you are a "Self-Pay Patient", you will be expected to pay for services at the time of the visit. We do offer a special rate for all self-pay patients.

Cancellations/Missed Appointments: If you fail to cancel your appointment, you will be assessed a $20 fee after two (2) missed appointments. This will be collected prior to your appointment. Insurance companies will not be billed.

Walk-Ins: We will try to accommodate same day appointments for established patients. Please call ahead of time.

Sports Forms & Camp Forms: Sports forms & camp forms can only be filled out if a patient has had a well visit within the last six (6) months. Please allow 48 hours from the time it is received. **There is a $15.00 fee.**

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party **Date**