Welcome to Seaside Pediatrics!

Please complete information for each of your children that come to our practice.

*If we are seeing your child on a call weekend, which practice do you usually go to: _____

Child's Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____ Social Security Number_____ Mother's Maiden Name_____
Gender (Please circle one): Male Female
Race (Circle all that apply): White Black or African American Asian American Indian or Alaskan Native Hawaiian Native Pacific Islander
Ethnicity (Please circle one): Hispanic or Latino Not Hispanic or Latino
Preferred Language (Please circle one): English Spanish Other _____

Child's Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____ Social Security Number_____ Mother's Maiden Name_____
Gender (Please circle one): Male Female
Race (Circle all that apply): White Black or African American Asian American Indian or Alaskan Native Hawaiian Native Pacific Islander
Ethnicity (Please circle one): Hispanic or Latino Not Hispanic or Latino
Preferred Language (Please circle one): English Spanish Other_____

Child's Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____ Social Security Number_____ Mother's Maiden Name_____
Gender (Please circle one): Male Female
Race (Circle all that apply): White Black or African American Asian American Indian or Alaskan Native Hawaiian Native Pacific Islander
Ethnicity (Please circle one): Hispanic or Latino Not Hispanic or Latino
Preferred Language (Please circle one): English Spanish Other_____

Parent & Guardian Information:

Guardian/Parent
Name:_____

Relationship to patient:_____

Guardian/Parent Date of Birth:_____

Guardian/Parent SS#_____

Lives with patient (Please circle one): YES NO

Street Address:_____

City/State/Zip:_____

Contact Information (Please circle one preferred method of contact):

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email Address:_____

Guardian/Parent
Name:_____

Relationship to patient:_____

Guardian/Parent Date of Birth:_____

Guardian/Parent SS#_____

Lives with patient (Please circle one): YES NO

Street Address:_____

City/State/Zip:_____

Contact Information (Please circle one preferred method of contact):

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email Address:_____

Insurance Information:

Insurance Company_____ Policy Number_____

Policy Holder's Name_____ Policy Holder's Date of Birth_____

Policy Holder's Gender (Please circle one): Male Female

**Please allow our receptionist to make a copy of your insurance card for our records.

Emergency Contact:

Please list one other individual that we may contact in an emergency (other than the parents/guardian listed on front)

Name_____ Phone_____

Relationship to Patient_____ Alternate Phone_____

Other Contacts:

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

Name_____ Phone_____ Relationship to Patient_____

Name_____ Phone_____ Relationship to Patient_____

Name_____ Phone_____ Relationship to Patient_____

Financial Policy: **PLEASE READ CAREFULLY**

- According to the contract you entered into with your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances at the time of your child's visit. Self-pay (un-insured) patients are expected to pay for service in full at the time of the visit. Those with HSA plans or high deductible plans are expected to pay $50 towards each sick visit upon check-in. The $50 payment will then be applied toward the sick visit. You will be billed for the remaining deductible balance after your insurance has processed. If you have met your deductible for the year, please supply a copy of a current Explanation of Benefits statement from your insurance company and we will waive the $50. _____ initials

- If there is a balance from a prior visit on your account, you are expected to pay the balance in full upon check-in, prior to your child being seen in our office that day. If you are experiencing financial difficulties, please ask to make special payment arrangements. We can set you up on a monthly payment plan with your credit card. _____ initials

- If we do not participate with your insurance plan, payment in full is expected at the time of your visit. We will then supply you with an invoice that you can submit to your insurance company for reimbursement. _____ initials

- The adult accompanying the patient to our office is responsible for payment of the applicable copay, deductible, or coinsurance, regardless of whether it is the parent or guardian accompanying the patient. For instance, if another family member brings your child to the office, he or she should have with them a copy of your insurance card and any applicable payment. In divorce or separation situations, we do not split the financial responsibility for payment of the service. _____ initials

- Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits (EOB). If after 90 days, you have not submitted payment or made acceptable payment plan arrangements with our billing department, your account will be turned over for collections and your child will be dismissed from our practice. _____ initials

- For your convenience we accept cash, check, debit cards, and credit cards (Visa and MasterCard), during check-in, check-out, or by phone for balances due. A $40.00 fee will be charged for any check returned for insufficient funds, and from that point forward we will only accept cash, debit, or credit as payment for services rendered. _____ initials

- We require 24 hour notice should you need to reschedule or cancel your well check appointment. Failure to provide appropriate notice will result in a $25.00 missed appointment fee. _____ initials

Person Completing Form _____ Relationship to Patient _____

Signature_____ Date_____

Seaside Pediatrics, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Seaside Pediatrics, P.A.'s Notice of Privacy Practices.
(Parent/Guardian)

_____ _____
Print Name of Patient Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby give my consent for Seaside Pediatrics, P.A. to use and
(Parent/Guardian)
disclose protected health information (PHI) about my child/children to carry out treatment, payment, and health care operations (TPO). (Seaside Pediatrics, P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Seaside Pediatrics, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Seaside Pediatrics, P.A.'s Privacy Officer at 1601 Wellington Avenue, Suite E, Wilmington, NC 28401.

I have the right to request that Seaside Pediatrics, P.A. restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Seaside Pediatrics, P.A. may **mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Seaside Pediatrics, P.A. may **call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my child's/children's clinical care, including laboratory test results, among others.

With this consent, Seaside Pediatrics, P.A. may **email to my home** or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Seaside Pediatrics, P.A.'s use and disclosure of my my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Seaside Pediatrics, P.A. may decline to provide treatment for my child/children.

_____ _____
Signature of Patient/Parent/Guardian Print Name of Patient

_____ _____
Print Name of Patient/Parent/Guardian Date