CALVARY PEDIATRICS
509 Sandhurst Dr.
Fayetteville, NC 28304
Office: 910-484-4233
Fax: 910-484-2990

SUNSHINE PEDIATRICS
514 Owen Dr.
Fayetteville, NC 28304
Office: 910-423-4233
Fax: 910-423-0513

WELCOME TO CALVARY/SUNSHINE PEDIATRICS

If you are a parent of a newborn, congratulations on this wonderful blessing to your family! We are here to act not only as your child's primary health care provider, but also to help you through some of the baby issues that inevitably arise when you bring a new life into your home.

If you are new to our practice and you have an older child or children, we hope to live up to all your expectations as your child's physician.

We look forward to working together with you towards your child's good health!

Should you have any questions, please do not hesitate to discuss them with the office manager, or the office director. Please fill out the questions below.

Sincerely,

Calvary Pediatrics

How did you hear about us?

☐ PHYSICIAN REFERRAL*
☐ TELEPHONE BOOK
☐ Facebook
☐ Year Book AD_________
☐ * Other : ____
☐Magazine______________
☐Website
☐Internet
☐ FRIEND OR FAMILY MEMBER

PHYSICIAN REFERRAL (PHYSICIAN

NAME)____

FRIEND OR FAMILY MEMBER

(NAME)____

DID OUR PHYSICIAN'S REPUTATION INFLUENCE YOUR DECISION? ☐ YES ☐ NO
DO YOU UTILIZE THE INTERNET FOR HEALTH ADVICE? ☐ YES ☐ NO
HAVE YOU VISITED OUR WEBSITE *www.calvarypediatrics.com*? ☐ YES ☐ NO
HAVE YOU VISITED OUR FACEBOOK PAGE www.facebook.com/calvarypediatrics ☐ YES ☐ NO

Calvary Pediatrics/ Sunshine Pediatrics

Patient Demographic Information Sheet

Please print clearly and provide us with all the information requested below. It is important that you keep us informed of any changes in your current address, phone numbers, and/or insurance information. Always bring your current/recent insurance card with you

Child's Last Name: ________________ First: __________________ Middle Initial ____
Child's Nickname: ______________________ Sex: M F Date of Birth: __________
Social Security #: _________________ Race: ____________ * Ethnicity: Hispanic/ Not Hispanic
Home Street Address____
City: ___________________ Country: ___________________ State: ________ Zip: __________
Home Phone #:_______________ Cell Phone #:____________ Preferred Language ______________

Parent/Legal Guardian Information:

Name: _____________________________
Circle Relationship to child: Mother Father Step-Parent Legal Guardian
SSN#: ______________________________
Date of Birth: ________________________
Address: ____________________________
____
Home Phone #:_______________________
Cell #: ______________________________
Occupation: _________________________
Employer: ___________________________
Work #: _____________________________

Name: ________________________
Circle Relationship: Mother Father Step-Parent Legal Guardian
SSN#: ________________________
Date of Birth: __________________
Address: ______________________
____
Home Phone #:_________________
Cell # ________________________
Occupation: ___________________
Employer: _____________________
Work #: _______________________

Insurance Information:
Primary Insurance Company:
____
Policy Holders Name:
____
Policy Holders Date of Birth: _______________ Relation to the Patient: ___________________
Effective Date:
____
TRICARE Unit Address: ___________________________Unit Phone #: ___________________

Parent/Guardian Initial ______

Secondary Insurance Company: ____

Policy Holders Name: ____

Policy Holders Date of Birth: _____________ Relation to the Patient: _________________

Effective Date: ____

TRICARE Unit Address: ________________________Unit Phone #: __________________

Emergency Contact (Please give us the name of the person you would like us to contact in case of an emergency)

Name: _____________________ Name: _______________________
Relationship: _______________ Relationship: __________________
Phone #: ___________________ Phone #: _____________________

I authorize the release of medical information to my insurance companies and payment of my child's medical bills to CALVARY/SUNSHINE PEDIATRICS. I also give permission to use my signature as a legal signature on file for the purpose of filing my insurance. I understand that I am responsible for any co-pays/deductibles not met at the time of service and any balances after my insurance has been filed and paid.

Parent/Guardian Signature: _________________________ Date: _______________

Consent and Authorization for Minors

By law, a health care provider must attempt to contact a birth/custodial parent or legal guardian prior to rendering treatment to a minor child (a person under the age of 18), except in those instances where the law recognizes the minor as having the capacity to consent to a specific form by the birth parent/custodial parent or legal guardian of a minor in order for the minor to be seen by any of our physicians or nurses for medical treatment. If a minor child is brought to Calvary Pediatrics by someone other than the birth/custodial parent or legal guardian, the minor child must be accompanied by a note ("Authorization"). The authorization must include the date when it was written, name of the patient, name of the person bringing the child, what the child is being seen for, the birth/custodial parent or legal guardian's signature, copy of the birth/custodial parent or legal guardian's photo I.D, and a telephone number where the birth/custodial parent or legal guardian can be reached.

I, ____________________________________
PLEASE PRINT NAME
(circle your relationship to the patient) parent/custodial parent/legal guardian give consent for the individual(s) identified below to bring the minor child identified below to Calvary Pediatrics for medical treatment. I hereby authorize Calvary Pediatrics and other personnel, to render medical care to my minor child in accordance with the Authorization without obtaining additional consent from me. This does not authorize the release of any medical records.

PRINT FULL NAME OF MINOR CHILD (PATIENT)

______________________________________ DOB ______________________

Name of person bringing minor in for appt (person must be over 18 and be able to show photo ID) ____

Relationship to Minor __________________ Purpose of Visit ___________________________

Phone number where parent or legal guardian can be reached ___________________________

This consent is for:

1. Single time only Date: __________________
2. Specific period of time From _________________ to ___________________
3. Indefinite period of time From ______________________ until revoked by me

____________________________________ ______________
(signature of Birth/Custodial Parent or Legal guardian) (date)

____________________________________ _______________
(print name and signature of witness) (date)

Financial Collections Policy

We do everything possible to maintain low cost to all of our patients here at Calvary Pediatrics. We would appreciate your help in this process by following the following payment.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Calvary Pediatrics accepts cash, personal checks (in-state only), VISA, DISCOVER, AMERICAN EXPRESS and MASTERCARD.
**** There is a $25 service charge for returned checks**.

PATIENT BALANCES

Patients with an outstanding balance will receive three (3) statements for patient account balances. If payment is not received the account will then be forwarded to a collection agency. Any patient with an account 60 days overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, we ask that you contact our Billing/Insurance department to set up a payment plan.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. We bill secondary insurance companies as a courtesy. **If you need assistance or have questions, please contact The Billing/Insurance Department between 8:30 a.m. and 4:30 p.m., Monday through Thursday at 910-484-4233**

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represents a cost to us, you and to other patient who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. We reserve the right to charge $25 for missed or late-canceled appointments. Excessive missed appointments may result in discharge from the practice. I have read and understand the Calvary Pediatrics Financial Policy. I agree to assign insurance benefits to Calvary Pediatrics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed. I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of Parent or Guardian ________________________

Date__________________

CALVARY PEDIATRICS

509 SANDHURST DR, FAYETTEVILLE, NC 28304
PHONE: 910-484-4233 FAX: 910-484-2990

AUTHORIZATION TO RECEIVE HEALTHCARE INFORMATION FROM OUTSIDE ENTITY

Patient's Name:________________________________ Date of Birth: __________________

Previous Name: ________________________________ Social Security #:________________

I request and authorize: Facility or Name: ____

Address: ____

Phone # ____________________ Fax #_________________________________

To release the above named patient's health information as described below to CALVARY PEDIATRICS. **Please fax or mail to Calvary Pediatrics; Fax: (910)-484-2990, Mail: 509 Sandhurst Dr. Fayetteville, NC 28304**.

This request and authorization applies to:
() The patients Entire Medical Record. Purpose: __ Moving__ Changing Doctors__ Personal File

__ Co-ordination Of Care w/specialist or Agency __ Life Insurance __ Other:________

() Certain Medical Data/Information Related To:

() Date of Service (s): _______________________________________

() Specific Condition(s):_______________________________________

()Specific service(s) Test(s) Procedure (s):
Lab: ____
X-Ray: ____
Immunizations: _________________________________
Specific Office Visit (s)/ Physician Exam:__________________
Specific Medication (s): ____________________________

() Other & Reason: ____

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _______________________________________ Date Signed: ___________________________

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED

The information contained in this facsimile is privileged and confidential and is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this information in error, please call us immediately and destroy the copy in your possession or return the entire transmittal to the address on this form via the U.S. Postal Service.

NOTICE OF IMFORMATION PRACTICES

Calvary Pediatrics is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. This notice describes how information about you may be used and disclosed and how you can gain access to this information. We are required by law to abide by the terms of this Notice. Please review it carefully.

1. Calvary Pediatrics may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations to include, but is not limited to, internal quality control and assurances including auditing of records.
2. Calvary Pediatrics is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Calvary Pediatrics will not make any other use or disclosure of a patient's protected health information without the individual's written consent or authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Calvary Pediatrics will abide by the terms of this notice currently in effect at the time of the disclosure.
5. Calvary Pediatrics reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Calvary Pediatrics will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office. The notice will also be posted in the reception area.
6. Any patient or guardian has the right to object to the use of their health information for directory purposes.
7. Any patient or guardian has the right to request to inspect and obtain copies of their medical record.
8. Any patient or guardian has the right to request amendments to be made to their medical record.
9. Any patient or guardian has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
10. Any patient or guardian has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.
11. Any person/patient may file a complaint to the Practice or to the Secretary of Health and Human Service if they believe their privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at the following address and or phone number: Calvary Pediatrics, 509 Sandhurst Drive, Fayetteville, NC 28304 Telephone: 910-484-42333 Fax: 910-484-2990. All complaints will be addressed and the results will be reported by the Privacy Officer.
12. It is the policy of Calvary Pediatrics that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

The Effective Date: _______________ Name of Patient: ________________________________

Name of Parent/Legal Guardian: ___________________________________ Date: ____________

Signature of Parent/Legal Guardian: ________________________________ Date: ____________

Calvary Pediatrics

509 Sandhurst Drive
Fayetteville, NC 28304
Office Phone: 910-484-4233 Fax : 910-484-2990

NO-SHOW POLICY

A pattern of repeated "No-Shows" for appointments will result in dismissal from this medical practice. A "No-Show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment within 24 hours prior to the appointment. We reserve the right to charge $25 for missed or late-canceled appointments.

Your signature below indicates that you have read and understand this policy. Should you have any questions, please direct them to our office manager or Dr. Asemota.

We appreciate in advance your cooperation.

Sincerely,
Dr. Ogie Asemota, M.D.
Medical Director

___________________________ ________________
Parent/Guardian Signature Date