Legacy Pediatrics

Welcomes You and Your Family

Welcome! **Legacy Pediatrics' Mission** is to provide quality, caring pediatric health care from birth to age 18. We strive to assist children and families in our neighboring communities to live quality, healthier and happier lives. Our goal is attainable with your continued support and cooperation.

Your Role: Is to maintain regular child well exams, as recommended by the American Academy of Pediatricians, along with visits for illnesses and concerns. ***Arriving on time for scheduled appointments*** helps us to keep everyone seen in a timely manner. Allow enough time for check-in and paperwork. Be prepared with change of address, phone contact(s) and current insurance card(s). Insurance co-pays are payable at check-in, deductibles will be billed. Advise the provider of any non-medical changes that may impact your child's health; such as - school, family, moving, job, family member illness, etc. Monitor your child/children at all times for acceptable behavior during your visit with us. Due to the impressionable age of our clients, appropriate dress will be required.

Office Hours: Our **phone hours** are: Mon – Thu, 8am-12pm and 1pm-4:00pm: Fri, 8am–11:45am; 910-483-2646.
Our **office is open**: Mon – Thu, 8am-12pm and 1pm-4:30pm: Fri, 8am–12pm.
Legacy employs CareLink to answer calls after hours and holidays. Holidays Observed: Easter Monday; Memorial Day; 4th of July; Labor Day; Thanksgiving Day & the Friday after; Christmas Eve & Christmas Day; New Years Eve & New Years Day. Please contact the office for changes if the holiday falls on a weekend.

Appointments: **All appointments are scheduled,** including accompanying siblings and immunizations. **We ask that you arrive 15 minutes prior to a scheduled Well Visit/Physical.** We do not have walk-in hours. If you arrive without an appointment, you will be offered the next available opening. ***Please provide 4 business hours notice for cancellations and/or changes to any appointment***; this allows us to offer the time to another patient in need. ***ADD/ADHD & AAP's must arrive no later than the scheduled appointment time***. All other appointment types- ***Arriving 15 minutes past the appointment time will result in rescheduling.*** We will attempt a courtesy reminder call, for Well-Visits only, to the primary phone number on file. In the case of an office emergency or an illness, our staff will attempt to reschedule your appointment to a convenient day and time. In the event of inclement weather, please call to verify if the office will be open or closed.

Legacy's Staff: Our Legacy Staff Members are expertly trained for the position they occupy. Every member of our staff will treat each parent and patient respectfully and compassionately as we know you will engage each of us.

Vaccines: Legacy Pediatrics promotes and follows the CDC and AAP Guidelines for Immunizations.
Alternative vaccine schedules may be discussed with your provider.

Forms & Refill Requests: We attempt to process all **Forms, Immunization Records and Prescription Refill Requests** within ***2 full business days***, some forms & letters may take longer. Please bring the ***Facilities original form*** to the office during regular business hours. Some institutions deem copies of forms to be unacceptable. Health Assessment forms and Asthma Care Plans will be completed and expire one year from the date of the patient's last physical/asthma plan. Cumberland Co. Schools require new forms each academic year. Prescriptions for Controlled Substances must be picked up at the office, during business hours, by an authorized adult with a valid picture ID.

Termination: Legacy Pediatrics endeavors to create lasting relationships with our patients and their families. Circumstances may arise were we find it necessary to terminate the Physician–Patient relationship. These may include, but are not limited to, unacceptable behavior, non-compliance with medical advice, multiple missed appointments or failure to produce current insurance information.

My signature indicates that one member of our family has read, understands and agrees to these terms.

Print Name:	Child's Name	Child's Name:
Signature:	Child's Name:	Child's Name:
Relationship to child/children: Date:	Child's Name:	Child's Name:

Legacy 3
PEDIATRICS

556 Sandhurst Drive
Fayetteville, NC 28304

Phone: (910) 483-2646
Fax no: (910) 483-9470
www.legacypeds.com

Patient Registration

Patient Information

Last Name First Name MI Date of Birth Male/Female

Home Address City State Zip Code

Social Security # **Biological / Adopted** **Primary Phone No:**

Parent/Guardian Information

CHECK ONE: RELATIONSHIP TO PATIENT: ☐Mother ☐Father ☐Grandparent ☐Foster Parent **DOB:**_____

Last Name First Name MI Social Security No.

Home Address City State Zip Code

Employer Name Occupation Work Phone #:

Work Address City State Zip Code

Home Phone # Cell Phone # Email Address

Parent/Guardian Information

CHECK ONE: RELATIONSHIP TO PATIENT: ☐Mother ☐Father ☐Grandparent ☐Foster Parent **DOB:**_____

Last Name First Name MI Social Security No.

Home Address City State Zip Code

Employer Name Occupation Work Phone #:

Work Address City State Zip Code

Home Phone # Cell Phone # Email Address

- Date(s) of the last ***Physical / Wellness Exam***_____
- ***Asthma Care Plan*** _____
- ***ADD/ADHD Visit*** _____

Health Insurance

1) Company Name _____

❑Primary Insurance

ID #, SS # or Policy #: _____

Group # _____

Subscribers Name: _____

Subscriber's Date of Birth: _____

2) Company Name _____

❑Secondary Insurance

Agreement or Policy #: _____

Group # _____

Policy Name: _____

Subscriber's Date of Birth: _____

Siblings

1. _____ Age: _____ Health: _____

2. _____ Age: _____ Health: _____

3. _____ Age: _____ Health: _____

4. _____ Age: _____ Health: _____

5. _____ Age: _____ Health: _____

I certify that the information provided is true and correct. I authorize the payment for services rendered should be made payable to Legacy Pediatrics. I authorize release of medical information necessary to process any claims. I understand that I am financially responsible to all charges not paid by insurance. I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

_____

Parent/Legal Guardian Signature Date

Referred by?_____

How did you hear about us? _____

_____

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Authorization by Parent/Legal Guardian

Patient's Full Name: _____

Patient's Date of Birth: _____

The following individuals have my permission to bring my child (as named above) to Legacy Pediatrics as well as participate in full consultation and authorized care with the doctor. They are also authorized to have access to my child's protected health information on a routine basis.

1. _____

Relationship to child: _____

2. _____

Relationship to child: _____

3. _____

Relationship to child: _____

4. _____

Relationship to child: _____

5. _____

Relationship to child: _____

_____

Parent/Legal Guardian Signature Date

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Patient's Name _____ Date of Birth _____

Acknowledgement of Receipt/Review of Privacy Practices

■ I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Legacy Pediatrics reserves the right to change their Notice of Privacy Practices and prior implementation and will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling the office or requesting a copy in person.

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient _____

Acknowledgement of Review of Office Policies

■ I have read, understand, and agree to the terms outlined in the Legacy Pediatrics Office Policies. I have also read and understand the Legacy Pediatrics vaccination Policy.

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient _____

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Financial Policy

I understand, accept, and acknowledge the following terms: (**please initial each line**)

_____ Payment for all services is my responsibility and is due and payable at the time services are rendered.

_____ If my health insurance carrier has accepted Legacy Pediatrics (hereafter referred to as LP) as a participating provider at the time of service. LP will submit a claim to my insurance carrier.

_____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____ If my health insurance carrier HAS NOT accepted LP as a participating provider at the time of service, I am responsible for full payment at time of service unless prior arrangements have been made with LP's billing department.

_____ Upon my request to LP's billing department, documentation will be provided so that I may submit a claim for reimbursement of out-of-pocket expenses from my insurance carrier.

_____ Any contract for insurance coverage is made between my employer, the insurance company and myself, LP has no influence over available benefits or the approval of claims.

_____ If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers, it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.

_____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible these requests should be made 5 days prior to the appointment date with the specialist. It is up to the discretion of a LP provider whether or not to issue a referral requested after the appointment or procedure date.

_____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.

_____ I am responsible for all co-payments and non-covered services at the time of service unless prior arrangements have been made with LP's billing department.

_____ Any co-insurance, deductibles or rejected claims are to be paid in full to LP within 30 days of receipt of a bill.

_____ If I pay these charges by check, I understand any checks returned unpaid by my financial institution will be subject to a fee of $25, *or any higher amount allowed by law.*

_____

Parent/Legal Guardian Signature Date

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Consent for Treatment

By signing this consent, I am authorizing Legacy Pediatrics to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my child's medical condition. This consent is valid for each visit made to Legacy Pediatrics unless revoked by me orally or in writing.

Please be informed North Carolina Law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1.) to screen blood, blood products, organs or tissues to determine suitability for donation; 2.) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as a needle stick; 3.) if a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or bodily fluids. This disclosure is to inform you that your child may be tested at the expense of Legacy Pediatrics if any of these situations occur during the treatment period.

Parent/Legal Guardian Signature Date

Authorization for Release of Information

I hereby authorize Legacy Pediatrics to furnish medical information pertinent to my child's medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to my child while a patient of legacy Pediatrics. I understand this information will only be furnished: 1.) to my insurer(s) to which my medical bills have been assigned for payment; 2.) as required by law. I understand that my medical information will not be released to any persons other than those named without my express written permission. I also understand that my written permission, my child's entire record including HIV status can be released to the healthcare provider as specified in my written request. Any revocation of this release must be submitted in writing to Legacy Pediatrics.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-rays, reports and/or other materials in the possession of Legacy Pediatrics relating to my child's medical condition and proposed or actual treatment. I understand that by signing this consent I am also authorizing release of any information contained within the medical records which may be released to AIDS and/or HIV antibody or antigen testing to the above mentioned persons.

By signing this consent to release medical information, I agree not to hold Legacy Pediatrics, their agents and employees liable for any unfavorable outcomes as the result of this information. I realize that release of my child's medical information may be necessary before my insurer will cover the cost of my child's medical treatment, and that by failing to authorize the release of this information; I maybe required to pay the entire bill at the time of service.

Parent/Legal Guardian Signature Date

Patient Name Date of Birth

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Patient Medical History – Required for all patients

Patient Name: _____ **DOB:** _____

Does your child have ANY medication or food allergies? _____

If so, what is the reaction? _____

List any medications your child is taking and include dosage and how taken (i.e. tablet, syrup):

_____

Hospitalizations: _____

Family History

Family History	Check		Maternal/Paternal Relationship Examples: Mom, Dad, Maternal Grandma, Paternal Grandpa
	Yes	No	
Anemia			
Arthritis			
Asthma			
Autism			
Autoimmune Disorder			
Cancer, Type:			
Diabetes, insulin dependent			
Heart Attack under age 50			
High Cholesterol			
Hypertension			
Kidney Disorder			
Psychiatric Illness			
Seasonal Allergies			
Sudden Death			
Other:			
Other:			

Patient Past History

Patient Past History	Check	
	Yes	No
Allergies		
Anemia		
Asthma		
Autism		
Bed Wetting		
Cellulitis		
Chickenpox		
Constipation		
Down's Syndrome		
Eczema		
Fracture History		
Frequent Ear Infections		
GERD (reflux)		
Learning Disabilities		
Migraines		
Murmur		
Sickle Cell		
Sleep Apnea		
Snoring		
Strep Throat		
Tuberculosis		
UTIs		
Other:		
Other:		

Surgical History -Patient

Surgical History -Patient	Check		
	Yes	No	Year
PET's (tubes)			
Adenoidectomy			
Tonsillectomy			
Other:			

Social History -Patient

Social History -Patient	Check	
	Yes	No
Is Child in daycare?		
Do you use a car seat?		
If under age 1 or under 20lbs, is car seat rear facing?		
Does Child have good bedtime habits?		
Does anybody smoke in household?		
Has child or anyone in household traveled out of the country?		
If so, where to? :		
Parent's Occupation – Mom: Dad:		

Birth History -Patient

Birth History -Patient	
Gestational Age	
Delivery Weight	
Type of Delivery	
Breast Fed	
How Long?	
Formula	
Water Supply	
Fracture History	
Normal Newborn Screening ☐Yes ☐No	

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Patient Name: _____

Social Security #: _____

Date of Birth: _____

Race:
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Other
- ☐ White
- ☐ Decline to Specify

Ethnicity:
- ☐ Hispanic/ Latino
- ☐ Non-Hispanic / Latino
- ☐ Decline to Specify

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other _____

Preferred Pharmacy:

Name: _____

Street Address: _____

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Records Release

Date of Request: _____

Name of Doctor or Clinic to Release Records, Phone and Fax numbers:

_____

_____

Name of Parent or Legal Guardian: _____ **Relationship:** _____

Patient Name _____ **Date of Birth:** _____

Request Records to be Forwarded to:
Legacy Pediatrics
556 Sandhurst Drive
Fayetteville, NC 28304

Delivery Method: ____Mail ___Fax ___Hand Carried **Released to:** _____

Records to Transfer:

_____ All Records	_____ Master problem List/Flow Sheet
_____ Clinic Visit-Notes	_____ Medical Summary
_____ Shot Records	_____ Last Physical Exam
_____ All Growth Charts	_____ Asthma Action Plan and/or ADD visit
_____ Records for a Specific Date:	_____

- I understand that I may revoke this authorization at any time by notifying the office in writing. I understand this authorization expires 180 days from the date signed.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.
- I understand that photocopy or facsimile of this authorization is as valid as the original.

_____
Parent/Legal Guardian Signature Date

_____
Witness Date