Legacy PEDIATRICS

556 Sandhurst Drive
Fayetteville, NC 28304

(910) 483-2646
Fax (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 # Primary Phone No:

Parent/Guardian Information

CHECK ONE: RELATIONSHIP TO PATIENT: ❑Mother ❑Father ❑Grandparent ❑Foster Parent D.O.B. _____

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 D.O.B. _____

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

Health Insurance

1) Company Name _____

CHECK ONE: ❑Primary Insurance ❑Secondary Insurance

Agreement or Policy #: _____

Group # _____

Policy Name: _____

Subscriber's Date of Birth: _____

2) Company Name _____

CHECK ONE: ❑Primary Insurance ❑Secondary Insurance

Agreement or Policy #: _____

Group # _____

Policy Name: _____

Subscriber's Date of Birth: _____

Siblings

1. _____ Age: _____ Health: _____

2. _____ Age: _____ Health: _____

3. _____ 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?_____

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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.

Parent/Legal Guardian Signature Date

HIPAA Privacy Notice

Updated June 2020

LEGACY PEDIATRICS, PA

NOTICE OF PRIVACY PRACTICES As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD (AS A PATIENT OF OUR PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Legacy Pediatrics, P.A. is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to him/her. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your child's IIHI

Your child's privacy rights in their IIHI

Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Site Manager at the office where your child is usually seen or our Privacy Officer at (910) 483-2646.

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

The following categories describe the different ways in which we may use and disclose your child's IIHI:

1. **Treatment**. Our practice may use your child's IIHI to treat your child. For example, we may disclose your child's IIHI as follows:

To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.

To write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for you.

To treat or to assist others in the treatment of your child.

To inform you of potential treatment options or alternatives or programs, such as our Asthma Program.

To others who you have given permission to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

To other health care providers for purposes related to their treatment.

To a parent guardian or other responsible person if the patient is a minor.

2. **Payment**. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items provided by us for your child. For example, we may disclose your child's IIHI as follows:

To contact your child's health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your child's insurer with details regarding your child's treatment to determine if the insurer will cover, or pay for, your child's treatment.

To obtain payment from other third parties that may be responsible for such costs.

To bill you directly for services and items.

To other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations**. Our practice may use and disclose your child's IIHI to operate our business. As examples of the ways in which we may use and disclose your child's information for our operations include, but are not limited to the following:

To evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.

To other health care providers and entities to assist in their health care operations under certain circumstances.

To contact you and remind you of your child's appointment.

To inform you of health-related benefits or services that may be of interest to you.

When we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

1. Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

maintaining vital records, such as births and deaths

reporting child abuse or neglect

preventing or controlling disease, injury or disability

notifying a person regarding potential exposure to a communicable disease

notifying a person regarding a potential risk for spreading or contracting a disease or condition

reporting reactions to drugs or problems with products or devices

notifying individuals if a product or device they may be using has been recalled

2. **Health Oversight Activities**. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement**. We may release IIHI if required by law to do so. For example:

Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

Concerning a death we believe has resulted from criminal conduct

Regarding criminal conduct at our offices

In response to a warrant, summons, court order, subpoena or similar legal process

To identify/locate a suspect, material witness, fugitive or missing person

5. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Research**. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. **Serious Threats to Health or Safety**. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Workers' Compensation**. Our practice may release your child's IIHI for workers' compensation and similar programs.

9. **Compliance**. We are required to disclose your child's IIHI to the Secretary of the Department of Health and Human Services or his designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to section E.3. below.

E. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI

You have the following rights regarding the IIHI that we maintain about your child:

1. **Confidential Communications**. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask us not to contact you work. In order to request a type of confidential communication, you

must make a written request to the Site Manager, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request that we limit the use and disclosure of your child's IIHI for treatment, payment and health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your child's care or payment for care, such as family members or friends. You must make your request in writing to the Site Manager. Under federal law, we must agree to your request and comply with your requested restrictions if:

Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of health care operations (and is not for purpose of carrying out treatment); and,

The medical information pertains solely to a health care item or service for which the health care provided involved has been paid out of pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is required by law or necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancelation and continue to apply the restriction to information collected before the cancelation.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Site Manager in order to inspect and/or obtain a copy of your child’s IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your child’s health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your child’s IIHI for non-treatment, non-payment or non-operations purposes. Use of your child’s IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor

sharing information with the nurse; or the billing department using your child's information to file your insurance claim. We also will not provide an accounting of disclosures made to you about your child, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Site Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Site Manager or visit our website at www.PediAlliance.com.

7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer, P.O. Box 25437, Tampa, Florida 33622. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Site Manager at the office you usually take your child or our Privacy Officer.

Privacy Officer

Legacy Pediatrics, P.A.

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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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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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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	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	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	Check		
	Yes	No	Year
PET's (tubes)			
Adenoidectomy			
Tonsillectomy			
Other:			

Social History	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	
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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Records Release

Date of Request: _____

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

_____

_____

Name of Parent or Legal Guardian: _____

Patient Name and Date of Birth: _____

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

Mail _____ **Fax** _____ **Hand Carried** _____

Records to Transfer:

_____ All Records

_____ Clinic Visit-Notes

_____ Shot Records

_____ All Growth Charts

_____ Records for a Specific Date: _____

_____ Master problem List/Flow Sheet

_____ Medical Summary

_____ Last Physical Exam

_____ Asthma Action Plan and/or ADD visit

- 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