



Developmental & Behavioral Pediatrics of the Carolinas

FAMILY INFORMATION SLIP

One form may be used for the entire family provided that the responsible party is the same for each child.

Today's Date: _____

Account #: _____

CHILDREN'S NAMES:

LAST FIRST MIDDLE SEX DATE OF BIRTH SS#

PT. ADDRESS: _____ CITY _____ STATE _____ ZIP _____

(THIS BOX IS FOR STAFF USE ONLY)

YEAR: _____ INITIALS _____ YEAR _____ INITIALS _____

FATHER'S NAME: _____ DOB _____ SS# _____

**ADDRESS IF DIFFERENT FROM ABOVE: _____

HOME PHONE # _____ EMPLOYER _____ WORK # _____
MOBILE # _____

MOTHER'S NAME: _____ DOB _____ SS# _____

**ADDRESS IF DIFFERENT FROM ABOVE: _____

HOME PHONE# _____ EMPLOYER _____ WORK # _____
MOBILE # _____

IF DIVORCED OR SEPARATED LIST CUSTODIAL PARENT: _____

LIST ANY STEP PARENTS AND RELATIONSHIP: _____

NEAREST RELATIVE NOT LIVING WITH YOU, But close by: _____ Phone # _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? _____ Phone # _____

MEDICAL INSURANCE INFORMATION: (PRESENT CARD AT FRONT DESK) (LIST PRIMARY FIRST)

COMPANY GROUP # ID# POLICY HOLDER'S NAME/RELATIONSHIP

*IF CAROLINA ACCESS PLEASE SUBMIT YOUR CARD AT EACH VISIT. **PLEASE NOTE DEVELOPMENTAL & BEHAVIORAL PEDIATRICS OF THE CAROLINAS MUST HAVE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN.*

As a parent, I understand I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Developmental & Behavioral Pediatrics of the Carolinas.

If I cannot come with my child, I agree to let _____ and/or _____
(Name & Relationship) (Name & Relationship)

give permission for any treatment. (Examples of persons to name here may be stepparent, grandparent, sitter, etc.)

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature, giving permission for treatment.

Child must be 18 years of age to be treated without a parent present, or to pick up a prescription

Patient Signature

(Date)

Parent or Guardian Signature

(Date)

Initials

Parent's E-Mail Address: _____

Signature also required on other side

Developmental & Behavioral Pediatrics Of The Carolinas

Authorizations and Notifications

TREATMENT: The undersigned hereby consents for the physicians and staff of Developmental & Behavioral Pediatrics Of The Carolinas to administer treatment deemed advisable for the patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I give permission to D & B Pediatrics to release any medical information about my child's treatment (including copies of my medical records) "Medical information needed for payment for my insurance claims, to provide my medical care, and as required by D & B Pediatrics for its health care operations. I understand that if my Medical Information contains behavioral health, mental health, substance abuse, AIDS and / or HIV records, that this may also be released only for payment of my insurance claim, to provide my medical care, and / or as required by D & B Pediatrics for its healthcare operations. Any other use would require my separate, written authorization before D & B Pediatrics can disclose my Medical Information except when such release is required by law.

PAYMENT OF CO-PAYS AND CO-INSURANCE: I understand that D & B Pediatrics is committed to providing me with the highest quality care possible. I also understand that D & B Pediatrics is committed to controlling costs. I acknowledge that I have a responsibility to assist with controlling cost by paying my co-pay at the time of each service, or my service in full, or paying my co-insurance at the time of each service.

CANCELLED VISITS: I understand that it is my responsibility to give my provider at least 48 hours notification if I cannot keep a scheduled appointment.

MEDICAID CERTIFICATION: (Applicable to Medicaid recipients only) I have given correct information on my application for payment under Titles XIX (Medicaid) of the Social Security Act. I ask that any authorized Medicaid benefits be paid on my behalf, for any physician or other services furnished by D & B Pediatrics. I give permission to D & B Pediatrics to release any of my medical or other information needed by Medicaid and their respective agents, in order to determine the benefits to which I am entitled.

NON-COVERED SERVICES: I understand that my physician may recommend that certain tests be performed to assist in his/her treatment/diagnosis of my medical condition. My insurance carrier may not cover the test my physician feels are necessary for treatment/diagnosis. If my physician thinks the test may not be covered by my insurance payor, I will receive advance notification and will be asked to sign a waiver stating that I accept responsibility for payment. I also understand that I have the option to decline having the test performed.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to D & B Pediatrics and all physicians involved in my treatment or diagnosis at D & B Pediatrics by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of treatment of the below named patient. I unconditionally assign any insurance benefits to D & B Pediatrics and all physicians involved in my treatment and further authorize them to apply any surplus insurance benefits or any other payment received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to D & B Pediatrics and physicians for charges not paid by insurance. If an unpaid balance is sent to collection agency, I will be responsible for any legal fees, expenses, and/or interest associated with collection of the debt.

REFERRALS AND AUTHORIZATIONS: I realize that Developmental & Behavioral Pediatrics of the Carolinas is a specialist service and that my insurance carrier may require that my primary care provider complete a referral and/or authorization for such treatment. I acknowledge that it is my responsibility to make sure that D & B Pediatrics has received the completed referral/authorization prior to my scheduled appointment. Furthermore, I realize that D & B Pediatrics may recommend that I receive additional treatment from a specialist and I understand that it is my responsibility to make sure that the specialist has received the completed referral/authorization prior to my scheduled visit. If the referral/authorization is not completed prior to the visit, I will be required to pay for the visit in full at the time of service.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

Patient Signature

(Date)

Parent or Guardian Signature

(Date)