



Carolinah HealthCare System

Welcome to Arboretum Pediatrics

Congratulations on your bundle of joy! We hope that you find this packet helpful in answering any questions you may have about our practice. If you have any questions or concerns about the new patient process after reviewing this packet, please do not hesitate to call our office at 704-512-2610.

If you choose to join our practice when you deliver your baby, let the newborn nursery know that you have chosen Arboretum Pediatrics to provide the primary care for your newborn. Your baby's nurse will contact our practice and a physician from our group will see your infant at Carolinas Medical Center. The rounding physician in the hospital will also be able to visit with you and answer questions about your newborn.

Currently, our doctors are only rounding at Carolinas Medical Center. At all other hospitals, please inform the nurse that you have chosen Arboretum Pediatrics, and the pediatric hospitalist will round on you and your baby. The hospital should then transfer the newborn records and notes to our practice.

Your baby's first newborn visit in our office will be approximately 3-6 days after your infant's birth date. The pediatrician who discharges your newborn will discuss follow-up care of your newborn with you.

Please review the enclosed materials for information about becoming a patient at our practice. Thank you for your cooperation, we look forward to providing excellent care to you and your family.

Sincerely,

Arboretum Pediatrics



Carolinas HealthCare System

Arboretum Pediatrics First Office Visit Information and Required Forms

Thank you for choosing Arboretum Pediatrics to be your pediatric practice of choice. It is our goal to provide excellent care and service to you and your newborn for years to come. Please fill out the enclosed forms and bring them to your first visit. In addition, **please plan to arrive 15-30 minutes prior to your first appointment**, as we need this time to enter your registration and insurance information.

Enclosed in this newborn patient packet are very important forms that will help us provide the best standard of care. These forms are as follows:

- **Patient Registration Form (required)** – Please make sure to fill this out completely. This form includes important contact and insurance information.
- **Family Information Form (required)** – Please complete both front and back prior to your appointment. Your physician will go over this information with you at your first visit.
- **Payment Policy and Patient Statement of Responsibility Form (required)**- This form states that insurance cards need to present at each visit, and if any portion of the bill is denied, that it will become the responsibility of the patient to pay the remaining balance. For those patients who are uninsured, we offer a “self-pay” discount of 30% for services rendered.
- **Parental Consent to Treat for Minor or Incapable Adult (optional)** – Please fill out this form to allow anyone other than the parent or legal guardian to consent to treatment for your child. This may include, but is not limited to, step-parents, grandparents, siblings, and/or the patient themselves. This form is valid for one year or until our practice is notified otherwise and it covers routine office visits, immunizations, etc.
- **Acknowledgement of Privacy Practices (required)** – Health Insurance Portability and Accountability Act (HIPAA) form. This form ensures that we keep your child’s medical information private, and that we do not release or share it without your permission.
- **Release of Information (optional)** – This form allows us to request information from your previous medical offices. Please complete the form with your prior doctor’s office information so that we can obtain your child’s historical medical records if applicable. If you already have all of your child’s medical history, you do not need to complete this form. Please note that we **MUST** have a copy of your child’s prior vaccination/immunization schedule to provide the best continuity of care.

Please complete all forms in their entirety. If you have questions about any of these forms, please do not hesitate to call our office at 704-512-2610 or speak with someone at the front desk. For additional information about our practice such as vaccination schedules, office visit policies and payment policies, visit our website at **CarolinasHealthCare.org/Arboretum-Pediatrics**.

Thank you for your cooperation, we look forward to providing excellent care to you and your family.



Carolinus HealthCare System

Arboretum Pediatrics Newborn Insurance Process

An important note about newborn insurance

All newborns are self-pay patients when first seen in our office because their insurance is not yet active. When insurance does become active, it will retroactively cover visits since birth.

You will receive an invoice as a self-pay patient for all doctor visits prior to your newborn's insurance becoming active and being entered into our system. Don't worry! Upon receiving this statement, you can do one of two things:

1. When your newborn has been added to your insurance, call our office at 704-512-2610 and give us your insurance information. We will be happy to file those visits to the insurance carrier.
2. Discard the statement and simply bring your newborn's new insurance card with you to your child's one-month check-up. We will scan your insurance card into our system and file previous visits to the insurance carrier.

Once the claims have been filed to your insurance company, you will then be billed for co-pay, co-insurance or deductibles that your insurance has deemed your responsibility per your individual policy.

Please note: When you receive an invoice/statement, there will be a 1-800 number listed on it to call for information. However, we would like to request that you call us here at Arboretum Pediatrics so that we may directly enter your insurance information into our system. Please call us at 704-512-2610 and we will be happy to help!

Information about Hospital Routine Newborn Care

The following routine newborn care is done by the newborn nursery at all local hospitals in the Charlotte area. Our physicians consider these treatments/screenings the basic standard of care for your newborn and therefore require *all* treatments be completed during your hospital or birthing center stay in order to continue your newborn's care at Arboretum Pediatrics.

- **Vitamin K Injection** – Newborns have only a slight amount of vitamin K in their systems at birth. Vitamin K is needed for normal blood clotting. The vitamin K injection will boost your child's ability to clot normally to help prevent a possible life threatening bleeding disorder.
- **Antibiotic Eye Treatment** – Newborns can be exposed to bacteria during the birthing process. Because of this, erythromycin ointment is applied to the eyes of newborns to prevent possible infection or blindness. This eye treatment is a state law in North Carolina.
- **Newborn Screening** – This screening is done by the state of North Carolina on all babies. The newborn nursery will draw a small sample of blood through a heel stick and send it to a state lab to be tested for eight different abnormalities. The results of the newborn screen are sent to our designated pediatrician. Your doctor will review the results with you after the report is received.

All of these treatments/screenings are important and necessary to ensure the healthiest newborn possible. At Arboretum Pediatrics, we strive to offer the best care possible for your child. This is why we require all three of the above treatments/screenings to be completed during your stay at your delivering hospital or birthing center. If all of the above standard treatments/screenings are not completed, you will need to seek primary care for your newborn elsewhere. Thank you for your cooperation.



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Arboretum Pediatrics

Date Completed: _____

PATIENT REGISTRATION

PATIENT INFORMATION: MRN: _____ ORG MRN: _____

Patient's Legal Name (Last, First, Middle) _____ Preferred Name _____

Social Security Number _____ Date of Birth _____ Sex M F _____ Home Phone Number _____

The child lives with:
 Mother Father Grandparent Guardian

Parent / Guardian's Name _____ Parent / Guardian's Name _____

Date of Birth _____ Sex _____ S.S.N. _____ Date of Birth _____ Sex _____ S.S.N. _____

Street Address (Required) _____ Street Address (Required) _____ Check if Same

P.O. Box (if applicable) _____ P.O. Box Zip Code _____ P.O. Box (if applicable) _____ P.O. Box Zip Code _____

City _____ State _____ Zip (+4 if known) _____ City _____ State _____ Zip (+4 if known) _____

Home Phone _____ Cell Phone _____ Work Phone _____ Home Phone _____ Cell Phone _____ Work Phone _____

Fax Number _____ Fax Number _____

E-Mail Address: _____ E-Mail Address: _____

Employer Name: _____ Employer Name: _____

Employer Address: (Street Address/P.O. Box) _____ Employer Address: (Street Address/P.O. Box) _____

City _____ State _____ Zip (+4 of known) _____ City _____ State _____ Zip (+4 of known) _____

Race: (Ancestral/genetic lineage with which you associate yourself) (check appropriate box)

- Black or African American Asian Caucasian
 Hawaiian/Pacific Islander Multiracial Native American
 Other Unknown Decline

Preferred Language: (check appropriate box)

- English Arabic Chinese French German Hmong Italian
 Japanese Korean Laotian Portuguese Russian Spanish Vietnamese
 Other: _____ Sign Language

Do we have permission to leave a voice message for routine matters such as appointments, pick-ups, and normal lab results?

- Yes No

How would you prefer to receive appointment reminders? (Please choose one)

- Home Telephone Mobile Telephone Mobile Text E-mail

EMERGENCY CONTACT: (Other than Parents or Legal Guardian)

Name (Last, First, Middle)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

Person responsible for bill / copayment: Name _____ Relationship _____

INSURANCE INFORMATION:

PRIMARY			SECONDARY / SUPPLEMENTAL		
Name of Plan			Name of Plan		
Claims Address (Street Address/P.O. box)			Claims Address (Street Address/P.O. box)		
(City)	(State)	(Zip code)	(City)	(State)	(Zip code)
Phone Number			Phone Number		
Patient Policy Number	Group Number		Patient Policy Number	Group Number	
Subscriber Name (if different from patient): (Last, First, MI)			Subscriber Name (if different from patient): (Last, First, MI)		
Subscriber Sex <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber Policy #		Subscriber Sex <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber Policy #	
Guarantor Employer Name			Guarantor Employer Name		
Effective Date	Expiration Date		Effective Date	Expiration Date	
Copay Amount \$	Relationship to child		Copay Amount \$	Relationship to child	
Plan Type: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Other			Plan Type: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Other		

I hereby consent to the treatment of _____ at Arboretum Pediatrics including diagnostic and other medical care that is deemed necessary. I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: ____ / ____ / ____

Referred by: _____

Office Use Only:
General Comment Section:



Carolina's HealthCare System

Arboretum Pediatrics Family Information

	Name	Date of Birth
Patient Name		
Patient Nickname		
Parent		
Relationship to Patient	___ Mother ___ Father ___ Stepmother ___ Stepfather	
Parent		
Relationship to Patient	___ Mother ___ Father ___ Stepmother ___ Stepfather	
Siblings		Male/Female
Others living at home		

Family Medical History	Mother	Father	Brother	Sister	Mat	Mat	Pat	Pat	Please add any other family medical history you feel is pertinent to your child's health below:
					Gr	Gr	Gr	Gr	
					Father	Mother	Father	Mother	
Allergies, Food									
Allergies, Seasonal									
Asthma									
Autism									
Cancer									
Celiac Disease									
Developmental Delays									
Diabetes									
Heart Attack									
High Cholesterol									
Migraines									
Seizures									

Form completed by: _____ Today's date: _____



Carolinus HealthCare System

Arboretum Pediatrics

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

Thank you for choosing Arboretum Pediatrics for your healthcare services. We strive to provide the highest quality of care, and at the same time, keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE – We accept MasterCard, Visa, Discover, American Express, as well as your personal check or cash for payment of services. Additionally, we will file your claim to your health insurance plan based upon the plan information that you have provided to us. Providing the correct information in a timely manner is your responsibility.

PAYMENT (such as co-pays, co-insurance & deductible) - is expected at the time of service. We request that you do not ask to be billed. Follow-up appointments will not be made for accounts that have outstanding balances. Co-payments are required at the time of service.

INSURANCE CARDS must be presented at each visit - Insurance plans are becoming more complicated and cards, policy numbers and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information in that time, you will be responsible for all charges incurred up to the date you provide us with your insurance information. Any balance you owe should be paid within 30 days.

Information about specific types of insurance

COMMERCIAL AND MANAGED CARE INSURANCE PLANS

Many plans have a network of participating providers. We participate with most major plans. However, please know that it is your responsibility to contact your carrier for participation confirmation before your visit. You may check with your plan through their website or call the benefits number on the back of your card. It is extremely important that you check with your insurance plan *prior* to your visit. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service. You will also be expected to pay for any non-covered services for which you are liable.

MEDICAID

We do accept **NC Medicaid** at our office, however, Arboretum Pediatrics must be listed as your provider on your Medicaid identification card prior to making an appointment at our office. Please check with your case worker if you need assistance with this listing, or call Community Care Partners at 704-512-5555 for additional help. You will need to bring your current Medicaid Identification Card to each visit. Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

SOUTH CAROLINA MEDICAID

Arboretum Pediatrics will only accept SC Medicaid patients if they are enrolled in either Molina Healthcare or traditional South Carolina Medicaid.

We do not accept SC Medicaid patients enrolled in non-contracted health insurance plans. These non-contracted plans include the following:

- Absolute Total Care
- BlueChoice SC Medicaid Plans
- First Choice Select Health
- Well Care of South Carolina

SELF-PAY PATIENTS

Patients who do not have insurance coverage are considered self-pay patients. Self-pay patients will be given a 30% discount on all services and fees. Payment in full is expected at the time of service.

Other Important Information

OUTSTANDING BALLANCES

In the event that a patient has an existing balance on their account, a \$50 minimum payment is expected at every visit until the account is paid in full. If the account balance is not set up on a payment plan with our Central Billing Office (CBO) and any balance transfers to our outside collection service for payment arrangements, the patient may be dismissed from the practice for non-payment. Call 704-512-4808 to contact the CBO for questions or payment arrangements. You are always welcome to drop your payment by our office if that is most convenient for you.

FORM COMPLETION

We request that you bring any necessary forms to your appointment for completion. If forms are brought during a scheduled appointment, there is no charge for their completion.

There is a charge for any form needed when that form is presented/requested outside of a scheduled visit. Form charges are as follows and will be completed within 5-7 business days after the form is received at the office. Please make sure you allow plenty of time for completion of these forms.

Our fees include:

- Camp/Sports Participation \$10
- FMLA/Disability/Medical leave Forms \$50
- Other Miscellaneous Forms \$10-25
- 24-hour business day turnaround request \$25

Our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient's Name _____ DOB _____

Patient/Guardian's Name _____

Patient/Guardian's Signature _____ Date _____



Carolinan HealthCare System

Arboretum Pediatrics

PARENTAL CONSENT FOR TREATMENT FOR MINOR OR INCAPABLE ADULT

Signing this form gives Arboretum Pediatrics permission to treat the patient indicated below for items specified below. This consent form will be valid for one year, or until the practice is notified otherwise.

As the parent or legal guardian, I _____ (your name) give
permission for _____ (*print patient's name clearly*) Date of
Birth _____ to be seen at Arboretum Pediatrics according to the guidelines below:

- May visit the physicians' office alone
- May visit the physicians' office with a responsible adult

Please print the name of the responsible adult that may bring your child for their appointments:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

As parent or legal guardian, I give permission for the following:

- Well chick checks or routine physical examinations
- Immunizations
- Sick Visits
- Other: _____

If additional treatment is needed, I am to be contacted to give verbal consent.

I can be reached at: _____ (cell/mobile phone) or _____ (home phone).

Parent/Legal Guardian Signature: _____ Date _____

Witness Signature: _____ Date _____



Carolinan HealthCare System

ACKNOWLEDGEMENT FORM

Patient's Name: _____ Medical Record # _____
Date of Birth ____/____/____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date : _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

ACKNOWLEDGEMENT FORM

DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICIANS NETWORK

Numero de Registro Medico _____
Nombre del Paciente _____ Fecha de Nacimiento ____/____/____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciento o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Fimar: _____



Carolinus HealthCare System

Instructions for Completing the Authorization for Release of Health Information

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization.

1. Patient Information:

Please fill out all patient information that is listed (Name, Address, City, State, Zip Code, E-mail Address, and Telephone). You may give the last 4 digits of the patient's social security number.

2. Release Information From/Release Information To:

- A. Assign what hospital, nursing home, doctors' office or other healthcare center(s) will be releasing (copying and sending) the medical records.
- B. List the name, address, fax number and phone number of the organization or person to whom you want the records sent.

3. Purpose:

- A. Check the reason you are giving permission for the records to be released.

4. Records to be released:

- A. Please list the **dates of service** of the records you want release. (Dates the patient was in the hospital or nursing home or seen at the doctor's office or clinic).
- B. Please be specific as to what part of the medical record is being requested.
- C. Select the format you prefer to receive the information, paper or electronic.
- D. Select the method delivery to receive the records.

5. Authorize:

Read the Patient Rights statements.

Please print your name, sign, and date the form to confirm the release of the medical information requested. **Please note that a fee may be charged for copying the records.**

Patient Name: _____

Date of Birth: _____

Street Address: _____

Last 4 numbers of SSN: _____

City, State, Zip: _____

Telephone: () _____

Email address: _____

Release Information From:

(List applicable Facility(s) and/or Practice(s))

(Phone number) (Fax number)

Release Information To:

(Name of facility, person, company) (Relationship)

(Street Address or PO Box, City, State, Zip Code)

(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care Insurance
Legal purpose including discussions & proceedings Other

Fill in dates of treatment for records to be released:

Treatment dates: From To

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):

- Hospital Summary
Discharge Summary
History and Physical
Consultation reports
Operative Reports
Laboratory reports
Radiology/X-Ray Reports
Pathology reports
Emergency Record
Cardiac Reports/EKG
Other

Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):

- Office/Clinic Summary
Office Visits
Physical Exam
Laboratory Reports
Radiology Reports
Other

Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):

- Hospital Summary
Assessments
Discharge Summary
Physician Orders
Progress notes
Medications
Lab reports
Other

Entire Record (Not including psychotherapy notes)

FORMAT:

- CD (charges may apply)
Email Address noted above, where permitted
Paper copy (charges may apply)
Other

DELIVERY METHOD:

- Reg.US Mail
Pick-up
Fax, where permitted
Overnight/Express Mail Service, where permitted
Secure email
Other

PATIENT'S RIGHTS - I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
A fee may be charged for providing the protected health information.
I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here:

Signature: Print Name: Date:

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

- Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Spouse
Parent Adult Child Affidavit Next of Kin Other

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: Print Name: Date:

Authorization given to patient / Date of release: via Mail Fax Other ID Verified DL/Other ID

CHS Employee Name & Title: CHS Employee Signature: Date:



Name:
DOB:
Medical Record #:
Account #:

Patient Information or Sticker