PATIENT REGISTRATION

Dr. Karen Harum, M.D., FAAP

Attached is necessary paperwork to start you and your child's process at the Clinic for Special Children. We ask that you pay close attention to the following instructions so that we can make sure this process is appropriately and efficiently handled! Please make sure that all the following information is filled in:

-Be sure all **demographics** are filled in (names, addresses, date of birth).
-Be sure to add **contact information** (numbers, emails, etc.) so that we can contact you.
-Be sure to complete all **bolded questions** (email, zip codes, contact information).
-Please provide us with your **Medicaid/Insurance** information, so that we are able to verify it prior to your scheduled appointment.
-Be sure to fill out **pharmacy / zip code** and **primary care physician.**
-Be sure to **sign all** of the important documents.

Thank you for choosing the Clinic for Special Children with Dr. Karen Harum M.D., FAAP.

Please contact our office if you have any further questions or concerns at

(910)319-7744

Or

csc@clinicforspecialchildren.net

Pediatric Patient Registration

Patient..... Sex ❑ M ❑ F DOB .....SS#.....

Mother..... DOB .....SS# .....

Address ..... Home #..... Cell #.....

City/State/Zip ..... **Email**.....

Employer ..... Work #.....

Father ..... DOB .....SS# .....

Address ..... Home #..... Cell #.....

City/State/Zip ..... **Email**.....

Employer ..... Work #.....

Primary Care Physician..... Phone #.....City .....

Pharmacy ..... **Zip Code** .....

Children live with: ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other.....

Emergency Contact ..... Relation.....Phone# .....

Insurance Information

Name of Insured..... DOB .....Relation.....

Primary ..... Claim Address.....

Policy #..... Group# .....Co-pay.....

Secondary..... Claim Address.....

Policy #..... Group# .....Co-pay.....

Authorization of Treatment and Assignment of Benefits

I authorize Dr. Karen Harum, MD to treat my child. I further authorize release of medical information necessary for the completion of insurance forms. I authorize payment directly to Clinic for Special Children for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following_____.
I understand that if my child's physician, or any person employed by or under the direction or control of my child's physician, is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines of the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's bodily fluids.

....
Parent/Guardian Signature Relationship Date

....
Witness Signature Date

HEALTH HISTORY

How would you describe your child's general state of health? Excellent Good Fair Poor

Is your child currently being treated for a health concern by other healthcare practitioners? Please explain.

_____

_____

Does your child have any known contagious diseases at this time? Y N If yes, what?

_____

List any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has experienced, along with the approximate date.

	Date		Date

List any X-rays, CT scans, blood work or other studies (hearing, vision, etc.) that your child has had, along with the approximate date.

Study	Date	Study	Date

MEDICATIONS

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

How many times has your child received antibiotics in the past three years? _____

Prescription Medications

Is your child sensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental agents? _____

Any chemicals? _____

Any supplements? _____

Has your child ever had an anaphylactic reaction? _____

Illnesses

What illnesses has your child had?

Scarlet fever____Diphtheria___Rheumatic fever_Mumps_____Measles____German measles (rubella) ____

Chicken pox____Impetigo_____Tuberculosis_____Mononucleosis_____Strep throat____Ear infections _____

Immunizations

What immunizations has your child had?

Hep B	Rotavirus
DTaP	Hib
PCV	IPV
MMR	Varicella
Hep A	HPV
MCV	Hep C
Smallpox	TB
Influenza	Other:

Please indicate if any immunizations caused adverse reactions _____

Adverse Reactions

Please indicate if any of your child's immediate family (parents, siblings, maternal and paternal grandparents) suffers from or has suffered from any of the following conditions

Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Drug abuse/alcoholism	
Depression	
Other Mental Illness	
Asthma / Eczema	
Allergies/Hay fever	
Kidney Disease	
Autoimmune (MS, RA,	
Lupus etc)	
Psoriasis	
Other	
Thyroid issues	

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

Did the mother experience any of the following during pregnancy:

Bleeding____High blood pressure_____Nausea_____Vomiting _____

Diabetes____Thyroid problems_____Physical/emotional trauma _____

Other _____

Did the mother use any of the following during pregnancy? If so, please list amounts, frequency:

Medications Y N _____

Tobacco Y N _____

Recreational drugs Y N _____

Prescription medications Y N _____

Supplements Y N _____

Birth History

Term length: Full Premature:_____wks Late:_____wks

Length of labor: Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-section_____Induced_____Forceps_____Anesthesia used _____

In the first few weeks, did the child experience any of the following (circle all that apply)?

congenital birth defects colic constipation vomiting

jaundice rashes seizures other _____

Age at first: sitting_____crawling_____teething_____walking talking _____

Diet

Was your child breast fed? Y N If, so for how long? _____

At what age did you introduce solid foods? _____

Are there any foods you exclude from your child's diet? If so, for what reason?

Are there any foods your child craves (chocolate, sweets, salty, rich/fatty, breads, spicy)? _____

How much water does your child drink daily? _____

How often does your child have a bowel movement? _____

Lifestyle

How is your child's energy?_____Stress level? _____
Does your child exercise regularly?_____How often?_____What type? _____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc.)? Please describe.

How many hours of sleep does your child typically get?_____Any problems with sleep? ____

Describe your child's temperament:

How does your child feel about school/day-care?

What are your child's main interests and hobbies?

How would you describe the emotional climate of your home?

Is there anything else that you feel is important that has not been covered?

Clinic For Special Children
TREATING THE WHOLE CHILD

Financial Policy

Please check below and initial beside the applicable statements as they apply to the *patient* being seen:

❑ **If primary insurance** is through a private carrier like ***Aetna, BlueCross/BlueShield, Cigna, Medcost, Tricare, United Heathcare***, etc. I understand that by accepting service from Dr. Karen Harum at the Clinic for Special Children (CSC) that I am *responsible for payment in full at the time services are rendered*.

I am also aware of the following:

_____ Fees for the initial developmental evaluation (approximately 1½ - 2 hours) can run between $350-550. Follow-up visits can range from $85-350 depending on the extent and complexity of the appointment. Initial integrative general pediatric care (approximately 1 hour) can run between $150 -$350. Follow-up integrative pediatric care can run between $75-$150. Extended and/or complicated visits will incur an additional $150.

_____ I am responsible for filing for reimbursement through my insurance carrier. CSC *does not* file claims for me nor does CSC routinely complete claim/reimbursement forms.

_ Clinic for Special Children is considered an "out-of-network provider" and reimbursement typically falls under my out-of-network benefits. These benefits usually carry a higher annual deductible and greater out-of-pocket expense for me.

_____ I am responsible for verifying my out-of-network benefits and eligibility (customer service # can usually be found on the back of my insurance card).

_____ CSC will provide me with the procedure codes and other pertinent information so I can file for reimbursement. CSC staff is available for consultation if I need assistance.

_____ I am responsible for follow-up with my insurance carrier for any denied claims or otherwise unpaid reimbursement.

_ Lab kits and testing are separate from Dr. Harum's fees and are usually billable through my insurance company. Lab work fees/deposits will be discussed with me prior to ordering/performing suggested tests.

_ CSC's protocol is to retain my credit/debit card number securely on file to expedite account settlement. I can provide this information when I schedule my initial evaluation.

_____I understand that payment is due in full at time of service and that I will receive the following if my account becomes PAST DUE:

30 days: 2nd statement mailed/emailed

60 days: 3rd statement and service suspension notice mailed/emailed

90 days: 4th statement and notice of service suspension, including prescription refills, until account settled

❑ **If primary insurance** is through ***NC Health Choice*** or ***NC Medicaid***, I am aware of the following:

_____ CSC will file claims on my behalf.

_____ I am responsible for any co-pays *at the time services are rendered*.

_____ CSC will require Carolina Access authorization from my primary care physician and I will request authorization from my primary care provider for this purpose, if necessary.

❑ **If secondary insurance** is through ***NC Medicaid***, I am aware of the following:

_____ All private carrier procedures still apply (see above).

_____ I am responsible for forwarding a copy of my Explanation of Benefits from my primary carrier to CSC so they can file a secondary claim to NC Medicaid.

_____ Medicaid typically does NOT reimburse for services provided by a provider who is *non-participating* with my primary insurance plan.

Patient Name _____

Guarantor's Signature Date_____

Clinic For Special Children
TREATING THE WHOLE CHILD

16-Nov-2013

Office Policy Notifications

Please initial beside each statement:

_____**No Show Appointments:** A $50.00 fee will be billed directly to the patient for all "no show" appointments.

_____**Late Cancellations:** A $50.00 fee will be billed directly to the patient for appointments cancelled without one full business day of notice.

_____**Phone Consultations, Web Consults (eg Skype), Research, and Document Review Outside the Scope of Routine Clinical Care:** Charges range from $35-$175 depending on the amount of time spent on the phone with Dr.Harum, the complexity of the subject matter and whether or not research is required. *A credit card number is required up front for these services*.

_____**Email Policy:** A minimum charge of $25 may be billed directly to the patient for an email consultation. This charge will vary depending on the time needed to answer questions.

_____**Parent Consultation:** From time to time a parent may want to have a consultation without the child present. Although we are happy to accommodate the parents' wishes for this consultation, in most cases insurance *will not pay for this type of office visit*.

_____**Letter/Form Policy:** In most cases, charges for letters requested by the parents are $35 to $50 and vary depending on the amount of time required to do research and write the letter. There is no charge for school forms if you bring it with you to your appointment. Otherwise, there will be a $25 charge for school forms.
Please allow at least one week for letters to be written and forms to be filled out and mailed. *A credit card number for prepayment is required up front for these services*.

_____**Medical Records/Lab Results Copying Policy:** We are happy to provide copies of your current lab results while you are at your appointment. Providing medical records up to 13 pages is a minimum charge of $10. The maximum fee for each request shall be seventy five cents per page for pages 14 through 25, fifty cents per page for pages 26 through 100, and twenty-five cents for each page in excess of 100 pages. The total charge will vary depending on the size of the chart. *A credit card number is required up front for these services*.

_____**Prescription Refill Policy:** Written prescriptions that need to be mailed will require a one week notice to renew. All other prescriptions may take up to 48 hours to renew. To expedite refills, please have your pharmacy fax a request to 910-319-7754.

_____**Returned Checks:** There will be a $35.00 processing fee for all returned checks. This includes checks returned due to NSF or stopped payment.

_____**Past Due Accounts:** Payment IN FULL is due at time of service.

30 days past due: second statement mailed/emailed

60 days past due: third statement and service suspension notice mailed/emailed

90 days past due: fourth statement and notice of service suspension, including prescription refills, until account settled

Patient Name _____

Guarantor's Signature Date_____

HIPAA Authorization Statement

Please complete the following so that we may contact you properly and securely.

- Please list family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name .....
Phone.....
Name .....
Phone.....

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN EMERGENCY.

Name .....
Phone.....
Name .....
Phone.....

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

.....
.....

- Please print the telephone number where you want to receive phone calls about your appointments, lab and x-ray results, or other health care information if other than your home telephone number.

.....
.....

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL ❑ Yes ❑ No

- Can confidential messages (i.e. appointment reminders) Be left on your telephone answering machine or voicemail? ❑ Yes ❑ No

.....
Patient Name *print* (parent / guardian, if under 18 years old)

....
Patient Signature (parent / guardian, if under 18 years old) Date

Notes

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.....

Clinic For Special Children
TREATING THE WHOLE CHILD

Patient Consent

For Use and Disclosure of Protected Health Information

(As required by HIPAA)

With my consent, *Clinic for Special Children*, may use and disclose protected health information about my child/children to carry out treatment, payments and healthcare operations. Please refer to *Clinic for Special Children's* Notice of Privacy Policies for a more complete description of such uses and disclosures.

The Notice of Privacy Practices has been made available to me and I have the right to a copy if I so desire. *Clinic for Special Children* reserves the right to revise its Notice of Privacy Policies Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Clinic for Special Children*, Privacy Officer, 5725 Oleander Drive · Suite C1, Wilmington, NC 28403.

With my consent *Clinic for Special Children* may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others.

With my consent *Clinic for Special Children* may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment remainder cards and patient statements.

With my consent, *Clinic for Special Children* may fax or e-mail my appointment reminder cards, patient records, and patient statements. I have the right to request that *Clinic for Special Children* restricts how it uses or discloses my protected health information to carry out treatment payment and healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting *Clinic for Special Children* to use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures or reliance upon my prior consent. **If I do not sign this consent, *Clinic for Special Children* may decide not to provide treatment to my child.**

_____

Print Name of Patient

_____

Signature of Parent or Legal Guardian

Date_____

Clinic For Special Children
TREATING THE WHOLE CHILD

Authorization for Disclosure of Health Information

I hereby authorize:

.....

.....

.....

.....

To share with/receive records from:

Clinic for Special Children
5725 Oleander Drive · Suite C1
Wilmington, NC 28403
910-319-7744 · 910-319-7754 (fax)

Patient: ..... DOB:.....

Address: .....

Phone:.....

Medical record release dates covering: (from).....(to).....

Parent/Guardian understands that by signing this document that they are enabling the providers listed above to discuss, exchange, and disclose information pertaining to their child's treatment. Parent/Guardian understands that this will include information relating to (check if applicable):

- ❑ **Medical care and treatment**
- ❑ **Education/academic planning and service records**
- ❑ **Behavioral health service/psychiatric care**
- ❑ **Treatment for alcohol and/or drug abuse**
- ❑ **Developmental history/evaluation and treatment**
- ❑ **Other**.....

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, even or condition one year from date signed. The facility, its employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

....
Parent/Guardian signature Date

.....
Relationship to patient

....
Witness signature Date