Pediatric Endocrinology & Diabetes Specialists
4501 Cameron Valley Parkway
Suite 200
Charlotte, NC 28211

Mark W. Parker, M.D., FAAP
Lisa D. Houchin, M.D., FAAP
Mark R. Vanderwel, M.D., FAAP
Jakub Mieszczak, M.D., FAAP

_____ has an appointment scheduled on:

_____, _____ at_____ am / pm with
Day of week Date Time

Dr. Mark Parker **Dr. Lisa Houchin** **Dr. Mark Vanderwel**

Dr. Jakub Mieszczak
at
4501 Cameron Valley Parkway, Suite 200
Charlotte, NC 28211

Please print the New Patient paperwork from our website, under the heading "Our Practice"
You will also find directions to our office

www.PedsEndo-Diabetes.com

Please arrive 20 minutes prior to your appointment time with your new patient paperwork completed.
If you arrive more than ***10 minutes late*****,** you will need to reschedule your appointment.

For this appointment, please bring with you:

- Your co-pay, co-insurance**,** and/or deductible amount (will be based upon your insurance plan s contractual rates). **Payment is due at the time of service**.
- Your **current medical insurance card** and information.
- Your **child's medical records** sent from your Prim ary Care Physician's office. **This is extremely important**. The lack of these records will result in a more costly initial work-up for you here at our office. Your m edical history is vital for ou r doctors to accurately review your child's condition.

Additionally:

- **We are a specialist office** . If your insuranc e plan requires **prior authorization to s ee a specialist,** it is **your responsibility** as the gu ardian to obtain the appropriate authorization before your visit with us . Without this authorization, your insurance company will not pay for this visit and you will be responsible for full payment at the time of service.
- In addition to the initial office visit, laboratory services may be performed. You may receiv e additional billing statements for these procedures directly from the laboratory.

If you need to cancel or reschedule this appointment, please notify us at 704-512-3636
or toll free at 866-926-0217 at least 48 hours in advance.

If you are located out of the Charlotte area, **ask us about our satellite office**, which is located in **Hickory** for your follow-up visits. Please note, if you miss a satellite appointment without 48-hour notice, you will only be able to reschedule in our Charlotte office. We offer satellite appointments as a convenience for our patients and their families, and this satellite location is generally 100% booked with a waiting list. We certainly appreciate your respectful adherence to these guidelines.

We look forward to seeing you at your upcoming appointment.
In the meantime, if you have any questions, please do not hesitate to call us!

Carolinas Physicians Network
Carolinas HealthCare System

Pediatric
Patient Registration Form

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 _____

Mother / Guardian's Name			**Father / Guardian's Name**		
Date of Birth	Sex	S.S.N.	Date of Birth	Sex	S.S.N.
Street Address *(Required)*			Street Address (Required)		
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: *(Start Address/P.O. Box)*			Employer Address: *(Start Address/P.O. Box)*		
City	State	Zip *(+4 of known)*	City	State	Zip *(+4 of known)*

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 ☐ M ☐ F	Subscriber Policy #		Subscriber Sex ☐ M ☐ 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: ☐ PPO ☐ HMO ☐ POS ☐ Other			Plan Type: ☐ PPO ☐ HMO ☐ POS ☐ Other		

Person Responsible for Payment of Bill ☐ Mother ☐ Father ☐ Guardian or Other _____

EMERGENCY CONTACT: *(Other than Mother or Father)*

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

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE:

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, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant 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 as valid as the original.

Signed: _____ Date _____ / _____ / _____

Office Use Only:
General Comment Section:

New Patient Information

Patient Name: _____ DOB: _____

Primary Care Physician & Practice Name: _____

Reason for Visit: _____

Past Medical History

Birth Weight: _____Any Problems with Pregnancy: YES NO If yes, please list below

_____

_____

Please circle: Vaginal C-Section Full Term Premature

Family History

Mother's Height: _____ Any Medical Problems: _____

Age of first menstrual period: _____

Father's Height: _____ Any Medical Problems: _____

Maternal Grandmother's Height: _____ Any Medical Problems: _____

_____

Maternal Grandfather's Height: _____ Any Medical Problems: _____

_____

Paternal Grandmother's Height: _____ Any Medical Problems: _____

_____

Paternal Grandfather's Height: _____ Any Medical Problems: _____

_____

Siblings and age and health problems, if any: _____

_____

_____

Development

How old was your child when he/she started walking? _____ Talking?_____

Were there any delays in development? _____

_____

How old was he/she when his/her first tooth erupted? _____first adult tooth? _____

Has growth/height been steady? _____

Age menstrual cycle began? _____

Any signs of puberty? _____ if yes, please explain: _____

_____

Any serious illnesses? _____ if yes, please explain: _____

_____

Any prior hospitalizations? _____ if yes, please explain: _____

_____

Any prior surgeries? _____ if yes, please explain: _____

_____

Any allergies to medications? _____ if yes, please explain: _____

_____

List any medications that your child is currently taking: _____

_____

Review of Systems

__ Frequent headaches	__ Frequent stomach pain	__ Seizures
__ Vision problems	__ Constipation	__ Loss of consciousness
__ Hearing problems	__ Diarrhea	__ Head trauma
__ Multiple ear infections	__ Blood in stool	__ Fatigue
__ Chest pain	__ Bladder infections	__ Excessive urination
__ Palpitations	__ Blood in urine	__ Excessive thirst
__ Heart problems	__ Yeast infections	__ Rapid weight loss
__ Pneumonia	__ Kidney problems	__ Rapid weight gain
__ Wheezing	__ Broken bones	__ Heat/Cold intolerance
__ Chronic cough	__ Joint swelling or tenderness	__ Dry skin

How is the child's appetite: Poor Average Good

What types of activities does your child enjoy? _____

_____

_____

_____

Who lives in the home? _____

Any other caretakers outside of the home? _____

What grade is your child in? _____ Is your child in daycare? _____

What school does your child attend? _____

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Kira Segebarth, RD, CPNP

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Pediatric Endocrinology & Diabetes Specialists for your healthcare services. We strive to provide the highest quality of care yet 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.

PAYMENT (such as co-pay, 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. You may feel this is unnecessary, but 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 within 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 thirty days.

COMMERCIAL INSURANCE PLANS require co-pays which are to be paid at the time of service. We participate with most major plans. However, because we are a specialty practice, please contact your carrier for confirmation before your visit. You will also be expected to pay for any non-covered services for which you are liable. 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.

SELF PAY PATIENTS are those patients who do not have insurance coverage. Self pay patients will be given a 25% discount of their services and fees. Payment in full is expected at the time of service.

MEDICAL LEAVE; DISABILITY; & MISCELLANEOUS FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. Our fees are:

♦ DMV	$15	♦ School Forms – Annually	$15
♦ Camp/Sports Participation	$15	♦ Growth Forms – Annually	$50
♦ Medical Records	$15	♦ Other Miscellaneous Forms	$15-50

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 Name _____

Patient/Guardian Signature_____Date_____

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Understanding of Commitment to Care

Pediatric Endocrinology & Diabetes Specialists is committed to providing pediatric endocrine specialty care to the children and families of this region. As a part of our dedication to each child's care we ask that each patient's family understand and acknowledge their responsibilities in accessing care for their child. Nationally there is a shortage of Pediatric Endocrinologists therefore limiting the availability of appointment times and resources to meet patient's needs. This practice has established the following criteria in an effort to provide the highest level of care for our patients.

- Patient appointments are scheduled at intervals determined by the patient's needs and diagnosis.
- In an effort to maximize the benefit of your appointment, if possible, we would like to ask that only the child being seem for the appointment come with the parent(s) to the office. If childcare arrangements for other children can not be made, please try to bring a second adult with you to the appointment to wait with the additional family members in the waiting room.
- Patients must give ***48 hours*** if a scheduled appointment is not going to be kept.
- Patients who no show for appointments will be required to pay a $50 deposit prior to making an additional appointment.
- Patients who cancel or no show without 48 hours notice may be discharged from the practice. In the event a patient is discharged from the practice it will be the family's responsibility to access care at another facility with the assistance of their primary care physician.
- Each patient is responsible for supplying current and complete insurance information to the practice prior to appointments. It is the patient's responsibility to obtain insurance authorizations prior to the appointment if required. Without prior authorization, you will be financially responsible for payment in full at the time of service.

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

Patient's Name: _____ DOB: _____

Parent/Guardian Printed Name: _____

Patient Guardian Signature: _____

Carolinas Physicians Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ 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 PHYSICANS 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: _____
(Paciente o Representante Autorizado)

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

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

One patient per authorization form

There may be a charge for record copies.

Carolinas HealthCare System

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request ❑ Other _____

RELEASE FROM: The facility / practice / individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ **Telephone #:** _____

Facility/Practice Address: _____ **Fax #:** _____

The facility / practice / individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): **From:** (MM / DD / YY) _____ **To:** (MM / DD / YY) _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details**
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab / Pathology Reports
❑ Medication Records
❑ Office / Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology / Imaging Reports
❑ Test Results
❑ Other (Please Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle / Maiden) _____ (Last)

Patient Address: _____ (Street Address / PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

RELEASE TO: This information may be released to and used by the following individuals / organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals / organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices / Policy.
- This authorization will expire when the information from the event / purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and / or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of of 18, the patient must also sign this authorization.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N / A

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: _____ via ❑ Mail ❑ Fax ❑ Other _____

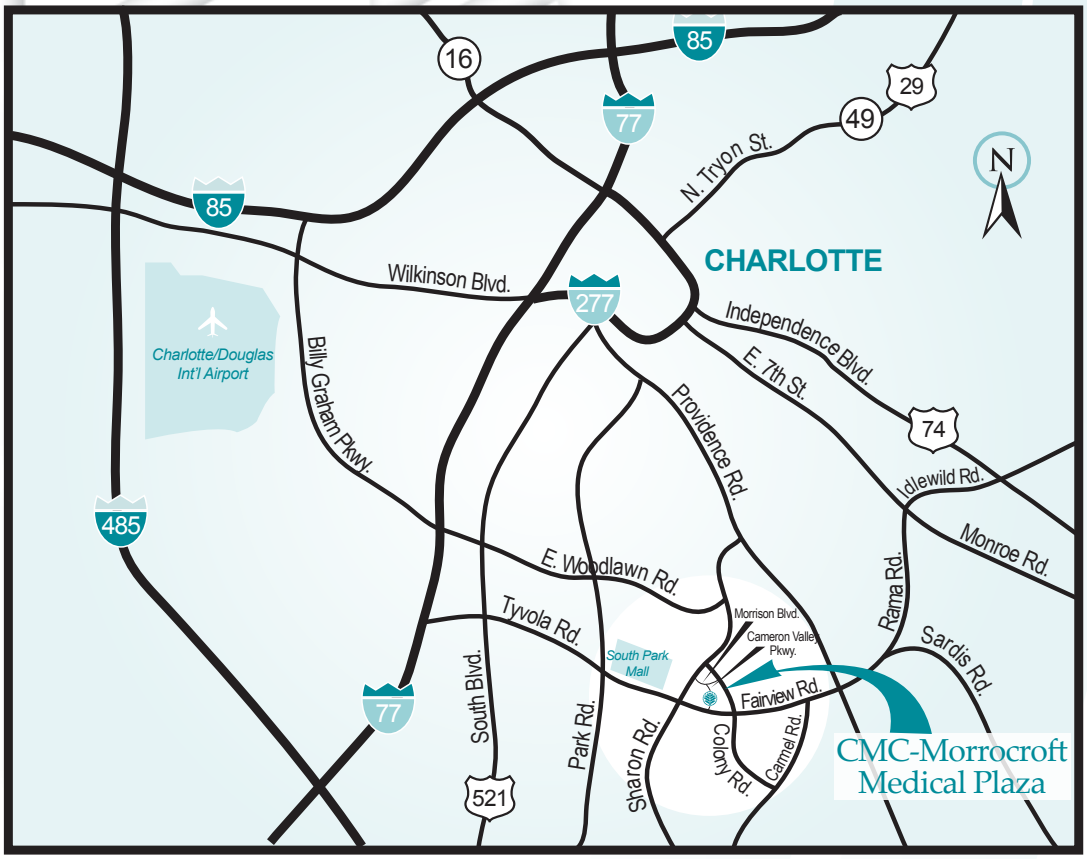
❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

_____

Employee Name & Title _____

Employee Signature: _____ Date: _____

Map and Directions



From I-77:

- Take Exit 5/Tyvola Road toward the SouthPark Mall Area;
- Continue on Tyvola Road for 2.7 miles until it becomes Fairview Road;
- Continue on Fairview Road for 1.4 miles;
- Turn left onto Cameron Valley Parkway;
- Arrive at 4501 Valley Parkway (second driveway on the right).

From US-74/Independence Avenue:

- Turn left onto Idlewild Road;
- Idlewild becomes Rama Road;
- Rama Road becomes Sardis Road;
- Sardis Road becomes Fairview Road;
- Turn right onto Cameron Valley Parkway;
- Arrive at 4501 Cameron Valley Parkway (second driveway on the right).

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