Carolina Pediatric Associates

301 West Pine St Blacksburg, SC 29702-----1610B N Limestone St Gaffney, SC 29340
(864) 839-4325 (HEAL)-----FAX (864) 839-9901

WELCOME TO OUR PRACTICE

If ALL Blanks are not filled in----Patient CANNOT be seen

HOME PHONE _____
CELL PHONE _____

CHILD's NAME _____
Last Name First Initial

Child's Street Address_____

City_____

State_____ Zip_____

Child's SSN _____ _____ DOB _____ AGE _____ **M F**

NAME OF SCHOOL SIBLINGS WHO COME HERE

Parent Name _____ Initial_____ Parent SSN _____ Parent DOB _____

Parent Employed By _____

Work Address _____ Work Phone _____

City_____ State_____ Zip_____

Other Parent Name _____ Initial_____ Parent SSN _____ Parent DOB _____

Parent Employed By _____

Work Address _____ Work Phone _____

City_____ State_____ Zip_____

Is this child covered by insurance? Y N Medicaid Number _____

Name of Insurance Company _____ **Subscriber #**_____ **Group #** _____

What pharmacy do you want your prescriptions sent to? _____ What is your email address? _____

EMERGENCY CONTACT **NOT IN THE HOME**: NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE NUMBER: _____ _

City_____ State_____ Zip_____

***How did you hear about our practice?** Yellow Pages Newspaper Billboard Sign Health Fair **FRIEND**_____ **tell us who** ☺

We will file your insurance claims for you but please understand this is a service we provide to you. We are not required to do this. If you fail to make payments to us, in a timely manner, for your portion of the bill, (for example….co-pay, deductible, payment for non covered services), **then you will be required to always, from then on, pay for the entire visit yourself and then you, yourself, have to bill the insurance company for reimbursement.** Please remember that insurance is considered a method of reimbursing a patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, **it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company** (unless otherwise restricted by law or agreement we might have made with insurer).

CONSENT: I authorize any holder of medical or other information about my child to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for all insurance claims made for mine or my child's medical care for all time patient is under this doctor's care. I permit a copy of this authorization to be used in place of the original. **I request payment of medical insurance benefits to Carolina Pediatric Associates and its legal representatives.**

I do hereby voluntarily consent to such diagnostic procedures, hospital care and medical, surgical, treatment by Carolina Pediatric Associates physician(s), physician assistants, nurse practitioners, or physician's designees as is necessary in his/her judgment to treat myself or my child**. I acknowledge that no guarantees have been made to me as the result of treatments or examination in this facility.**

SIGNATURE: _____ DATE: _____

I certify that I have received notice of Carolina Pediatric Associates: (see previous page **FOR YOU TO KEEP**)

Office Hours/ Mission Statement/ Complaints Policy/ Missed Apt/cancellation Policy/ Payment Policy/Rx Policy/ Discrimination Policy /AND A COPY OF THE **PRIVACY POLICY**
1._____signature

Dr. Carling would like to **take a picture of your child** for his/her record so that all staff members can quickly learn the faces of the children we care for. Please sign here if Dr. Carling has your permission to take a picture.
2. _____ (sign)

……

If your child is to be treated by Dr. Carling in any way and you are not with the child, we must have your permission.

In some cases we may need a copy of the legal documents giving you guardianship/custody responsibilities.

The following family members, friends, and caregivers, have my permission to bring my child in for treatment and have access to my child's **protected health information**. **Please be sure to list the parents and guardians as well**.

NAME	RELATIONSHIP	PHONE
	MOTHER	CELL/WORK
	FATHER	CELL/WORK

Regarding Medical Records--Please Read Regarding YOUR responsibility:
Other Doctor's who have treated your child: _____

I accept the responsibility of requesting that a copy of my child's **health records** from their other doctor's be sent to this office. **Y N** 3. **_____(initial)**

I understand that if I choose not to make these requests myself, Carolina Pediatric Associates will not have a complete picture of my child's health thus limiting Dr. Carling's ability to properly treat my child and that Dr. Carling can not be held responsible for information he does not have access to. 4._____ **(initial)**

…….

STRICT PAYMENT AND COLLECTIONS POLICY: *Please Read Carefully*

Insurance cards, co-pays, deductibles, payments due to lack of insurance and old balances are expected at the time of check-in. OUR OFFICE OPERATES ON A POLICY THAT ALL OLD BALANCES FOR ANY CHILDREN RELATED TO THE CHILD YOU ARE BRINGING IN BE PAID BEFORE YOU ARE SEEN. Statements that you were never notified will not be accepted. If you leave without paying your bill or if we have to send you a bill, we may charge you interest and accounting fees based on the total of your balance. WE DO NOT OFFER PAYMENT PLANS.

Bad checks require an additional charge of $25.00. We participate in the Worthless Check Program and your unpaid check will be turned over to the Sheriff's office if not paid promptly.

BY SIGNING THIS DOCUMENT YOU AGREE THAT YOU HAVE READ THIS POLICY, UNDERSTAND IT AND AGREE TO FOLLOW THE PAYMENT AND COLLECTION POLICY OF CAROLINA PEDIATRIC ASSOCIATES.

_____ SIGNATURE _____DATE

Carolina Pediatric Associates

301 W. Pine Street
Blacksburg, SC 29702
864 839-4325

Prescription History Consent Form

I _____ give Carolina Pediatric Associates permission to access my child's prescription history thru Surescripts.

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Parent Signature _____

Date _____

FOR YOU TO KEEP

CHECK- IN WITH RECEPTIONIST BEFORE AND AFTER APPOINTMENTS IS MANDATORY EVERY VISIT!

MISSION STATEMENT: It is our goal to provide your child with unmatched health services. We strive to educate parents and the community to be stronger advocates for their children. We will work hard to meet the physical and mental needs of the children in our area.

DISCRIMINATION: We will treat every patient equally regardless of race, color, religion, culture, sex, (or age and handicap, assuming the needs are within the scope of this practice's ability to properly provide treatment). We want you to know that we will treat all patients in a life threatening emergency situation regardless of ability to pay.

Regarding payments:

- All payments are expected at time of service.
- Bad checks will require you to pay your bank fee, our bank fee is ($25), and an additional $25 for accounting fees. If you write two bad checks all future payments will need to be paid by cash or money order.

Please be advised of our **office hours**

Dr. Carling has 2 offices.

BLACKSBURG at 301 W Pine Street

Doctor or Physician Assistant is in:
Monday thru Friday: 9-5
STAFF OFFICE HOURS: Monday through Friday 9-5

GAFFNEY at 1610B N. Limestone Street

Doctor or Physician Assistant is in:
Monday thru Friday: 9-5
STAFF OFFICE HOURS: Monday through Friday 9-5

ALL CALLS FOR BOTH OFFICES ARE TAKEN AT 839-HEAL (4325)

S P R E A D T H E W O R D

Dr. Carling has a PEDIATRIC NIGHT CLINIC in his Gaffney office open Monday – Thursday from 5-7pm (possibly later during really bad cold/flu days) Any children ages 0-21 can be treated at this night clinic. Please let your friends know that even if they do not see Dr. Carling during the day for care they can see him in the NIGHT CLINIC! Calls for this are also taken at 839-4325.

*****PLEASE NOTE***** The NIGHT CLINIC is ONLY FOR SICK or PROBLEM VISITS**
Dr. Carling will not see people in the night clinic who need to be treated for the following conditions: Prescription Refills, ADHD treatment, Wart removal, Sports Physicals, Well Child Visits.

COMPLAINTS: If you would like to make a complaint about how your personal health information has been handled by our office you may do so by requesting a complaint form from our privacy officer, Amy Carling. Our privacy officer can be reached by coming to our office or calling (864) 839-4325. YOU WILL SUFFER NO NEGATIVE REPERCUSSIONS FOR MAKING A COMPLAINT. We welcome your input. All complaints will be addressed within 10 working days of receiving the written complaint.

ARTWORK: Dr. Carling wants to invite all of his patients to share their artwork with him.

If your child has colored, painted, drawn, etc. a special picture please encourage them to bring it to the office where we will display it. Also encourage your child's teacher to do a class art project that Dr. Carling can display in the office.

Dr. Carling is helping to sponsor an **ADHD support group**. This is an opportunity for **parents, teachers and caregivers** who work with and care for these children to learn more about treatment options, behavior management strategies, and support for the child and themselves. ANYONE IS WELCOME. If you are interested in attending please ask the staff for details.

We do have **FLU SHOTS** available. Please ask us if your child qualifies to receive this protection! NOTE: Flu shots are given twice a year. Once in October and once in November. We will have a late night where we welcome ALL patients to come and receive a flu shot. We do not offer flu shots during regular visits or hours. PLEASE sign up for the flu shot and ATTEND OUR FLU CLINIC

WALK IN POLICY

Our goal is to see all sick children as quickly as possible while giving quality health care. We reserve the right to give priority to patients with appointments. We will see walk- ins as our schedule permits. **Calling Ahead may make your wait shorter**.

ADDING A SIBLING

If you have a child with an appointment and their sibling needs to be seen as well please let us know as soon as you arrive. Waiting until you are in the room with the provider is not acceptable and will not relieve you of your copay obligations as the provider is required by law to record any examinations he/she performs and to bill for those exams. If you do not tell the receptionist that you will be discussing concerns about a sibling we reserve the right to move that sibling's visit to the back of the line which may increase your wait time.

LATE POLICY:

We reserve the right to give priority to patients who arrive on time for their appointments. If you are more than 15 minutes late for a well visit your appointment will be rescheduled.

BAD BEHAVIOR: This is a PEDIATRIC PRACTICE. The office and lobby are full of children. Even if you are frustrated you are not permitted to swear, throw things, call our staff stupid or any other names. Using discriminatory names for our staff WILL NOT BE TOLERATED. You need to remain calm no matter what your issues are. We WILL call the POLICE if you act rudely in our offices. PLEASE remember there are many children in the office who do not feel well and do not need to be subjected to anger, negativity or swearing.

PAPERWORK: We have at least 48 hours to get you paperwork that you request. You must understand that in some situations this will take longer. Paperwork is handled by our staff who area also handling patient care.

RXs that are not delivered to your pharmacy:

We send our Rxs electronically. We coordinate with may pharmacies. MOST of the time when your Rx isn't at the pharmacy it is because the pharmacy has not checked their fax or email or they are having electronic problems. Our system shows us the time we sent the Rx and if it was received. If your Rx isn't at the pharmacy and you have asked them to see if they have received it but just have not filled it then please call our office. 839-4325 to inquire. You will be directed to the provider on call that evening.

CAROLINA PEDIATRIC ASSOCIATES
301 West Pine St. Blacksburg SC 29702---1610B N Limestone St Gaffney SC 29340
864-839-HEAL Fax 864-839-9901

Daren E Carling, MD

NOTICE OF PRIVACY PRACTICES:THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.

Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care for treatment, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health records is the physical property of this practice, however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your request for any of these actions:

Request Restriction: You have a right to request restriction on the use of your information.

Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this notice.

Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage, and supplies used.

Amend: You have the right to request that we amend your health information. If anything is incorrect.

Obtain an Accounting of Disclosure: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for purposes other than treatment, payment, or healthcare operations and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.

Request Communications of your Health Information: You have the right to request that you receive communication regarding your information in a certain manner or at a certain location.

Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

Confidentiality: Maintain the privacy of your health information.

Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.

Abide by the terms of this notice.

Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.

Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate your information by alternative means or at alternative locations. We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information

If you have a question or would like additional information, you may contact our privacy officer.

If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice. If you would like to make a complaint about how your personal health information has been handled by our office you may do so by requesting a complaint form (which must then be mailed tour office) from the front desk or mailing a letter explaining the situation to the Office Manager/Privacy Officer. Our privacy officer can be reached by coming to our office or calling (864) 839-4325. YOU WILL SUFFER NO NEGATIVE REPERCUSSIONS FOR MAKING A COMPLAINT. We welcome your input. All complaints will be addressed within 10 working days of receiving the written complaint. If your concerns are not resolved to your satisfaction you can contact the secretary of Health and Human Services in the U.S. Office of Civil Rights

You can contact our privacy officer during business hours at (864) 839-HEAL(4325)

We will use your health information for treatment purposes. As an example information given to a nurse or physician will be recorded in your health records and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.

We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatment and supplies used.

Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

Business Associates: There are some services provided through contracts with business associates. As an example, we contract with the company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care information about your general condition.

Communication with family: We will use good judgment in disclosing to a family member or any person you identify health information relevant to that person's involvement in your care or payment related to your care.

Research: We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.

Funeral Directors: We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.

Organ Donation: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food supplements, products and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.

Public Health: Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.

Correctional Institution: If you are an inmate of a correctional institutional, we may disclose to the institution or its agents health information that is needed for your health or the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Health investigation: Federal and state law made provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers, or the public.

Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to see or disclose information about you, you may revoke this authorization at any time.