Dr. Carey Molin Gully, MD, FAAP
(864) 888-4464
(864) 888-4462 fax
www.blueridgekids.com

BLUE RIDGE PEDIATRICS
Professional, Personalized Care for Newborns, Children & Adolescents

NORTH PARK OFFICE PARK
457-B HWY 123 BYPASS
SENECA, SC 29678

PATIENT REGISTRATION FORM

Referred By: _____ Please circle: Male Female

Patient Name: _____ Date of Birth: _____
(FIRST) (MIDDLE) (LAST)

Address: _____ City: _____State/Zip: _____

PARENT OR GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____ S.S.N.: _____

Home phone #: _____ Cell #: _____ Email: _____

Employer/Occupation: _____ Work Phone #: _____

Father's Name: _____ Date of Birth: _____ S.S.N.: _____

Home Phone #: _____ Cell #: _____ Email: _____

Employer/Occupation: _____ Work Phone #:_____

Emergency Contact: _____ Address: _____Phone#: _____

(Other than Parent/Guardian)

Closest Relative: _____ Relationship: _____ Phone#:_____

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE FOR BILL) AND BILLING INFORMATION

Person Responsible: (please circle) Father Mother Other: _____ Relationship: _____

Billing Address: _____ Phone #: _____

Insurance Company: _____ ID#: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Blue Ridge Pediatrics, LLC, for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

Patient Name: _____ Date: _____

Parent/Guardian Signature: _____

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FINANCIAL POLICY

The following financial policy has been developed to allow the office of **Blue Ridge Pediatrics, LLC,** to provide the highest quality of care at the lowest cost to you, our patient.

Patient Name: _____ Date of Birth: _____

Co-Pays & Deductibles	All insurance plan co-pays are payable upon Check In. Deductibles are payable upon Check Out. It is the patient's responsibility to be aware of their co-pays and/or deductibles at the time of service.
Self-Pay	Payment is expected at the time of service. We accept cash, check, or credit card for your convenience. Outstanding balances must be paid in full before being seen again. If the balance cannot be paid in full, payment arrangements will need to be made. You may do this by contacting the Billing Department at (864)888-4464.
Medicaid	You will need to bring your Medicaid card with you to your appointment. If the patient is not eligible for Medicaid, at the time of service, then the patient will need to pay before services are rendered. **This payment will not be refunded if retroactive coverage is obtained.**
Newborns	We can use the mother's Medicaid card. Once a child has been reported to a case worker, a Medicaid number will be assigned in the child's name and date of birth.
Private Insurance	As a courtesy, our office will file your insurance for you, but ultimately the responsibility of payment is yours.
Collections	Accounts turned over to a Collection Agency will receive a dismissal letter from our office and will incur a **$25.00** administrative fee as well as any additional fees associated with that effort, including court cost.
Other Information	Any check returned to our office for non-payment will generate an additional processing fee of **$25.00. American Sign language is available** by request with 24 hours notice.

My signature below certifies I have read and understand/accept the terms of the Financial and Collections Policy as stated above. I agree and understand that the office of Blue Ridge Pediatrics, LLC., will file my insurance for services rendered.

_____ _____ _____

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date

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AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND NOTICE OF PRIVACY PRACTICES

- **CONSENT FOR MEDICAL TREATMENT:** I understand that the office has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the Physician(s) and/or Midlevel Practitioner in charge of my child's case to administer treatments as deemed necessary or advisable in the treatment of any condition of my children.
- **PAYMENT GUARANTEE:** I/we agree to pay the established rates of the clinic for all services rendered.
- **RELEASE OF MEDICAL INFORMATION:** I do hereby authorize the office Blue Ridge Pediatrics, LLC, to release medical or other information about me or my child(ren) to any insurance companies involved or any other agency assisting in the payment for the patient's care.
- **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:** By signing this form, you acknowledge receipt of the notice of privacy practices of Blue Ridge Pediatrics, LLC. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at 864.888.4464.
- **USE OF PHONE NUMBER AND EMAIL:** I hereby authorize Blue Ridge Pediatrics LLC to send me text messages and/or emails regarding upcoming appointments and health announcements.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION/AUTHORIZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES.

Patient Name:_____ DOB: _____

Parent/Guardian Signature: _____ Date: _____

IMMUNIZATION POLICY

One of the top preventative measures practiced in our office is immunizations. Our practice follows the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommended immunization schedule. The recommended schedule is designed to immunize your child in a time frame that will give your child proper immunity from the disease. Deviations can put your child at risk.

Therefore, our practice does not participate in any forms of a modified immunization schedule and we do not accept or retain patients that do not immunize their children.

Please feel free to talk to one of our healthcare providers regarding immunizations. For further immunization information, visit www.cdc.gov or www.aap.org.

I agree to Blue Ridge Pediatrics Immunization Policy.

Patient Name: _____DOB _____

Parent/Guardian Signature: _____Date: _____

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Authorization for Use and/or Disclosure of Protected Health Information

I hereby authorize Blue Ridge Pediatrics to use or disclose my protected health information as described below:

Name of person/ facility authorized to **RELEASE** the information: _____

Phone: _____ Fax: _____

Name of person/ facility authorized to **RECEIVE** the information: __Blue Ridge Pediatrics, LLC_____

_____ Immunization record, most recent physical and growth chart
_____ Most recent ADD/ADHD visit and initial assessment

This release is for:

_____ Information only
_____ Permanent transfer of records for treatment

This authorization will expire **one year** from date of signature.

This Practice will _____ will not_____ receive payment or other remuneration from a third party in exchange for using or disclosed the protected health information.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by the federal HIPPA regulations. I have the right to revoke this authorization in writing, and I understand that the revocation will not apply to information already released based on this authorization.

Patient name and birth date:

_____ _____
(Patient Name) (Birth Date)

_____ _____
(Patient Name) (Birth Date)

_____ _____
(Patient Name) (Birth Date)

I am the parent or legal guardian of the above named patients and I am authorized to provide this release.

_____ _____
Parent/Guardian Signature Date

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New Patient Policy

Blue Ridge Pediatrics is growing. We are currently accepting new patient requests.

New Patient Requests:

In order to determine if we can accept a patient into the practice, we will ask you to sign consent for transfer of medical records for physician review. You may also be asked to complete a patient registration form. All forms are available on our website at **www.blueridgekids.com**. You can print copies of these forms and complete them before coming in if that is more convenient.

Visiting Patients:

We are happy to see patients from out of town or patients seeking emergency pediatric medical care. Often we can provide a same day appointment. We will forward copies of our notes to your physician upon request. We do not require transfer of records for these type of visits unless medically necessary.

Pending Patient Status:

Patient acceptance decisions shall be based on the medical needs of the patient in relationship to the scope of the physicians' and providers' expertise. Please understand that a patient will not be accepted into the practice until the physician receives and reviews the complete patient medical record. Upon receipt of medical records, our providers will review each patient's individual medical needs to determine if our practice will provide a "good fit" for your child. Usually this decision is made within 1-2 weeks of receiving medical records. During this time, our practice will be happy to provide care on a pending patient basis. Please understand that this does not guarantee acceptance as a new patient. As our practice grows, we are sometimes unable to care for a child's specific healthcare needs. Blue Ridge Pediatrics LLC does not discriminate based on race, color, national origin, religion, sex, disability, or familial status.

If your child has been seen by one of our providers but not accepted into the practice, we will continue to provide care for 30 days from the date of your child's first visit. We will be happy to provide a list of providers in the area upon request.

Patient Dismissals

Blue Ridge Pediatrics LLC believes the physician/patient relationship to be a professional one based upon mutual trust. If a breakdown in this relationship occurs we reserve the right to refuse treatment. Reasons for dismissal include (not all-inclusive):

- Dishonesty
- Aggressive, inappropriate or threatening behavior (actual or implied)
- Persistent non-compliance with treatment plans
- Refusing to see and/or be treated by members of our staff
- Illegal activity by patients or their caregivers
- Patients or caregivers felt to be dangerous to self or others
- Requests for services beyond our scope of care
- Failure of payment
- Multiple missed/canceled appointments
- Transfer to another local practice

In the event that a patient is dismissed, it is Blue Ridge Pediatrics policy to:

- Notify patient/parent or guardian
- Continue to see patient for follow-up or emergency care for 30 days
- Clearly state the date termination becomes effective
- Provide information to assist patient in finding another physician
- Offer to transfer records to the new physician upon receipt of a signed authorization to do so

I have read and understand the policy above

Signed_____ Date_____

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TELEMEDICINE PATIENT CONSENT FORM AND FINANCIAL POLICY

I, (name of patient or parent/guardian) _____, agree to participate in telemedicine evaluations for myself/my child. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small but possible].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation in the office.

I understand that, as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a physician in person.

I understand that Blue Ridge Pediatrics will charge for these services. Ultimately, I am responsible for payment. It is my responsibility to determine if my insurance covers telemedicine services. I agree to keep a credit card on file upon request if I plan to participate in telemedicine for my child.

I give consent to receive SMS messages from Blue Ridge Pediatrics and our telehealth software. I am aware that data and messaging rates may apply. Blue Ridge Pediatrics may send text messages to remind me of a telehealth appointment with a provider or staff or to facilitate a video meeting.

Patient Name: _____DOB _____

Parent/Guardian Signature: _____Date: _____