

Please confirm your awareness of the following...

...by reading and initialing (▶) each statement and then adding your signature (★)

1. Parent Requesting Treatment		
I understand the policy of this office is that the parent who requests treatment for the child is responsible for services rendered. Payment is required at each office visit.		
		▶ Please initial _____
2. Services Not Covered by Insurance		
I understand that I am financially responsible for all services not covered by my insurance, including, but not limited to co-payments, deductibles, and non-coverage of services.		
		▶ Please initial _____
3. Services Billed by Another Entity		
I understand services unable to be performed by this office (such as <i>all</i> radiology and <i>some</i> labwork) will be sent to another provider (Rex Hospital from the Blue Ridge office and WakeMed from the Brier Creek office). I will inform Raleigh Children and Adolescents Medicine if I (or my insurance) have a different preference.		
		▶ Please initial _____
4. Some Patients are Eligible for Free Vaccines from the State		
The state of North Carolina provides free vaccines to children who are of Native American or Native Alaskan descent. So that our office can be sure that eligible patients are identified, is your child of Native American or Native Alaskan descent?		
		▶ <input type="checkbox"/> YES <input type="checkbox"/> NO
5. Authorization to Release Medical Information		
I authorize Raleigh Children and Adolescents Medicine, P.C.:		
<ul style="list-style-type: none"> • To file insurance claims for all services provided to my dependant(s) and I authorize payment for those services to be made directly to the provider. • To release information about my dependant(s) to any referring physician or other provider or to any institution as necessary to provide treatment or diagnosis for dependant(s). • To release information about me necessary to process claims for services provided to me, including to health and liability insurance companies; agencies processing Medicaid, or Workers' compensation claims; medical benefit plans, case managers, or reviewers; or third parties responsible for paying claims for services provided to me. 		
		▶ Please initial _____
<i>My signature below authenticates my initials with each statement (1-4) above:</i>		
★		
_____ (Signature)	_____ (Relationship to Patient)	_____ (Date)

» » » » » » » » **NEW PATIENTS** « « « « « « « «

5. Where did you find out about our office (please mark all that apply)?	
<input type="checkbox"/> Friend / Neighbor / Family member _____	
<input type="checkbox"/> Obstetrician _____	
<input type="checkbox"/> Internet	
<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Other _____	