Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Please PRINT **DATE:**

PATIENT INFORMATION

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **NICKNAME**

DATE OF BIRTH **GENDER** ___**Male** ___ **Female**

RACE (Optional)
___ Black Non-Hispanic ___ American Indian / Alaskan Native ___ Hispanic ___ Asian/Pacific Islander ___White Non-Hispanic ___Other

HOME ADDRESS **APT #** **CITY** **STATE** **ZIP CODE**

HOME PHONE **INSURANCE PLAN & ID NUMBER**

PRIMARY INSURANCE PLAN SUBSCRIBER NAME AND BIRTHDATE **SECONDARY INSURANCE**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

RELATIONSHIP TO PATIENT ___SELF ___PARENT ___FOSTER PARENT ___OTHER

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

DATE OF BIRTH **SOCIAL SECURITY NUMBER**

HOME ADDRESS **APT #** **CITY** **STATE** **ZIP CODE**

HOME PHONE **OTHER** __**Cell** __**Other** **EMPLOYER PHONE**

EMPLOYER **EMPLOYMENT STATUS** ___**Active Duty Military** ___**Employed Full-Time** ___**Employed Part-Time** ___**Not Employed** ___**Homemaker** ___**Retired**

EMAIL ADDRESS

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

LAST NAME **FIRST NAME** **RELATIONSHIP TO PATIENT**

ADDRESS **APT #** **CITY** **STATE** **ZIP CODE**

HOME PHONE **WORK PHONE** **OTHER** ___**Cell** ___**Other**

Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Custody Policy

Child's Full Name : _____ **Date of Birth** : _____

Does the child live with both parents ? ***YES / NO***

Name(s) of child's legal guardians: _____

_____

Is there a *legal custody policy* in place ? YES / NO

If "YES", our office <u>MUST</u> be provided with a copy of the legal custody agreement prior to the child's next visit.

Divorce, Separation & Custody Agreements Policy

We believe that such matters should not enter into a child's medical treatment. The individual who is requesting the medical treatment is responsible for the payment of the medical bills. We are not a party to your divorce agreement - you are. We will collect co-pays and deductibles from the attending parent / caregiver.

"Joint Custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results. We will not call the other parent for consent prior to treatment.

Unless stated in the court order, both parents have equal rights and we cannot get involved.

We will discuss with the accompanying parent information pertinent to the child's history and/or present exam. Should the issues that come between parents become disruptive to our Medical Practice, we will discharge the patient and family from further treatment.

I declare under penalty of perjury of law that the above information is true and correct.

_____

Parent / Guardian Name (PRINT)

_____ _____

Parent / Guardian Signature Date

Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Patient Consent for Use and Disclosure of PHI

I hereby consent to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by **Anrae G. Applewhite M.D., PLLC and staff** in order to carry out treatment, payment, and healthcare operations. I have reviewed the Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information.
Anrae G. Applewhite M.D., PLLC and staff has the right to change the Notice of Privacy Practices at any time. If the terms of the Notices of Privacy practices are changed the Patient has the right to obtain a copy of the revised Notice.

I acknowledge and agree that **Anrae G. Applewhite M.D., PLLC and staff** may disclose my protected health information and / or medical record / billing / insurance information to the following (*please include names of all legal guardians)*:

_____ _____

_____ _____

I also acknowledge and agree that *the following person(s) can bring my child to an appointment* at this office and participate in their medical care (*please include names of all legal guardians*):

_____ _____

_____ _____

Anrae G. Applewhite M.D., PLLC and staff may utilize the patient's address and telephone numbers for communications.

At all times I have the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that **Anrae G. Applewhite M.D., PLLC and staff** has already taken action in reliance upon this Consent.

Anrae G. Applewhite M.D., PLLC and staff may refuse to treat the Patient if he / she (or authorized representative) does not sign this consent form. **Anrae G. Applewhite M.D., PLLC and staff** has the right to refuse further treatment after the time this Consent is revoked (except to the extent **Anrae G. Applewhite M.D., PLLC and staff** are required to provide treatment under the law).

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES AND THE INFORMATION PROVIDED IN THIS CONSENT. I AM THE PATIENT'S GUARDIAN OR AM AUTHORIZED TO ACT ON THEIR BEHALF.

Patient's Name : _____ **DOB** : _____

_____ _____

Signature of Parent / Guardian OR Patient if OVER AGE 18 **DATE**

Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Financial Policy

Roots & Wings Pediatrics participates with *most* insurance plans. Each insurance policy is different and it is impossible for us to know what your particular benefits may be. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits or what your payment obligations will be at the time of service.

All co-payments, patient responsibility of deductibles not met, and account balances are due at the time of check-in unless previous arrangements have been made prior to your appointment. If you arrive for an appointment and are unable to pay your co-payment or account balance, ***you will be asked to reschedule your appointment for a later date***. We accept cash, checks, VISA, Mastercard, American Express, and Discover.

I understand that I am responsible for all fees for medical services rendered by physicians, physicians' assistants, and nurses of Anrae G. Applewhite, M.D. PLLC. Any fees deemed patient responsibility or are not covered by my insurance company will be due on the day of service or upon resolution of my insurance claim. *I am aware that if my account balance is over 120 days old, the balance will be sent to collections and I will be notified of discharge from the practice*. It is my responsibility to notify the office of any changes in my health care coverage before services are rendered.

In order to ensure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be "patient responsibility", as spelled out on your Explanation of Benefits (EOB). You will be contacted by phone 7 days prior to your card being charged. Once your card is charged, a receipt will be sent to you by email.

I have read and understand the payment policy and agree to abide by its guidelines:

Name of Patient : _____ **DOB :** _____

Name of Parent / Guarantor : _____ **DATE:** _____

Signature of Parent / Guarantor : _____

Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Cancellation and Missed Appointment Policy

Our office has enacted a strict no-show / missed appointment policy for scheduled appointments. A no-show/missed appointment is any appointment that is not canceled or rescheduled prior to the scheduled appointment date and time. As a courtesy, our office staff will call the primary phone number the day before an appointment is scheduled to remind you of a patient's upcoming appointment. If there is no answer, a reminder voicemail will be left if able. It is the parent's responsibility to make sure this phone number stays up to date.

Additionally, if you arrive ***late*** for a scheduled appointment, you may be asked to reschedule to the next available date.

IF 4 SCHEDULED APPOINTMENTS ARE MISSED (per FAMILY), it will be necessary to terminate our professional relationship with the *patient **and** family*. In this instance, time was set aside multiple times for your child(ren) to be seen by the physician. When you do not appear, time is lost for the pediatrician who was planning to see your child and for the children we might not have been able to schedule for a visit at that time. We will be available to treat the patient for 30 days on an emergency basis only so that he or she will have access to care while the family chooses another physician.

Please be sure to call prior to your scheduled time if you are unable to keep your appointment. If you call *after* your scheduled appointment time, it may be considered a missed appointment.

_____ _____

Patient Name **Date of Birth**

I have read and acknowledged the Cancellation and Missed Appointment Policy.

_____

Name of Parent / Guardian *(please print)*

_____

Parent / Guardian Signature **Date**