ASHEVILLE PEDIATRICS ASSOCIATES, PA

Date _____ Chart # _____

Please Use Gel Pen or Other Dark (Black) Pen to Complete

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Gender at birth _____ Identifies as _____ Preferred Pronouns _____

Date of Birth _____/_____/_____ Preferred Physician _____

Race _____ Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred Language _____

PLEASE LIST ALL CHILDREN IN THE HOME UNDER 18 YEARS OLD

1. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
2. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
3. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)

FAMILY INFORMATION

Parent/Guardian *(circle one)*

Name_____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/_____ SSN # _____/____/_____

Relationship to Patient _____ (Bio/Step/Other)

Custody Joint Exclusive Marital Status _____

Home Phone_____ Cell _____

Email_____

Preferred contact method? __ Phone __ Text __ Email

Employer _____Work Ph._____

☐ By checking this box, I agree that information for my child can be left on voicemail.

Parent/Guardian *(circle one)*

Name_____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/_____ SSN # _____/____/_____

Relationship to Patient _____ (Bio/Step/Other)

Custody Joint Exclusive Marital Status _____

Home Phone_____ Cell _____

Email_____

Preferred contact method? __ Phone __ Text __ Email

Employer _____Work Ph._____

☐ By checking this box, I agree that information for my child can be left on voicemail.

AUTHORIZED INDIVIDUALS

Please list all people, ***other than parent/guardian,*** *who may schedule appointments, and what type of information each person is allowed to receive (i.e. grandparents, baby-sitter, neighbor).*

Name_____ Relationship _____ Phone _____ ☐ Medical ☐ Billing ☐ Appointment

Name_____ Relationship _____ Phone _____ ☐ Medical ☐ Billing ☐ Appointment

INSURANCE INFORMATION

Insurance Name _____ Policy Holder Name_____

Policy Holder DOB _____

(See Back)

Authorization to Consent to Healthcare Treatment for a Minor
By signing this statement, I authorize the doctors and staff of Asheville Pediatric Associates, PA to provide necessary health services for my child, even if I am not present. Furthermore, the name, relationship to patient and phone number of all persons who may schedule appointments, call for medical advice, or bring my child to the office for treatment will be provided to Asheville Pediatrics. If someone other than these people contact Asheville Pediatrics relative to my child or in the event of a medical emergency, the practice will attempt to contact the parent/guardian for permission to treat. I authorize Asheville Pediatric Associates, PA to release my child's medical records to any party involved in their treatment.

Financial Policy
I hereby authorize Asheville Pediatric Associates, PA, to share my child's medical information with their insurance carrier concerning their illness and treatment. I agree to present my child's current insurance ID card at every visit and to contact Asheville Pediatrics with any changes to their insurance coverage. Asheville Pediatrics agrees to make every reasonable effort to obtain payment from the patient's insurance carrier. If the insurance carrier rejects a claim, denies payment or a portion of the payment is the responsibility of the guarantor, I understand the balance will be billed and I agree to make payment in a reasonable amount of time. This includes paying the co-pay at the time of my child's appointment. I authorize payment of all applicable benefits directly to Asheville Pediatrics. This authorization will remain in effect until revoked by me in writing. For the full financial policy, please request a copy or reference it on our website.

Code of Conduct Policy
Asheville Pediatrics is committed to the safety of our patients, their families, and our staff. Any verbal abuse, threatening, aggressive and destructive behavior will not be tolerated. Firearms, including concealed firearms are not permitted within our building. While we understand that disagreements may occur, these need to be resolved in a respectful and civilized manner. Asheville Pediatrics reserves the right to terminate a patient from the practice or involve Child Protective Services, law enforcement and other appropriate agency, depending on the nature of the infraction.

No-Show Policy
I acknowledge patients that miss more than three appointments without prior notification may result in the termination of care from Asheville Pediatrics.

Vaccine Policy
I acknowledge that Asheville Pediatrics requires all patients to follow the recommended vaccine schedule as determined by the ACIP and AAP. Failure to comply with this schedule may result in termination of care from the practice.

Consent for Use of AI Systems
I understand and acknowledge that some or all providers at Asheville Pediatric Associates, PA may use an AI system to support administrative and clinical workflows, including but not limited to transcription assistance and procedure coding support, while maintaining patient privacy, data security, and provider oversight. AI systems are not permitted independently used to diagnose, treat, make clinical decisions, or solely document patient encounters without direct review and approval by the licensed healthcare provider. All patient care decisions remain the sole responsibility of the treating provider. Asheville Pediatric Associates, PA, utilizes only HIPAA compliant AI vendors and platforms, maintains business associate agreements (BAA's), limits AI access to the minimum necessary patient information, and implement appropriate administrative, technical, and physical safeguards.

Patient Name _____

Parent or Legal Guardian Signature _____

Print Name _____