Today's Date: _____

Ashe Pediatrics
Patient Registration

Name of Child: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Social Security # _____-_____-_____
Address (street, city, state, zip): _____
Mailing address (if different-PO Box): _____
Mailing address (city, state, zip): _____
Mother's Maiden name: _____ Child's school/Daycare: _____

Parent/Guardian: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Soc. Sec. # ____-__-____ D/L_____ State____
Address (street, city, state, zip): _____
Mailing address (if different-PO Box): _____
Mailing address (city, state, zip): _____
Home Phone: _____ Cell #: _____ Email: _____
Employer: _____ Relationship to child (circle): Parent / Guardian / Other_____

2nd Parent/Guardian: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Soc. Sec. # ____-__-____ D/L_____ State____
Address (street, city, state, zip): _____
Mailing address (if different-PO Box): _____
Mailing address (city, state, zip): _____
Home Phone: _____ Cell #: _____ Email: _____
Employer: _____ Relationship to child (circle): Parent / Guardian /Other_____

Child lives with: Mother / Father / Both Parents / Alternates / Other (specify) _____
Emergency Contact (name, relationship & phone): _____

Insurance Info: *Medicaid / *Health Choice / BCBS / United / Cigna / Aetna / Other (specify)_____
***If Medicaid/Health Choice which Health Plan:** WellCare / United Community Plan / AmeriHealth Caritas / Healthy Blue
Insurance Address: _____
Insurance City, State, Zip: _____
Policy holder's name: _____ Policy holder DOB: _____
Policy Holder SS#: _____ Policy #: _____ Group #: _____

Email address to use for our Patient Portal: _____

Please circle (regarding your child):

1. **Preferred Language** (for info & handouts)
English/Spanish/Hmong/Other_____

2. **Ethnicity:** Hispanic / Not Hispanic

3. **Race:** American Indian / Alaska Native / Asian / African American / Native Hawaiian / Other Pacific Islander / White

Note: Info collected is used only for reports and is not associated with individual patient names.

Preferred Pharmacy: _____ **Pharmacy City:** _____

Please return forms to receptionist with your child's insurance card so that we may make a copy.

Eff. 6/2022

Date: _____

Ashe Pediatrics

New Patient History Form

_____ DOB: _____

First Name Middle Name Last Name(s)

Preferred name: _____ Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native Indian ☐ Other

Completed by: ☐ Mom ☐ Dad ☐ Caregiver/other: _____

Medications, vitamins, supplements, and allergies

Medication Name	Dose	Frequency

Allergy	Reaction or Side Effect

If you need to list more medications or allergies, you can use the back of the paper

Birth and Pregnancy History

Is your child by: ☐ Birth ☐ Adoption ☐ Step-child ☐ Other: _____

Birth Hospital: _____ City/State: _____

Problems during pregnancy? ☐ No ☐ Yes If yes, explain: _____

_____

Problems during labor and delivery? ☐ None ☐ Oxygen ☐ Trouble breathing ☐ Other: _____

_____

Type of delivery: ☐ Vaginal ☐ C-section ☐ Emergency ☐ Repeat ☐ Planned - why: _____

Birth weight: _____ Weeks of pregnancy: _____ ☐ Single Birth ☐ Multiple Birth

Problems as a newborn: (Jaundice, Trouble breathing, Oxygen): _____

_____

During pregnancy, did mother:

Use tobacco products: ☐ No ☐ Yes Drink alcohol: ☐ No ☐ Yes Use prenatal vitamins: ☐ No ☐ Yes
(Vaping, e-cigarettes)

Use medications: ☐ No ☐ Yes If yes, what: _____

Use drugs: ☐ No ☐ Yes If yes, what: _____

- **Nutrition:**

Breast-fed, how long: _____ Formula-fed, name: _____

Any feeding/eating problems or restriction? ☐ No ☐ Yes If yes, explain: _____

_____

(Only Infants) Ounces per feeding: _____ Frequency of feedings: every _____ hours

Water source: ☐ Well ☐ Spring ☐ Bottle with fluoride ☐ Bottle without fluoride ☐ Town/City ☐ Nursery

Social History:

Are the child's parents: ☐ Married ☐ Never Married ☐ Separated ☐ Living Together ☐ Divorced - how long? _____

Mother's employer and occupation: _____

Father's employer and occupation: _____

If the patient doesn't live with biological parents, please complete the information of the person taking care of him/her:

Caregiver/Guardian/Kinship employer and occupation: _____

Is your child in school/daycare? ☐ No ☐ Yes If yes, where and current grade: _____

Is your child home schooled? ☐ No ☐ Yes

Have you ever refused vaccines for your child? ☐ No ☐ Yes If yes, why? _____

_____

_____

Who lives in the house with the patient?

Name	DOB/Age	Relationship

Patient's Medical History: Has the patient had or have any of the following:

Illness	Yes	No	Illness	Yes	No
Chickenpox/Measles			Hepatitis/Liver Disease		
Cavities or dental problems			Urinary Tract Infections		
Skin conditions (Eczema, acne, psoriasis, etc.)			Urinary/Kidney Problems (Bedwetting after 5 yrs. of age)		
Frequent Ear problems (Hearing/Ringing)			Musculoskeletal Problems		
Frequent sinus infections			Scoliosis		
Strep or Chronic Sore Throat			Thyroid Problems ☐Hypo ☐Hyper		
Eye conditions (Lazy eyes, Nearsighted, Farsighted)			Diabetes / High Blood Sugar		
Wears glasses/Contacts			Epilepsy/Seizures		
Migraines/Frequent Headaches			Brain/Neurological disorders (type): _____		
Concussion or head injury			ADD/ADHD / Attention Concerns		
Asthma/Wheezing/Chronic Cough			Mood Swings/Anger		
Shortness of breath (With exercise/activities)			Anxiety		
Bronchitis/Bronchiolitis			Depression		
Croup			Bipolar/Disruptive Mood Disorder		
Covid-19			Bullying Problems		
Tuberculosis/Lung Disease			Suicide Attempts		
Heart problems, Congenital Heart Defect (Murmur, irregular heartbeat, etc.)			Victim of abuse: (choose) ☐ Sexual ☐ Emotional ☐Physical		
Blood disorders (Anemia, clotting problems, etc.)			Post-Traumatic Stress Disorder (PTSD)		
History of blood transfusion(s)			Alcohol abuse		
Constipation/Diarrhea			Substance abuse		
Heartburn/Gastric Reflux			Sexually Transmitted Disease (STD's)		
Chron's Disease/Irritable Bowel Syndrome (IBS)			History of birth control		
Celiac Disease			Polycystic Ovarian Syndrome (PCOS)		
Cancer: (type): _____			Other: _____		

Patient's Medical History (continuation):

History of trauma? (Serious injuries, accidents, or fractures) ☐ No ☐ Yes If yes, when and where: _____

_____

History of hospitalizations? ☐ No ☐ Yes If yes, when and where? _____

_____

History of surgeries? ☐ No ☐ Yes If yes, how many? _____ When and where: _____

_____

Has the patient had:

Tonsillectomy? ☐ No ☐ Yes-age? ___ Adenoidectomy? ☐ No ☐ Yes-age? ____ Tubes? ☐ No ☐ Yes-age? ___

(Male only) Is your child circumcised? ☐ No ☐ Yes If yes, when and where: _____

(Female only): Has your child started her menstrual cycle? ☐ No ☐ Yes If yes, is it painful? ☐ No ☐ Yes

First menstrual cycle? (Age and/or year) _____ How many days does it last? _____

Other social/medical history:

- **Social:**

Number of hours your child sleeps? _____

Any sleep problems? ☐ No ☐ Yes If yes: ☐ Going to bed ☐ Staying in bed ☐ Waking up frequently ☐ Nightmares ☐ Sleep Walking ☐ Snoring

Daily screen time: TV: _____ iPad/Computer: _____ Video Games: _____ Cellphones: _____

- **Growth and development:**

Are there any concerns about growth? ☐ No ☐ Yes If yes, explain: _____

_____

Any concerns about: ☐ Speech ☐ Learning ☐ Development ☐ No If yes, explain: _____

_____

Has your child received any services: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ IEP ☐ CDSA ☐ Extra Assistance: ☐ Reading ☐ Math ☐ None

Explain services: _____

- **Nutrition:**

Any feeding/eating problems or restriction? ☐ No ☐ Yes If yes, explain: _____

_____

Child's milk intake? (oz) _____ Milk type: ☐ Cow's milk __ % ☐ Almond Milk ☐ Soy milk ☐ Rice milk ☐ Other: _____

☐ Lactose Intolerant symptoms: _____

- **Respiratory:**

Has your child ever used a nebulizer or inhaler? ☐ No ☐ Yes

Does your child have any of the following? ☐ Nebulizer ☐ Spacer ☐ Peak Flow Meter ☐ None

- **Other:**

Has your child ever fainted? ☐ No ☐ Yes

Has your child ever been seen by a specialist? ☐ No ☐ Yes If yes, please list the provider(s) and reason below:

Provider/Specialist	Reason

Please include dentists, counselors, eye specialists or any other specialist/provider your child is receiving services from

Is there any other information (not listed above) that we need to know? ☐ No ☐ Yes If yes, please list below:

_____

_____

- **Safety and Security:**

Does anyone smoke inside or outside the house? ☐ No ☐ Yes If yes, who: _____

Are there any animals inside or outside the house? ☐ No ☐ Yes If yes, type: _____

Is there any concern of safety or violence in the home or neighborhood? ☐ No ☐ Yes

Are there any guns in the home? ☐ No ☐ Yes

If yes, are they locked in a secured place and separate from ammunitions? ☐ No ☐ Yes

Are there any smoke detectors in the house? ☐ No ☐ Yes

In case of emergency, do you have an emergency plan discussed with the child? ☐ No ☐ Yes

Are there any other social concerns of health such as: (Whitin the past 12 months)

Worried whether your food would run out before you got money to buy more? ☐ No ☐ Yes

The food you bought just didn't last and didn't have money to get more? ☐ No ☐ Yes

Do you ever need to have someone help you when you read instructions, pamphlets, or other written material from your health care provider or pharmacy? ☐ No ☐ Yes

Family History: (Indicate mom, dad, maternal grandmother/father, paternal grandmother/father, aunt, uncles, or siblings)

Illness		Relationship	Illness		Relationship
High Blood Pressure	☐ Yes ☐ No		Autoimmune disorders (Arthritis, lupus, fibromyalgia)	☐ Yes ☐ No	
High Cholesterol	☐ Yes ☐ No		Blood Disorders (Anemia, clotting disorders)	☐ Yes ☐ No	
Irregular heart beat Heart Defect	☐ Yes ☐ No		Genetic/Metabolic Disorders	☐ Yes ☐ No	
Early Heart Attack (50 or less)	☐ Yes ☐ No		Celiac Disease	☐ Yes ☐ No	
Sudden unexplained death (Long QT)	☐ Yes ☐ No		Constipation	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No		Gastric Reflux or Ulcers	☐ Yes ☐ No	
Marfan Syndrome	☐ Yes ☐ No		Chron's Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Ulcerative Colitis	☐ Yes ☐ No	
Asthma/COPD Bronchitis	☐ Yes ☐ No		Irritable Bowel Syndrome (IBS)	☐ Yes ☐ No	
Tuberculosis/Lung Disease	☐ Yes ☐ No		Hepatitis/Liver disease	☐ Yes ☐ No	
COVID-19	☐ Yes ☐ No		Kidney Disease	☐ Yes ☐ No	
Allergies food/medications/seasonal	☐ Yes ☐ No		Urinary Tract Infection	☐ Yes ☐ No	
Skin conditions (Eczema, psoriasis)	☐ Yes ☐ No		Urinary Problems (incontinence)	☐ Yes ☐ No	
Migraines/Headaches	☐ Yes ☐ No		Polycystic Ovarian Syndrome (PCOS)	☐ Yes ☐ No	
Epilepsy/Seizures	☐ Yes ☐ No		Eye Problems	☐ Yes ☐ No	
ADHD/ADD	☐ Yes ☐ No		Hearing Loss	☐ Yes ☐ No	
Learning Disabilities Developmental Delay	☐ Yes ☐ No		Ear Infections	☐ Yes ☐ No	
Autism	☐ Yes ☐ No		Thyroid Problems	☐ Yes ☐ No	
Anxiety/Depression/Bipolar	☐ Yes ☐ No		Scoliosis/ Musculoskeletal Problems	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No		Cancer/Type/Relationship: ☐ No ☐ Yes		
Alcoholism	☐ Yes ☐ No				
Substance Abuse	☐ Yes ☐ No				
HIV/Aids	☐ Yes ☐ No		Other: _____		

Ashe Pediatrics, PLLC

Acknowledgment of Receipt of Notice of Privacy Practices and Consent Form

_____(Parent/Patient initials) **Notice of Privacy Practices:** I acknowledge that I have received or been given opportunity to review a copy of the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my individually identifiable health information (IIHI) for treatment, payment, healthcare operations. To the extent permitted by law, I consent to the use and disclosure of this information for the purposes described and the permitted uses and disclosures in the practice's Notice of Privacy Practices. I understand that I may contact the Privacy Officer designated on the notice in writing to revoke my authorization at any time or if I have a question or complaint.

_____ (Parent/Patient initials) **Release of Information:** I hereby permit the practice and the physicians or other health professionals involved my child's care to release healthcare information for purposes of treatment, payment, or healthcare operations, for example:

- For Treatment- TO PROVIDE INFORMATION TO ANY OTHER HEALTHCARE PROVIDER AND FACILITY WE HAVE REFERRED A PATIENT TO. With the exception of psychotherapy notes which will require a separate authorization.
- For Payment- TO SEND INFORMATION OR RESPOND TO A HEALTH INSURANCE CARRIER'S REQUEST FOR INFORMATION IN ORDER TO RECEIVE PAYMENT.
- For Healthcare Operations-TO ASSESS AND IMPROVE THE QUALITY OF CARE WE PROVIDE TO OUR PATIENTS, TO REPORT COMMUNICABLE DISEASES, DOMESTIC VIOLENCE OR CRIMINAL ACTIVITY.

_____ (Parent/Patient initials) **Release of Information to Family/Friends**: Our practice may release your child's health information to a friend or family member that is involved in your child's care, or who assists in taking care of your child. For example, you may ask that a family member or friend or employee take your child to the office for treatment, or we may contact you about lab results and leave a message with a family member, friend or babysitter. In this example, the family member or babysitter would have access to your child's medical information.

_____ (Parent/Patient Initials) **Approval to release Immunization Information:** I give my permission for the office to disclose/release proof of immunization to any school/camp/program attended by my child at my request.

Consent to Receive Mail, Phone, Email or Text Messages for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via mail, phone, email and/or text messaging to be reminded of appointments, to discuss their health and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders, account balance reminders and other healthcare communications/information at that street address, email or phone number from the Practice.

_____ (Parent/Patient initials) I consent to receive voice, email and text messages from the practice at any phone numbers and emails I designate below, and to any number forwarded or transferred to that number or emails to receive communication as stated below. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ health information unless I request a change in writing.

The phone number(s) that I authorize to receive voice or text messages for appointment and other health reminders, treatment, other information about my health and/or payment for healthcare I received at Ashe Pediatrics, PLLC is:

_____Home/Cell/Work (please circle one)

_____Home/Cell/Work (please circle one)

The email that I authorize to receive email messages for appointment reminders and health information, or other information about my health and/or payment for services I received at Ashe Pediatrics, PLLC is: _____

Prescription/Health form Pick-up. There may be times when you need a friend or family member to pick-up a prescription order, health form or other medical information from our office. In order for us to release this information to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____(Parent/Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____(Parent/Patient initials) I do not want to designate anyone to pick-up my prescription order/health form from Ashe Pediatrics, PLLC.

Patient Name: _____ Date of Birth: _____

This acknowledgement and consent form should be signed by patient, not parent, if patient is 18 years or older

PRINTED Name of person signing: _____ Relationship to patient_____

Parent/Patient Signature_____Date _____

Witness:_____ Date:_____

Ashe Pediatrics

Sheila Driver PNP-BC, AE-C

PO Box 1499 303 East 2nd Street
West Jefferson, NC 28694
336-846-4543 Fax 336-846-7337

Privacy Practices Acknowledgment of HIPAA

Release of Records to Designated Individuals

Patient's Name: _____

Date of Birth: _____

My signature below states I have read the posted Notice of Privacy Practices and can obtain a copy, per my request.

By signing this release, I am giving Ashe Pediatrics permission to release any of my or my child's protected health information, including but not limited to, medical, social and personal history, problems and symptoms, examination and test results, diagnoses and treatment to the below named individual(s)

If anyone other than yourself will be bringing your child to this office, please list their name and relationship (grandparent, aunt, uncle, friend, etc) to the patient.

Name (First, Last)	Relation	Contact Number

I am giving Ashe Pediatrics permission to leave a phone message for me or my child regarding upcoming appointment or a message to return their call.

Yes _____ No _____

Patient/Parent's Signature: _____

Signed: _____ _____

(specify relationship if other than patient: Parent or Legal Guardian)

Date: _____

Witness: _____

03/2016

Ashe Pediatrics PLLC

Sheila Driver PNP-BC (ANCC), AE-C

PO Box 1499 303 East 2nd Street Suite A

West Jefferson, NC 28694

336-846-4KIDS (4543) Fax 336-846-PEDS (7337)

ashepediatrics@hotmail.com

Due to the nature of your child's health and well-being, sometimes issues might arise when the provider needs to speak with someone other than the caregiver, such as the child's teacher or school nurse. By signing this form, you are giving permission for the provider to speak with the person listed on this form.

Consent to Disclose Personal Health Information

I, _____, authorize Sheila Driver, PNP to disclose
(Parent name) *(Provider)*

the personal health information of _____ consisting of:
(Child's name)

☐ Physical Health ☐ Emotional health ☐ Educational performance including attendance

☐ All the above ☐ Other _____

to _____.
(Print name and address of person requiring the information, ie school or daycare)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form or revoke at any time.

Parent/Guardian Name: _____

Relationship: _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Provider: Sheila Driver PNP-BC **Date:** _____

Sheila Driver, PNP-BC, AE-C

***Please note: A substitute decision-maker is a person authorized under PHIPA, (Personal Health Information Protection Act) to consent, on behalf of an individual, to disclose personal health information about the individual.**

Ashe Pediatrics, PLLC

Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. If the insurance company that you designate is incorrect, you will be responsible for the payment of the visit.
2. If we are your primary care physician, make sure our name and phone number appears on your card. If your insurance company has not been informed that we are your primary care physician as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialist, if a preauthorization is required prior to a procedure, and what services are covered.
5. If our physician does not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit, or payment arrangement made.
7. All co-payments are due at the time of service.
8. A $25.00 service fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. Advance notice is needs for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
10. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings.
11. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
12. It is your responsibility to know your insurance plan benefits if it is not covered, you will be responsible for payment at the time of visit.

Patient Name _____ DOB _____ Date _____

Parent Signature _____

Witness _____

4/20/2016

Ashe Pediatrics' Vaccine Policy

As a patient of Ashe Pediatrics, you must agree to follow the mandatory vaccine requirements for school. Due to the increasing outbreaks of vaccine preventable disease, we do not accept patients whose caregivers decide not to vaccinate.

Vaccines required for school are as follows:

- 5 doses of DTaP
- 4 doses of Polio
- 3-4 doses of Hib
- 2 doses of MMR
- 3 doses of Hep B
- 2 doses of Hep A
- 2 doses of Varicella (Chicken Pox)

Teen Vaccines:

- Tdap
- Mengiococcal

Vaccines not required but highly recommended:

- Yearly Influenza
- HPV
- MenB

If you have concerns about vaccines, do not be afraid to ask questions. We will provide you with medical based information to help decide what is best for you and your child. Vaccines saves lives and prevent illnesses that can have a devastating lasting effect for your family. We want only the best for you and your child.

By signing this form, I agree to the vaccination schedule required Center of Disease Control (CDC) and American Academy or Pediatrics (AAP).

Child's Name: _____

Parent Signature: _____ Date: _____

Witness: _____

Ashe Pediatrics Family Behavior Policy

Patient Name:_____ DOB:_____

This practice is a family friendly pediatric office caring for impressionable young children and their families. Although occurances are rare, Ashe Pediatrics feels strongly that our patients, their families, AND our staff deserve to be protected from verbal abuse and aggressive behavior. We all need to respect each other and to "follow the golden rule".

For this reason we have developed and strictly enforce a "No Tolerance Policy" for abusive conduct, "cussing", crude graphics or language on clothing, threatening or aggressive behavior, and larceny. These restrictions apply to any such actions towards patients, other family members, visitors and Ashe Pediatrics staff. Furthermore, these rules shall also apply to telephone calls and written communications to our office staff and clinicians. We expect a civil and harmonious environment for our office staff and clinicians.

Please sign below that you understand, agree to, and will abide by this policy. As a "No Tolerance Policy", there will be no further warnings, second chances or exceptions. Violations will result in immediate transfer of care to another healthcare provider of your choice. (We will provide up to 30 days of emergency care while you are completing this transfer of care.) Failure to sign this contract will result in discharge from this practice.

While we understand that disagreements may occasionally occur, these need it to be resolved in a civil manner. Depending on the degree of infarction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we deem necessary. We may press charges at our disgression.

Thank you for your interest in the making of Ashe Pediatrics office and grounds a wholesome and safe, family-friendly environment.

Signed:_____ Relationship:_____

Printed Name:_____ Date:_____

Ashe Pediatrics, PLLC

Sheila Driver, PNP, AE-C

Welcome to Ashe Pediatrics!

If you are new to our practice, this form will provide you with some important information about us, our policies and how we strive to be the best medical provider office for your child. If you are returning to us, we want to take this opportunity to remind you of our goals and policies.

Whether you are "new" or "old", we are happy you are with us.

After hours

We realize your child may become suddenly sick and may need us. As your Medical Home, we provide after hours services that covers 24 hours a day. You can access Ms. Sheila at ***336-698-6999.*** Depending on your child's needs, she will offer phone advice, or meet you in the office. Of course, we ask that this service only be used for emergency situations and to please call the office during regular business hours for routine questions.

Medical Home

We want to be your child's medical home. We are the place to take your child for All their healthcare needs. We provide complete primary care including check-ups, immunizations, sick visits, asthma care, ADD/ADHD care, as well as other special needs your child might need. Our pediatric care team will help access and coordinate referrals to specialists, provide educational resources and information about community programs beneficial to you and your child. We are ALWAYS here and willing to assist your needs. Your child will grow to know and trust us. And because our staff knows your child's history, you can rest assured that they are receiving the best care possible.

For more information about Medical Homes, please visit:
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

Appointments and Scheduling

When your child becomes sick, we will be here for you. We offer a sick walk in session Monday-Friday from 8:00-9:00am. No appointments are needed during that time. We see patients in the order they are received. If your child becomes sick during the day, just call our office and we can schedule a same day appointment.

We understand that patients sometimes miss appointments: however, no-shows and last-minute cancelations have a negative effect of office efficiency and also prevent other patients from being scheduled for an appointment time. Therefore, we ask that if you are unable to keep your scheduled appointment, to call us as soon as possible to reschedule. This can give another patient an opportunity for that scheduled time. Office policy dictates after three (3) no-shows, your child may be discharged from the practice and seek another medical provider. We will provide instructions for the transfer of care.

Patients who no-show for a double appointment (scheduling two children to come in together) twice in a 12-month period, will be restricted from scheduling double appointments in the future.

Vaccine Policy

As a patient of Ashe Pediatrics, you must agree to follow the mandatory vaccine requirements for school. Due to the increasing outbreaks of vaccine preventable disease, we do not accept patients whose caregivers decide not to vaccinate. Vaccines required for school are as follows: 5 doses of DTaP, 4 doses of Polio, 3-4 doses of Hib, 2 doses of MMR, 3 doses of Hep B, 2 doses of Hep A, and 1 dose of Varicella.

Ashe Pediatrics, PLLC

Sheila Driver, PNP, AE-C

If you have concerns about vaccines, please feel free to ask questions. We will provide you with medical based information to help decide what is best for you and your baby. However, vaccines are administered as one off the safes and disease prevention.

Financial Policy

Payment is due at the time of service. If you have verifiable insurance, we will happy to file your claim for you. By signing this document, you are authorizing your insurance company to make payment directly to Ashe Pediatrics and authorizing Ashe Pediatrics to release all information to your insurance company necessary to secure payment of benefits. You will be responsible for co-pays at the time of service as well as remaining charges not covered by your insurance company. We accept cash, checks, credit and debt cards via Square. Insurance is a contract between you and your insurance company. Ashe Pediatrics is only a third party to this agreement.

Please be aware of what your insurance covers. Because there are so many policies, each with its own set of coverage, we cannot keep track of every possible plan. Many vaccines required are very costly and might not be covered by your plan. **You are responsible for the cost of these vaccines, as well as any other charges that your insurance does not cover, even if you do not have complete coverage or cost is applied to your deductible.** Payment is expected in a reasonable amount of time from the date of service. Payments more than 90 days late may be charged 1-1.5% per month and are subject to collection.

If we are unable to verify your insurance on the date of service, or if coverage is pending, you are responsible for the charges incurred on that date of service, unless other arrangements are made. We will give you a receipt, which you may file with your insurance company.

If you do not have insurance, we offer a lower self-pay rate. However, payment is expected on date of service.

Medication Refills

We ask that you allow 24-48 hours' notice when your child needs a medication refill. We do e-scribe our medications to your pharmacy of choice. Though we strive to get these done as quickly as possible, depending on type of medication, we often need time to review your child's records to see if a follow up appointment is needed prior to providing the medication.

If your child requires medications for ADHD/ADD, emotional of behavioral concerns, you will be asked to sign a contract outlining the treatment plan, including random drug screening. Violation of this plan will result in immediate termination from the practice. This is outlined in the contract.

Parent or Guardian: _____

Child's name: _____

Date: _____

Witness: _____

Ashe Pediatrics

Sheila Driver PNP-BC, AE-C

PO Box 1499 303 East 2nd Street Suite A

West Jefferson, NC 28694

336-846-4KIDS (4543) Fax 336-846-PEDS (7337)

Medical Release Form for Requesting Records

Patient's Name _____ **Date of Birth** _____

Facility/Physician's office being asked for information

(name and address) _____

_____

_____

I, _____ authorize the above named facility to release

(Self, Parent, Legal Guardian name)

specified information concerning me to: name and address of facility or person to which disclosure is to be made to:

Ashe Pediatrics

_____ **Mail records to:** PO Box 1499 West Jefferson, NC 28694

_____ **Fax records to:** 336-846-PEDS (7337)

_____ **FedEx/UPS records to:** 303 2nd East Street Suite A, West Jefferson, NC 28694

This data shall include:

- ☐ **Vaccine records**
- ☐ **Growth charts**
- ☐ **Complete records**
- ☐ **Lab data**
- ☐ **Inpatient records**
- ☐ **Outpatient records**
- ☐ **Consultations**
- ☐ **X-ray reports**
- ☐ **Labor & delivery, newborn record with labs including newborn screening & hearing**
- ☐ **ER records with labs and x-ray from** _____
- ☐ **Hospital admission note/H & P and Discharge Summary/Note records**
- ☐ **Other** _____

(extent and nature of data to be disclosed)

The purpose of releasing this data shall be: medical follow-up, insurance, personal, legal,

Circle: Transfer of care Continuation of care Follow-up visit Consultation

other_____.

The above information will be released only to the specified facility. The information that is released is subject to redisclosure and is no longer protected by the privacy regulations. I understand that I may revoke this authorization at any time by submitting a written notice of revocation of this authorization. This consent will expire 365 days from the date of signature.

Signed: _____ _____

(specify relationship if other than patient: Parent, Legal Guardian, or Administrator of Estate)

Date: _____

Witness: _____

12/27/15

Ashe Pediatrics PLLC

Sheila Driver PNP-BC (ANCC), AE-C
PO Box 1499 303 East 2nd Street Suite A
West Jefferson, NC 28694
336-846-4KIDS (4543) Fax 336-846-PEDS (7337)

Medical Records Request for Ashe Memorial Hospital

Fax: 336-846-0747

(Parents Complete top only)

Child's Name: _____ DOB: _____

Parent Name: _____ Signature _____

Relationship: _____

Witness: _____ Date: _____

Records Requested: (To be filled out by office staff only)

☐ Labor/Delivery Record including STD and Strep Testing

☐ New Born Discharge Summary

☐ ER Notes - Date(s) of service requested _____or last 2 years

☐ Admission Notes - Date(s) of service requested: _____

☐ Discharge Note - Date(s) of service requested: _____

☐ Labs: _____or last 2 years

- Blood Type
- Newborn Screen

☐ Radiology: _____

- Chest
- KUB
- Extremity _____
- Scoliosis