Kevin J. Foley, MD PA
1145 Depot Street, Franklin, NC 28734
Phone: (828) 349-6670 Fax: (828) 349-6675

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____ How did you hear about us? _____

Patient Name (First Middle Last): _____ Social Security Number: _____ Sex: ☐ M ☐ F

Relationship to Guarantor: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Preferred Telephone: (_____) _____

E-Mail Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____ Mode of contact: ☐ Telephone ☐ Email

Siblings who visit this office:	**Name**	**Sex** (M/F)	**DOB** (mm/dd/yy)	**Social Security #**

PARENT INFORMATION

Marital Status of Parents: ☐ **Married** ☐ **Divorced or Divorce Pending** ☐ **Single (never married)**

Mother's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (For federally mandated patient portal use only)

Home Address (☐ Same as Child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Father's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (For federally mandated patient portal use only)

Home Address (☐ Same as Child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Full Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer: _____ Policy Type: ☐ HMO ☐ PPO ☐ PPC ☐ Other: _____

ID Number: _____ Group Number: _____ Co-Pay Amount: _____

Preferred Pharmacy Name: _____ Location/Phone: _____

Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Financial Policy, Assignment Information, and Release of Information

I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance to be paid directly to Kevin J. Foley, MD PA or its assignees. I am responsible for any non-covered services, supplies, co-payment or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This is acceptable and assignment will be in force for all future services by practitioners from this office.

Patient/ Parent/ Guardian Signature **Date** **Witness Signature** **Date**

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TO BE FILLED OUT BY PARENT

Child's Name _____ **Date of Birth** _____
Mother's Name _____ **Father's Name** _____

A. PREGNANCY AND BIRTH

1. Mother's age at birth _____
2. Maternal illness during pregnancy? Yes No
3. Any meds other than vitamins and iron? Yes No
4. Was the baby on time (>37 wks)? Yes No
5. Was the baby breeched? Yes No
6. What was the birth weight? _____
7. Did the baby have any trouble while in the hospital? (jaundice, infection, breathing problems, etc.) Yes No
8. What kind? _____

B. PAST MEDICAL HISTORY

1. Where was your child's last check-up done?
2. Date of last check-up? _____
3. Allergic reaction to meds, food or insects? Yes No
   Which ones? _____
4. Any serious reactions to immunizations? Yes No
   Which ones? _____
5. Any hospitalizations besides birth? Yes No
   For what? _____
6. Any Serious Injuries? Yes No
   What kinds? _____
7. Medications taken regularly or currently? Yes No
   Which ones? _____

C. FAMILY HISTORY

1. Are the child's parents in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, sibilings, aunts, uncles, cousins have had: anemia, asthma, allergies, eczema, diabetes, high blood pressure, heart trouble, high cholesterol, tuberculosis, mental illness, drug problems, inherited illness, cancer, AIDS, learning disorder, attention deficit disorder or hyperactivity, strabismus, or others.
3. List age, sex and general health of brothers and sisters
4. Have any of your children past away? Yes No

D. FEEDING AND NUTRITION

1. Was there severe colic or any unusual feeding problem during the first three months? Yes No
2. If breastfed, for how long? _____
3. Does he/she take: vitamins or fluoride? Yes No
4. Does your child use homeopathic or herbal medicines? Yes No

E. RECORDS

1. Do you have a Record of Immunizations? Yes No

F. REVIEW OF SYSTEMS

HAS YOUR CHILD HAD:

1. Frequent ear infections? Yes No
2. Eye problems, glasses? Yes No
3. Frequent colds or sore throats? Yes No
4. Chickenpox? Yes No
5. Asthma, pneumonia, recurrent cough? Yes No
6. Heart murmur or heart problems? Yes No
7. Problems with urination, urine infections? Yes No
8. Frequent diarrhea or constipation? Yes No
9. Convulsions or other problems with the nervous system? Yes No
10. Eczema, hives or other skin conditions? Yes No
11. Anemia or other blood problems? Yes No
12. Please list any other medical problems
13. List any sub-specialists your child has seen
14. Do you currently or do you plan to vaccinate your child with the NC Public School Required Vaccines? Yes No

G. DEVELOPMENTAL/BEHAVIOR

1. Age he/she sat alone? _____
2. Age he/she walked alone? _____
3. Was he/she saying words by 18 months? Yes No
4. Does he/she have trouble sleeping? Yes No
5. What grade is he/she in? _____
6. Has he/she had any trouble in school? Yes No
7. Does he/she get along with other children Yes No
8. Circle if your child has had any of the following: thumb sucking, bed wetting, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline

H. SAFETY/ENVIRONMENT

1. Are the parents of the child: married, divorced, separated, deceased
2. The child lives with: both, one, joint custody, guardian, foster, stepmother, stepfather, other
3. Is the child adopted? Yes No
4. The child is also in: daycare, preschool, with a nanny, with relatives
5. Are there any pets in the home? Yes No
6. Are there smokers in the home the child is exposed to? Yes No
7. Do you have a pool, spa or pond at home? Yes No
8. Does he/she always wear a helmet when riding a bike or skating? Yes No
9. Does he/she use a car seat/seat belt? Yes No

PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Kevin J Foley MD PA Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____

Signature of Patient or Representative Date

_____

Print Name Patient's Date of Birth

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the following patient:

_____

_____

_____

FOR Kevin J Foley MD PA USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

DETAILED FAMILY HISTORY FORM

Child's Name:_____ **DOB:**_____

Has your child's family member had any of the following? Please check all that apply:

				GRANDPARENTS	
	MOM	DAD	SIBLINGS	DAD SIDE	MOM SIDE
AIDS					
ANEMIA					
ADHD					
ALLERGIES					
ASTHMA					
AUTISM					
BIRTH DEFECTS					
BLEEDING DISORDERS					
CANCER (TYPE)					
CEREBRAL PALSY					
DEPRESSION					
DIABETES					
DIGESTIVE PROBLEMS					
DOWN SYNDROME					
DRUG ABUSE					
EAR/HEARING PROBLEMS					
ECZEMA					

CONTINUED ON REVERSE

	MOM	DAD	SIBILINGS	GRANDPARENTS DAD SIDE	GRANDPARENTS MOM SIDE
VISION/EYE PROBLEMS					
GENETIC DISORDERS					
HEART DISEASE					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
INHERITED ILLNESS					
KIDNEY PROBLEMS					
LEARNING DISORDER					
LIVER DISEASE					
MENTAL ILLNESS					
MRSA					
SEIZURES					
SKIN DISORDERS					
STRABISMUS					
STROKE					
THYROID PROBLEMS					
TUBERCULOSIS					
ULCERS					
OTHER EXPLAIN					

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name:_____ ***Date of Birth:***_____

1. I authorize _____ (healthcare provider) to release the protected health information described below to **Kevin J. Foley, M.D.,PA.**
2. This authorization for release of information covers the period of healthcare from:

   a. ☐ **specific date/diagnosis**_____ **OR** b. ☐ **all** past, present and future periods.

3. a. ☐ I authorize the release of my complete health record ***(including*** records relating to labs, immunizations, mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse.

   ****OR****

   b. ☐ I authorize the release of my complete health record with the ***exception*** of the following information:

   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol/Drug abuse treatment
   - ☐ Other (please specify):_____

4. This medical information may be used by the person/facility I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect **until**_____(date or event), at which time authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand the revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may be no longer be protected by federal or state law.

Today's Date	*Signature of patient or personal representative*	*Printed name of patient/personal representative **and** relationship to patient*
Today's Date	*Signature of Witness*	*Printed name of Witness*

Kevin J. Foley M.D., PA
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CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

YOU MUST LIST THE NAME OF THE FAMILY MEMBER(S) OR PERSON(S) BELOW

_____

_____

Check all that may apply:
o All my medical information
o Information necessary to schedule appointments for me
o Lab or test results
o Information necessary to help my family member(s) take care of me
o Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Kevin J Foley MD PA unless and until I notify Kevin J Foley MA PA in writing of any changes.

_____

Signature of Patient or Representative Date

_____

Patient's Name Patient's Date of Birth

_____

Relationship to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

OFFICE FINANCIAL POLICY

KEVIN J. FOLEY MD PA
1145 DEPOT STREET FRANKLIN, NC 28734
PHONE: (828)-349-6670 FAX: (828)-349-6675

We would like to thank you for choosing **Kevin J. Foley, MD PA**, as your child's doctor. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

PAYMENT

Payment is expected at the time of service. This is an insurance company rule and an office rule for self pay patients. This includes co-pays or co-insurance for participating insurance companies. **Kevin J. Foley, MD PA** accepts cash, personal checks, VISA, Mastercard, Discover and American Express. There may be an additional fee if co-pays are not paid at time of service. There is a service charge of $25.00 for returned checks.

PAST DUE ACCOUNTS

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance (that we take or do not take) for whatever reason, except where prohibited by law or prior contractual agreement.

If we have to turn your account over to collections, you will be charged interest on the outstanding balance from the date your bill was due, and you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees. If you get sent to collections this will result in an automatic discharge from the practice.

INSURANCE

It is the patient's responsibility to provide us with the most current insurance information and to present and active insurance card at each visit. If your plan requires, you must name **Kevin J. Foley, MD PA** as your primary care physician prior to your first appointment. If **Kevin J. Foley, MD PA** is not named on your insurance as your primary care physician, your appointment will need to be rescheduled.

Kevin J. Foley, MD PA **DOES NOT** file any insurances that we **DO NOT TAKE OR CONSIDERED AN OUT OF NETWORK PROVIDER.** If you have one of these insurances that we **DO NOT** take, then you will be a self pay patient and payment of all services provided for your visit will be due before being seen by Dr. Foley.

REFERRALS

You must make an appointment with **Dr. Foley** for a consult prior to getting a referral to a specialist. No retroactive referrals will be given.

CANCELED APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment at **828-349-6670** to cancel or reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge for appointments that are not canceled at least 24 hours in advance. The amount of the charge is up to the discretion of the practice. If you miss any appointments or have canceled appointments more then three times this will result in an automatic discharge from the practice.

MORE INFORMATION

Please call (828)-349-6670 if you have a question about your bill. Most problems can be settled quickly, easily and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with the secretary. Satisfactory arrangements can almost always be made. Financial considerations should never prevent children from receiving the care they need at the time they need it. Again thank you for trusting **Kevin J. Foley, MD PA** to care for your children. If you would like a copy of this Office Financial Policy please ask the secretary at the front desk.

I have read and understand the policies of Kevin J. Foley MD PA practice.

Patient name:_____
DOB:_____
Parent signature:_____
Print Parent Name:_____

UPDATED: 6/14/2023

Kevin J Foley MD PA

Pediatric & Adolescent Medicine

Franklin, NC (828) 349-6670

Dear Parent or Guardian,

As of **August 1, 2023**, Kevin J Foley MD PA will start charging a **$25.00 fee** for appointments that are canceled or rescheduled at last minute or appointments that are missed without calling to let us know.

We do apologize for the inconvenience, but due to the amount of appointments that are being missed, canceled or rescheduled we have had to resort to charging a fee. We are a busy practice that stays booked up all day. We understand that there are unavoidable or personal reasons for missing appointments, but we do require a 24 hour notice. Please keep in mind that we do have a No Call No Show Policy that states if you miss three appointments without notifying us you will be discharged from the practice.

Sincerely,

Kevin J Foley MD PA

NO CALL NO SHOW POLICY

We understand that sometimes you may not be able to make it to a scheduled appointment. When we make your appointment please understand that we are reserving this time for child/children to be seen by Dr. Foley. This is a courtesy to allow the best service possible here at Kevin J Foley MD PA. If you are unable to make it to an appointment, please call us and let us know so that we can get another sick child in for that time.

If you have missed 3 appointments and have not called, you may be charged a fee or discharged at the discretion of the office. Thank you for allowing us to care for your child/children.

Sincerely,

Kevin J Foley MD PA

Patient Name: _____ Date of Birth: _____

Parent Signature: _____ Date: _____