Chapin Pediatrics

Our staff continues to strive to offer the best pediatric health care in the area and will remain unwavering in that endeavor. We consider it a privilege when you choose us because we know that you have many excellent choices. We are dedicated to the physical, emotional, and spiritual health of your children. It is our desire to see them healthy, thriving, and growing up to be productive members in society. You will not find a more dedicated pediatric health care team to see these aspirations come to fruition.

Chapin Pediatrics is pleased to announce they are officially recognized as a Patient Centered Medical Home (PCMH) through The National Committee of Quality Assurance (NCQA). We were first recognized in August of 2018 and continue to strive to provide the utmost health care to our patients!

What Does this Mean for You:

The NCQA Patient-Centered Medical Home standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication, and patient involvement. The Patient-Centered Medical Home is a model of care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. Patient centered care ensures that Chapin Pediatrics and our patients, families, and caregivers work together to provide the best care possible and help manage the care needs of our patients. It is important that we have all of our patient's information, including but not limited to medications, medical, family, and social histories, health status, and physical, behavioral, and social development.

Office Hours:

Dr. Luke Bonnett
Mon, Tue, Thurs, & Fri
8:00 am to 5:00 pm

Dr. Jerri Lynn Shealy
Mon, Tues, & Thurs
8:00 am to 1:30 pm
Wed – 8:00 am to 5:00 pm

Mr. Jay Johnson
Mon through Fri
8:00 am to 5:00 pm
Thursday - 8:00 am to 11:45 am

Mrs. Julie Edwards
Tues through Thurs
8:00 am to 5:00 pm

Dr. Kimberly Bolen
Mon, Wed, Thurs, & Fri
8:00 am to 5:00 pm

Mrs. Tori White
Mon, Tues, Wed, & Fri
8:00 am to 5:00 pm

After Office Hours & Weekends:

You should always call our main number to reach after-hour or weekend assistance. There are Saturday sick appointments at our office starting at 9:00 am until around noon. We reserve the right to charge $25.00 for after-hours phone calls. We hope you consider the information you receive after-hours to be valuable and worth that expense. Please note that many of your insurance companies provide you with free nursing advice so you may want to call them first. However, if you use our services we will expect you to pay for them.

Patient Portal (Follow My Health):

Our Patient Portal is available to manage our patient's health care needs on-line. The portal is an easy way to see appointments, request refills, and review lab results, etc. Please ask our front staff how to get signed up!

723 Chapin Road Chapin, SC 29036 Phone (803) 932-2200 Fax (803) 932-2225p

Patient Information Form
Date: _____

Primary Provider:

□ Bonnett, MD □ Johnson, APRN
□ Shealy, MD □ Edwards, APRN
□ Bolen, MD □ White, APRN

1.Fullname:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

2. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

3. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

4. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

5. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

6. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

Primary Residence Mailing Address:_____

City:_____ State: _____ Zip Code: _____

Primary Phone Number: _____ □ Home □ Cell

- **Race**: □American Indian □Alaskan Native □Asian □ Native Hawaiian □Hispanic
  □Other South Pacific Islander □African American/Black □White □Other
- **Ethnicity**: □Hispanic or Latino □Not Hispanic or Latino
- **Preferred Language**: _____
- **Preferred Notification Method:** □Postal Mail □Telephone □Patient Portal Message
- **Emergency Contact**:
  Name:_____Relationship:_____Phone#_____

SEE BACK

Parent/Guardian Information

MOTHER: Full Name: _____ Date of Birth _____

SSN_____Relationship: □Biological □Step □ Foster □ Legal Guardian □ Other_____

Address: □ Same as Child_____City_____ ST_____ Zip_____

Home #_____ Cell # _____

Employer _____ Phone # _____

Email: _____

FATHER: Full Name: _____ Date of Birth _____

SSN_____Relationship: □Biological □ Step □ Foster □ Legal Guardian □ Other_____

Address: □ Same as Child_____City_____ ST_____ Zip_____

Home # _____ Cell # _____

Employer _____ Phone # _____

Email: _____

PATIENT PORTAL: Chapin Pediatrics has a patient portal (FollowMyHealth). Visit (**CHAPINPEDIATRICS.COM)** for details.

If you wish to receive an invite to the patient portal please indicate here: □Mother □Father □Both

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Effective Date: _____	Effective Date: _____
Subscriber Name: _____	Subscriber Name: _____
SS#: _____D.O.B._____	SS#: _____D.O.B._____
Relationship to Patient: _____	Relationship to Patient: _____

Consent For Treatment and Discussion of Information

I authorize the following adults, other than parent or legal guardian listed above, to be involved with the evaluation, management, and discussion of my child's healthcare.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Chapin Pediatrics Financial Policy

We would like to thank you for choosing Chapin Pediatrics to provide healthcare for your child. Our staff is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our financial policy, which is an agreement between the practice and the child's parent or guardian. Your clear understanding of the financial policy agreement is important to our professional relationship. We require a signature to document that you have read and understand these policies.

INSURANCE/PAYMENT

Payment for services is due at the time services are rendered, except as outlined as follows. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and present your current insurance card at every visit. It is the responsibility of the parent/guardian to provide ***accurate*** and ***timely*** insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. According to your contractual agreement with your insurance plan, you are responsible for your copayment, coinsurance, and/or deductible at the time of service. Please understand that all copayments are due at the time of service and that you will be charged a $10.00 convenience fee if you do not pay your copayment at the time of service. It is important for you to be an informed consumer who understands the specifications of your insurance policy regarding vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiographs, laboratory tests, emergency hospital care, etc. You should refer to information from your insurance company or call them if you have questions about your coverage.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY, all services performed in our office will be submitted as a courtesy to your insurance. All insurance carriers have a fee schedule from which they will reimburse. However, the doctor's fee may be higher than the insurance company's reimbursement amount or it may not be a covered service. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the parent/guardian.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY, we are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with a bill so that you may submit the charges to your insurance company for reimbursement.

BILLING

We accept cash, checks, MasterCard, Visa, and Discover. Balances are due within 30 days unless prior arrangements have been made with the billing department. For balances over 60 days, you will receive a request for payment letter and a $20.00 billing charge will be added to your existing balance. ***Outstanding balances not paid in full within 90 days of the first billing statement will be forwarded to a collection agency.*** If your account is turned over to a collection agency, you will be charged $75.00 for collection agency fees. You will also be responsible for any court and attorney fees. IF YOUR ACCOUNT IS FORWARDED TO A COLLECTION AGENCY, WE WILL CONTINUE TO SEE YOUR CHILD/CHILDREN ON AN EMERGENCY BASIS ONLY FOR THE NEXT 30 DAYS. After 30 days, the child/children under your account will be dismissed from the practice. In order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

The accompanying parent/guardian is responsible for full payment at the time of service. In case of parental separation or divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account. Should your account balance become uncollectible due to bankruptcy, we will continue to see your child on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

Please call our office if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. 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.

WALKIN APPOINTMENTS

Patients are seen by appointment only. We are not a walkin clinic. Should you choose to walk in for an appointment or add an additional child onto a visit already scheduled, we will decide if we can see your child time permitting. If your child is seen, you will be responsible for a $25.00 walkin fee due at the time of service. True emergencies will be respected and triaged by our staff accordingly.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, a 24 hour notice prior to the appointment is requested. However, we understand that emergencies arise so please call us if you must miss an appointment. We reserve the right to charge a $60 fee for missed appointments without proper notification. After a third missed appointment in a family within a one year period, the family will be seen for 30 days to allow time to find a new medical home as we will discharge them from the practice due to a failed professional relationship.

AFTER HOUR PHONE TRIAGE SERVICES

Chapin Pediatrics provides nursing triage phone services for free during regular business hours. Most insurance companies also provide free 24 hour nursing triage phone services. We reserve the right to charge $25.00 if you choose to utilize our after hour phone triage services.

AFFIDAVITS/LEGAL MATTERS

There will be a $75.00 fee for notarized affidavits/letters that we prepare for custody, divorce, or any other legal matters. There will be a $300.00 per hour fee (also applies to travel time) for any time needed for legal matters, depositions, or appearances in court. These fees are not billable to your insurance company and are due at the time of service.

FORMS/PRESCRIPTIONS

We require at least 48 hours for all forms to be completed. Please allow 24 to 48 hours for prescription refills to be completed.

MEDICAL RECORDS

We will provide a copy of our records on your child to another physician or medical office one time at no cost. PLEASE NOTE: ONCE RECORDS ARE TRANSFERRED FOR A PATIENT TO ANOTHER OFFICE FOR PRIMARY CARE, WE WILL NO LONGER BE CONSIDERED THE PRIMARY CARE OFFICE. In most cases, we will not accept transferred patients back into our care.

REFERRALS

If your insurance plan requires a written referral for your child to see a specialist, for procedures, or laboratory tests, you must allow at least 3 business days to complete the appropriate form(s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Only emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we do not agree to a referral for a problem we have not been consulted about first.

MINORS

Effective January 1, 2016: to be in accordance with the South Carolina Code of Laws, we will not see children under the age of 16 in the office without being accompanied by a parent/guardian.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CHAPIN PEDIATRICS. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ THE FINANCIAL POLICY.

Please print names of children:

_____ _____

_____ _____

_____ _____

_____ _____

Name of parent or legal guardian:

_____

Signature of parent or legal guardian:

_____

Date: _____

FINANCIAL POLICY UPDATED MAY 17, 2023

Consent For Disclosing Protected Health Information (PHI)

SCHOOL/DAYCARE: I authorize Chapin Pediatrics to disclose the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* _____ *Permission for Medication*
directly to (list schools and/or daycare below) via _____ fax and/or _____ mail:

_____

_____

_____

_____

EMAIL: I authorize Chapin Pediatrics to send the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* via email.
I understand that email is not a secure method of communication and is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Chapin Pediatrics from any liability for submitting PHI using email upon my verbal request and this signature located on this form below. **_____initial.**

FAX: I authorize Chapin Pediatrics to fax the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* to my work place (if applicable).
I understand that this is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Chapin Pediatrics from any liability for submitting PHI using my work's fax number upon my verbal request and this signature located on this form below. **_____initial.**

Authorization, Assignment of Benefits and Record Release

I consent to my child's treatment and allow Chapin Pediatrics to use and release their protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Chapin Pediatrics Notice of Privacy Practices. A copy has been made available to me and is also available at www.chapinpediatrics.com.

I understand that my child's medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Chapin Pediatrics for all medical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and noncovered services.

A photocopy of this form shall be considered as effective and as valid as the original.

I know it is my responsibility to keep Chapin Pediatrics informed about changes to any of my contact information. Failure to do so may interfere with the ability to contact me concerning my child's health care.

_____
Print Parent or Legal Guardian's Name

_____ Date_____
Parent or Legal Guardian's Signature

HIPAA AUTHORIZATION FORM

I authorize **Chapin Pediatrics, PA** to use and disclose my *protected health information* (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____Appointments _____Restrictions _____Medications _____Released from care

_____Date of visit _____Reason for visits _____Diagnosis

Entity or person(s) authorized to receive this information:

_____School/Daycare/Preschool _____Camp _____Employer _____Social Worker

_____Personal Representative's Employer _____Truant Officer _____Parole Officer

_____Family/Friends

This PHI is being used or disclosed for the following purposes:

____Work/School Excuse _____To verify restrictions _____Verify return to work/school

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

_____No longer in school ____Employment terminated _____Released from care

_____Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at *info@chapinpediatrics.com* or *723 Chapin Road Chapin, South Carolina 29036*. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Personal Representative's Authority

(Provide a signed copy of this form to the patient.)

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE **Chapin Pediatrics, PA** TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
GRANDPARENTS	☐ YES	☐ NO	_____
SIBLINGS	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____
OTHERS _____			

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE _____

DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

CHAPIN PEDIATRICS MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
GRANDPARENT	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE _____

DATE _____

I UNDERSTAND THAT **CHAPIN PEDIATRICS** WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

Patient Acknowledgement
Receipt of Privacy Notice

I, _____(**Parent or Legal Guardian Name**) hereby affirm that I have received, on behalf of the patient indicated below, a copy of the *Notice of Privacy Practices* from Chapin Pediatrics, PA. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice* and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider in paper format or electronic format, whether I sign this Acknowledgement or not.

PATIENT(S) NAME: _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient or Personal Representative (Parent or Legal Guardian)

Print Name of Patient or Personal Representative (Parent or Legal Guardian)

_____ _____

Relationship to Patient

Today's Date

_____

For Office Use Only

Received by:	
Date Received:	Time Received:
Patient Declined: ☐	
Staff Signature:	