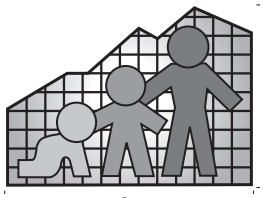
HENDERSONVILLE PEDIATRICS, P.A.

Foster Child Information Sheet



Date _____ Chart # _____

** If there are any changes to the information below, the case worker must complete a new form**

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

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Sex ____

Date of Birth ____/____/_____ County with Custody _____ Preferred Physician _____

Race _____ Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred Language_____

CASE WORKER INFORMATION

Case Worker Name _____ DSS Office Phone _____

DSS Fax _____ Cell Phone _____ Email _____

FAMILY INFORMATION

Foster Parent/Guardian	**Foster Parent/Guardian**
Name_____	Name _____
Mailing Address _____	Mailing Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Preferred Contact Method? Phone___ Text___ Email ____	Preferred Contact Method? Phone___ Text___ Email ____
Home Phone _____ Cell Phone _____	Home Phone _____ Cell Phone _____
Email _____	Email _____

OTHER BIOLOGICAL SIBLINGS IN HENDERSONVILLE PEDIATRICS' CARE

Please list all other **biological children** that are patients of Hendersonville Pediatrics.
This will be used for the sole purpose of family medical history.

1. Child's Full Name_____ Date of Birth_____
2. Child's Full Name_____ Date of Birth_____
3. Child's Full Name_____ Date of Birth_____
4. Child's Full Name_____ Date of Birth_____
5. Child's Full Name_____ Date of Birth_____

AUTHORIZED INDIVIDUALS

Please list the biological parents' names below and the appropriate level of access they have to their child.

____Parents have no contact and are not allowed to receive information.

Name _____ Phone _____

☐ Parents are involved
☐ Parents allowed to attend visits
☐ Parents allowed to make appointments and bring child to office alone.

Name _____ Phone _____

☐ Parents are involved
☐ Parents allowed to attend visits
☐ Parents allowed to make appointments and bring child to office alone.

(See Back)

Patient Name:_____ **Chart #:**_____

Authorization to Consent to Health Care for Minor

By signing this statement, I authorize the doctors and staff of Hendersonville Pediatrics, P.A. 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 people who may schedule appointments, call for medical advice or bring your child to the office for treatment will be provided to this office. If someone other than these persons contacts us relative to your child, or in the event of a medical emergency, we will attempt to contact the parent or guardian for permission to treat. I authorize Hendersonville Pediatrics, P.A. to release my child's medical records to any party involved in their treatment.

Parent or Legal Guardian Signature Print Name

Financial Policy

I hereby authorize Hendersonville Pediatrics, to furnish medical information to insurance carriers concerning my child/children's illness and treatment. Please present your current insurance ID card at every visit and if anything changes you agree to contact us immediately. Our office makes every reasonable effort to obtain payment according to your coverage. If your insurance company rejects the claim or denies payment our office will bill you for the unpaid portion. All co-payments are to be paid at time of service. I authorize payment of all applicable benefits directly to Hendersonville Pediatrics. This authorization will remain in effect until revoked by me in writing.

Parent or Legal Guardian Signature

Code of Conduct Policy

Patient and Staff Safety: Our office 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 any of our office locations. While we understand that disagreements may occasionally occur, these need to be resolved in a civil manner. Depending on the degree of infraction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we deem it necessary. We may press charges at our discretion.

Parent or Legal Guardian Signature

Missed Appointment Policy

I acknowledge families missing a total of four appointments without calling or prior notification will result in termination of care from the practice.

Parent or Legal Guardian Signature