Wake Pediatric Gastroenterology
Because Children Deserve The Best

(919) 261 3232
www.wakepediatricgi.com

PATIENT REGISTRATION FORM

Welcome to Wake Pediatric Gastroenterology (WPG). Please complete this form completely and accurately to help us meet your healthcare needs. Let us know if you have any questions or need assistance.

- Name_____/_____/_____ Nickname_____
  Last First Middle
- Birth Date_____/_____/_____ Gender: M / F
- Phone (home)_____ (work)_____ (cell)_____
- Address_____
  Apt#_____ City_____ State_____ Zip_____
- Email _____
- Emergency Contact:_____
  Phone (1):_____ Phone (2):_____ ext:_____
  Address_____ Apt#_____ City_____ State____ Zip_____
- Primary Insurance Card Holder: ____ Patient ____ Spouse ____ Parent
- Insurance Company _____. Policy number _____
- Guarantor (Main policy holder) Name _____ DOB ____/____/_____
- Primary Care Provider _____ Phone # _____

For your privacy, please answer the following:

You may leave a message regarding my medical care/billing on my home phone	**Y / N**
You may leave a message regarding my medical care/billing on my cell phone	**Y / N**
You may send information regarding my medical care/billing to the email address provided	**Y / N**

Your name _____ Relationship with patient _____

Signature_____ Date _____

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Wake Pediatric GI (WPG) Office Policy

1. **Consent for Treatment:** I authorize WPG for the examination and treatment of the patient by the WPG provider and clinical staff and to perform any procedure or investigation deemed necessary as a part of the medical care provided.
2. **Authorization to Release Information:** I authorize WPG to release personal or medical information of the patient, to my insurance company(s) or worker's compensation carrier necessary to process claims, and to other providers when necessary to assist in the treatment or care of the patient, as well as when required by the law.
3. **Insurance:** I understand that the provider will be making medical recommendations based on my health needs and not on insurance reimbursement. I acknowledge that I must be familiar with my particular insurance plan. I understand that I am responsible for verifying that WPG or its physicians participate with my insurance plan before receiving services. If my insurance plan requires pre-authorization for any services or referrals, I am responsible for ensuring that the services have been pre-approved by my insurance plan. I authorize and request my insurance company(s) to pay directly to the physician or WPG for their services.
4. **Financial Responsibility:** I understand that I am responsible for payment at the time services are rendered including previous balances, copayments, coinsurance, deductibles, or services not covered by my insurance plan. I acknowledge that I have provided current and accurate insurance information/insurance card to enable timely reimbursement for medical services. If insurance information cannot be verified or if I do not have health insurance coverage, I will pay in full at the time of service by credit card, cash, or check. I will also present my insurance card at each visit, without which, I may be responsible for payment in full for services rendered. I understand that any balance after my insurance company has paid is due within 30 days of receipt of the billing statement. I understand that accounts not paid after 90 days from the service date will be turned over to a collection agency and reported to the credit bureau.
5. **Payment**: Charges will be collected at the time of your office visit. If your insurance is based on a copay payment plan, we will collect the specialist copay amount. If you are a private pay patient, or if your insurance is based on a deductible plan, and if the deductible has not been met, a payment of **$275** (for a new visit) and **$125** (for a return visit) will be collected regardless of the level of service provided. This amount is subject to change in the future.
6. **Cancellation Policy:** I understand that if I cannot keep a scheduled appointment, I must notify the office at least 1 day in advance of the clinic appointment, and 3 days in advance of the procedure appointment. I am aware that if I do not provide the cancellation notice or do not show up for the scheduled appointment, a cancellation fee of **$25** may be charged.
7. **Testing** (labs, radiology imaging, procedures, and other investigations): I understand that an outside laboratory, radiology department, endoscopy center, or other facilities will be used for investigations. These facilities may process blood, urine, or tissue specimens as ordered by the physician. These services will be billed separately by respective facilities. It is my responsibility to contact the lab or these facilities with any questions regarding the cost of the investigations, or if you have any questions regarding their bill.
8. **Minor Patients:** I understand that as the adult accompanying the minor, I am responsible for any payment amount due for services rendered regardless of the responsible party or insurance policyholder. I will be provided with a receipt for my reimbursement.

9. **Doctor-patient Relationship:** I understand that a healthy and trustworthy relationship between doctor and patient is necessary for good patient care. If this relationship becomes unhealthy or if the patient becomes non-compliant with the recommended care, the doctor and patient are encouraged to communicate with each other and terminate this relationship.
10. **Discharging (termination of) the Patient:** I understand that WPG has the right to discharge/terminate a patient from the practice. I understand that following such an event, WPG will provide the patient with written documentation (physically or via patient portal) and provide emergency medical care only for 30 days following the termination. The reasons may include (but are not limited to):
    a. Being verbally, digitally, or physically abusive to WPG or its physician or staff
    b. Unresolved debt (unpaid bills) for 6 months.
    c. Non-compliant patient: missing 3 clinic appointments; not accepting 2 appointment requests made by WPG; missing 2 endoscopy/procedure appointments; non-compliant with the treatment plan (tests, medications, diet, follow-up visits, etc.);
    d. The untrustworthy and unhealthy doctor-patient relationship
11. **Not Allowed:** No audio or video recording is allowed during the visit. Smoking/vaping, recreational substances/alcohol, and weapons are prohibited in the clinic.
12. **Use of 'patient portal':** I understand that test results may be communicated to me via the patient portal and it is my responsibility to check my patient portal.
13. **Electronic Communication:** Getting parent/patient feedback is essential for good patient care. I agree to receive communication via email or text that might be used to get feedback or reviews regarding clinic experience (such as Google Reviews).

I have read and understood and agree to adhere to the abovementioned policies. I have also been provided an opportunity to review or receive notice of privacy practices.

Caregiver's name: _____

Caregiver's relationship with the patient: _____

Caregiver's signature: _____

Date: _____