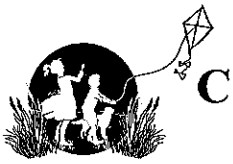
DEMOGRAPHIC INFORMATION



Children's Urology
of the Carolinas

PATIENT'S NAME _____ Sex: F M Goes by_____

Date of Birth_____ Age_____ Social Security #_____

Patient's Address_____ City_____ State_____ Zip_____

Legal Guardian: Mother Father Grandparent(s) Foster Care Adopting Parent(s) Guardian

MOTHER'S (GUARDIAN'S) NAME_____ DOB_____

Mother's Social Security #_____ Driver's License #_____

Home Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____E-mail_____

Mother's Employer_____ Work #_____

FATHER'S (GUARDIAN'S) NAME_____ DOB_____

Father's Social Security #_____ Driver's License #_____

Home Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____ E-mail_____

Father's Employer_____ Work #_____

EMERGENCY CONTACT (Name & Relationship to Patient)

_____

Address_____ Phone #_____

PRIMARY PHYSICIAN _____ Phone #_____

Practice Name_____ Address_____

PRIMARY INSURANCE COMPANY_____

Policyholder's Name_____ DOB_____

Policy #_____ Group #_____

Insurance Co. Claims Address_____

City_____ State_____ Zip_____ Phone #_____

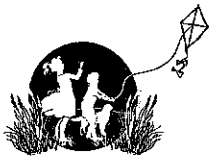
SECONDARY INSURANCE COMPANY _____ Policy #_____

Group _____ Policyholder's Name_____ DOB_____

I agree this information is accurate as of the date of my signature. I am responsible for all charges whether or not covered by insurance including co-pay, deductible, and non-covered expenses. I am responsible for updating the office with any changes or additions in insurance coverage.

X_____ Date_____

Print Name_____



Children's Urology
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Patient's Name_____ **DOB**_____

FAMILY HISTORY (check if there is a family history of the following – include patient's natural parents, brothers, sisters, aunts, uncles, and grandparents only):

· Anemia___
· Anesthesia Problems___
· Asthma___
· Arthritis___
· Bedwetting___
· Cancer___
· Cerebral Palsy___
· Cholesterol Problems___
· Cystic Fibrosis___
· Birth Defects___
· Bleeding Disorders___
· Diabetes___
· Down Syndrome___
· Gastrointestinal Problems___
· Heart Problems__
· High Blood Pressure___
· HIV / Aids___
· Kidney Problems___
· Liver Problems___
· Lung Problems____
· Seizures____
· Sickle Cell Disease___
· Sickle Cell Trait___
· Skin Problems___
· Spina Bifida___
· Thyroid Problems___

How many brothers does patient have? _____ (list ages:_____)
How many sisters does patient have? _____ (list ages:_____)

SOCIAL HISTORY (please check where appropriate): Patient's School Grade_____

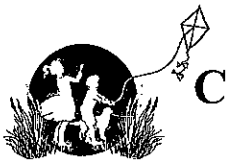
Parents are married____ divorced___ separated___ never married____
Patient lives with natural parents___ guardian___ foster care___ adopting parents___
Mother's place of birth_____ Father's place of birth_____

REVIEW OF SYSTEMS (Please check if your child currently is suffering from any of the following):

Constitutional	Fever___	Fatigue__	Headache__	
Eyes	Blurred Vision__	Double Vision__	Glasses__	
Ears/Nose/Throat	Ear Infection__	Throat Infection__	Sinus Infection__	
Respiratory	Wheezing__	Pneumonia__	Cough__	
Intestinal	Nausea__	Vomiting__	Stomach pain__	Stomach swelling__
Musculoskeletal	Joint pain__	Joint swelling__	Muscle pain__	Back pain__
Neurological	Seizure__	Leg pain__	Leg weakness__	
Endocrine	Excessive thirst__	Weight loss__	Weight gain__	
Cardiovascular	Chest pain__	Palpitations__	Heart murmur__	
Hematological/Lymphatic	Easy bleeder__	Swollen glands__		
Immunologic	Hay fever__	Environmental allergies__		

PATIENT'S URINARY HISTORY (check where appropriate):

Bedwetting ___ Day wetting ___
Urinary frequency is: normal ___ Increased ___ Decreased ___
Wakes-up to urinate: 0-1 x per night ___ 2-4 x per night ___ >4 x per night ___
Urine is not bloody ___ Visibly bloody urine ___ Informed of blood in urine by doctor only ___
Chronic constipation ___ Accidents or soiling of stool ___ Chronic diarrhea ___
Burning with urination ___ Deviated Urinary Stream ___
Urine Infections ____ Genital Pain ___ Kidney stones ____



Children's Urology
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PATIENT & FAMILY HISTORY

Reason for Visit_____

When did the Problem Begin? _____

What Tests / X-rays have been done? _____

Current Medications & Dose (list all prescription, non-prescription & natural medications)

_____

_____

Allergies (medicines, latex, tape, foods, etc.): _____

_____

_____

BIRTH HISTORY

Full-term___ Premature____ (# of weeks premature_____)

Birth weight_____ Birth Hospital_____ Birth City & State_____

Complications with pregnancy or delivery_____

PATIENT'S MEDICAL HISTORY (check if the child or adolescent has been diagnosed with the following):

·ADD ___
·ADHD___
·Allergies (environmental) ___
·Anemia ___
·Anesthesia Problems ___
· Asthma___
· Arthritis___
· Autism ___
· Birth Defects___
· Bleeding Disorders___
· Bone Problems___
· Cancer___
· Cerebral Palsy___
· Cholesterol Problems___
· Cystic Fibrosis___
· Constipation (chronic)___
· Diabetes___
· Down Syndrome___
· Hearing Impairment___
· Heart Problems___
· Heart Murmurs___
· High Blood Pressure___
· HIV / AIDS___
· Immune Problems___
· Learning Problems___
· Liver Problems___
· Lung Problems____
· Measles___
· Migraine Headaches ___
· Muscle Problems___
· Psoriasis___
· Seizures____
· Seizure Disorders ___
· Sickle Cell Disease___
· Sickle Cell Trait___
·Sinus Problems___
· Skin Problems___
· Speech Problems___
· Spina Bifida___
· Stomach Ulcers___
· Stomach Reflux___
· Strep Throat___
· Thyroid Problems___
· Tracheomalacia___

Any Other Specific Medical History of Patient?_____

_____

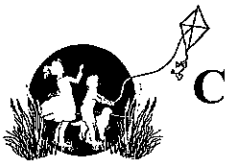
Patient's Hospitalizations (dates & reasons)_____

_____

Patient's Previous Surgeries (include ear tubes):_____

_____

_____



Children's Urology
of the Carolinas

FINANCIAL POLICY

We require the following financial policy to be read and signed prior to any treatment. Copayments and deductibles are due at the time of service. We accept cash, checks, money orders, Visa, MasterCard and Discover only.

INSURANCE

We are in network with most, but not all major private insurance plans as well as North and South Carolina Medicaid. We are not in network with some of the South Carolina Medicaid HMOs. Please call prior to your appointment to confirm we are in network with your specific insurance plan. You are responsible for providing us with an active insurance card at each visit. We will file your insurance at time of service. You are responsible for all non-covered expenses, co-pays, and deductibles. If your plan requires a referral, you are responsible for obtaining the authorization. If a required authorization is not obtained and your child's condition is non-emergent, we may reschedule your appointment. You are responsible for knowing what is covered by your insurance company's plan. We charge what is usual and customary for our region. Some, and perhaps all, of the services provided by us may be non-covered by your insurance company.

SURGERY PRE-CERTIFICATION

We will obtain pre-certification for surgery from your insurance company if necessary. We ask that you alert us of any insurance changes and all insurance plan(s) coverage before your surgery.

DEPOSITS AND PAYMENTS

Our office may verify your benefits and create an estimate of anticipated charges prior to any appointment or surgery. You will be notified if a pre-payment or deposit will be required for your appointment or surgery. After your insurance processes your claim, you will receive an invoice if additional payment is due or will receive a refund if an overpayment was made. Payment plans are available; if you are interested in setting up a payment plan please contact the billing department.

SOCIAL SECURITY NUMBERS

We must obtain the social security number of at least one parent at the time of service. If you chose not to provide us with this information, credit cannot be extended and payment of anticipated charges will be collected at check in.

MISSED APPOINTMENT FEE

A missed appointment fee of $30 will be charged for any patient who misses 3 appointments. The fee will be charged regardless of what insurance the patient has and will not be billed to insurance. The fee will be collected prior to creating a new appointment.

DELINQUENT ACCOUNTS

Accounts with delinquent balances and/or accounts that have been sent to a third-party collection agency may be required to pay a portion or all of the balance before scheduling a new appointment. A prepayment of anticipated charges may also be collected.

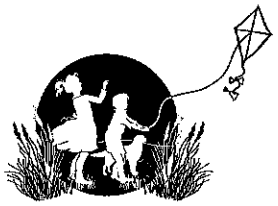
DIVORCE

Divorce decrees are only binding between the two parties who made the agreement. It is our policy that the parent or guardian who signs this form is the responsible party for arranging payment.

I have read the Financial Policy and asked appropriate questions as necessary. I understand and agree with the Financial Policy.

X_____ Date_____

Print Name of Responsible Party_____



Children's Urology
of the Carolinas

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you are granting consent to Children's Urology of the Carolinas to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent. A copy of the Notice of Privacy Practices can be found on our website www.childurology.com and can also be obtained by a staff member. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change at any time. You may obtain a copy of the revised notice by contacting our office at 704-376-5636.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment and health care operations. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Children's Urology of the Carolinas requires that a parent or legal guardian accompany all patients to all appointments, procedures and/or surgeries. Any person, other than the parent, will be asked to provide proof of legal guardianship and/or written consent from parent to bring patient in for medical consultation. If legal documentation cannot be provided, the appointment will be cancelled. Written consent will not be permitted for procedures and/or surgery. A parent or legal guardian must be present for any procedures or surgeries to be performed.

I have been given the opportunity to read the full Notice of Privacy Practices and asked appropriate questions as necessary. I understand and agree with these Privacy Practice policies.

X_____ Date _____

Print Name of Responsible Party _____

Patient Name _____