

Pediatric Possibilities, P.A.  
7209 Creedmoor Rd, Suite 101  
Raleigh, NC 27613  
Phone: (919) 844-1100  
Fax: (919) 844-1102



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## Patient Information

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's S.S.# \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M or F

Person completing this form: \_\_\_\_\_ Relation to patient \_\_\_\_\_

Father's Name: _____	Mother's Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: (H) _____	Phone: (H) _____
(W) _____ (C) _____	(W) _____ (C) _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____

Email \_\_\_\_\_

Best time, place and person to contact: \_\_\_\_\_  
With whom does the patient live with? \_\_\_\_\_  
Ages and genders of siblings: \_\_\_\_\_  
\_\_\_\_\_

Person responsible for the bill: \_\_\_\_\_ Relation to patient \_\_\_\_\_  
S.S.# \_\_\_\_\_ Phone number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Policy number: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Who referred the patient for services? \_\_\_\_\_

Reasons for the referral/visit/concerns you would like to share: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*Please read and sign the backside. Thank you.\*\*\*\*\*

### Our Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees and policies with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask, if you have questions about fees, financial policy, or your responsibility.

- **PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE**

The adult accompanying a minor at the time of service is responsible for full payment. For unaccompanied minors, the parents or guardians are responsible for full payment.

- Insurance is a contract between you and your insurance company. You will need to pay us for the services at the time of your appointment. We will provide you with the necessary information for you to submit to your insurance company for reimbursement (if applicable).
- We accept cash, check, Visa/Master cards.
- Pediatric Possibilities is a Medicaid provider. We need a copy of your Medicaid card along with any other health insurance information prior to receiving services and a copy of your Medicaid card monthly thereafter. If services are denied by Medicaid, you will be responsible for payment of therapy services.
- No show fee- Appointments that are missed without a 24-hour advance notice will be assessed a \$30.00 no show fee which will be applied to the patient's balance and will need to be paid at the following appointment.

**Services and Fees:**

Evaluation Fee: \$210 per hour includes: record review, evaluation time, scoring and a written report.

Treatment: Fee: \$125 per hour, \$93.75 for 45 minutes, and \$62.50 for 30 minutes

- **Use and Disclosure of Your Protected Health Information and Consent for Treatment**

\_\_\_\_\_ (initial) I have received a copy of the Notice of Privacy Practices Form.  
\_\_\_\_\_ (initial) I consent to the use or disclosure of my protected health information (PHI) by Pediatric Possibilities for the purpose of treatment, payment and general healthcare operations.

My consent is evidenced by my signature on this document.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature (Parent or Guardian if Patient is a minor)

\_\_\_\_\_  
Print Name  
This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature (Parent or Guardian if Patient is a minor)

\_\_\_\_\_  
Print Name