Wake Pediatric Gastroenterology
Because Children Deserve The Best

Sachin Kunde, MD, MPH
www.wakepediatricgi.com
(919) 261 3232

PATIENT REGISTRATION FORM

Welcome to Wake Pediatric Gastroenterology (WPG). In order to help us meet your healthcare needs, please fill out this form completely and accurately. 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 _____
- 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 hereby 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 hereby 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 prior to 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 make payments directly to the physician or WPG for the services they provide.

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 date of service 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. 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 24 hours in advance of the appointment time. I am aware that if I do not provide 24 hours' notice before the cancellation or do not show up for a 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

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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 personal 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 at any point during the care, both the doctor and patient are encouraged to communicate with each other, terminate this relationship, and seek patient care elsewhere.

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 send the patient a written notice and provide emergency medical care only for the next 30 days after 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-compliance by the patient: missing 3 clinic appointments; not accepting 2 appointment requests made by WPG; missing 2 endoscopy/procedure appointments; not following the given treatment plan (tests, medications, diet, follow-up visits, etc.);
    d. The untrustworthy physician-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. **Email Communication:** Getting parent/patient feedback is essential for good patient care. I acknowledge receiving communication via email and that my email address might be used for getting feedback or reviews regarding clinic experience (such as Google Reviews).

I have read and understood and I agree to adhere to the above-mentioned 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: _____