PLEASE PRINT CLEARLY **2026**

Doctor:_____

Patient Information

Name: _____ Date of Birth: _____ Sex: ☐M ☐F

Preferred Name: _____ SSN (optional) _____

Race: ☐White ☐Black ☐Asian ☐Multi-racial ☐Other Hispanic : ☐ Yes ☐ No

Address: _____City_____State____Zip_____

Primary Phone: (_____)_____-_____(home/cell) Alternate Phone: (_____)_____-_____(home/cell)

May Leave Messages at: **Primary/Alt/Both** Appointment Reminders will be made to **ALL PHONE NUMBERS ON ACCOUNT**.

E-mail Address: _____

Note: by providing my e-mail address, I understand that I will receive e-mail newsletters announcing important updates.

Parent's Information

Parent #1: _____ _____ SSN(required)_____ Date of Birth: _____

Parent #1's Maiden Name:_____

Address (if different from Patient):_____

Phone_____ Employment_____Work#_____

*Parent #2:*_____ SSN(required)_____Date of Birth: _____

Parent #2's Maiden Name:_____

Address (if different from Patient) _____

Phone_____Employment_____Work#_____

Parents Married? Yes/No If divorced, who has legal custody?_____ *(Please provide legal documentation)*

Siblings:

Name_____ Date of Birth_____ Name_____ Date of Birth_____

Name_____ Date of Birth_____ Name_____ Date of Birth_____

Insurance Information:

In order to file insurance claims, we must have complete information below and a scanned copy of the insurance card(s).

Primary Insurance _____ID#_____Group#_____

Insurance P.O. Box (on back of card):_____ Payor ID (EDI): _____ Ins Phone #:_____

Effective Date of Insurance?_____

Who Carries the Insurance (Subscriber)? ☐ Father ☐ Mother ☐ Other _____

Who is Responsible for payment of unpaid balances on this account (Guarantor)? ☐ Father ☐ Mother

Do you have Secondary Insurance? ☐ Yes ☐ No

Secondary Insurance _____ID#_____Group#_____

Effective Date of Insurance?_____

Subscriber for Secondary? ☐ Father ☐ Mother ☐ Other _____

PLEASE CONTINUE TO THE OTHER SIDE

Consent To Treat

I give the physicians of Carmel Pediatrics, LLC consent to provide and perform medical care, tests, procedures, and administer medications and vaccines as are considered necessary or beneficial for my child's health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

SIGN HERE Parent Signature: _____ Date: _____

Authorization to consent for Medical Treatment in my absence:

I hereby grant the following person(s) the authority to bring my child to Carmel Pediatrics for medical care, tests, procedures, and immunizations.

_____ _____

_____ _____

SIGN HERE Parent Signature: _____ Date: _____

Electronic Communications

Automated Calls: As an added convenience, we *may* offer automated reminders via a text message or an automated call for those who wish to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Carmel Pediatrics, LLC and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or e-mails, providing that I have consented below. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

□ Yes, I want to participate. My cell phone number is: _____

My e-mail address is: _____ □

No, I do not wish to participate at this time.

SIGN HERE Parent Signature: _____ Date: _____

Release of Protected Health Care Information:

{Unless otherwise stated only the Mother and Father may receive protected health care information.}

I give consent and authorization for the medical, or billing staff of Carmel Pediatrics to discuss protected Health Care Information about my child with the following person(s):

Name Relationship Phone

_____

_____

FINANCIAL RESPONSIBILTY: PLEASE READ CAREFULLY!

By signing below, I confirm that all personal information is correct, and I verify that I have provided the most current/accurate insurance information for my child. I acknowledge that I have read and understand the Financial Payment Policy for Carmel Pediatrics and have been offered a copy. I understand that if I do not pay my balance in a timely manner, I may be subject to a collections filing fee of $25.00. I authorize the release of any information regarding my child's exam and treatment for the purpose of obtaining insurance compensation, precertification or medical records. Carmel Pediatrics, to the best of its ability, will always provide good faith estimates. A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our office. Indiana state law HEA 1447 requires that an estimate be provided within five (5) business days of scheduling the nonemergency health care service unless the nonemergency health care service is scheduled to be performed by the physician within five (5) business days of the date of the patient's request. I authorize payment of medical benefits for services rendered by, Anna G. Gilley, M.D., and Elizabeth J. Beach, M.D., Danielle N. Wiese, M.D., Danielle M. Erney, M.D., Jacqueline S. Nti, M.D., and Appolinia Stephenson, M.D.,PharmD

SIGN HERE Parent Signature: _____ Date: _____

For Office Use Only :_____ Entered by: _____

carmel pediatrics

13450 North Meridian Street, Suite 260
Carmel, IN 46032
(317) 582-7257 (phone)
(317) 582-7413 (fax)

Anna G. Gilley, MD **Elizabeth J. Beach, MD** **Danielle N. Wiese, MD**
Danielle Erney, MD **Jacqueline Nti, MD** **Appolinia Stephenson, MD, PharmD**

Carmel Pediatrics Patient Agreement

By signing this form, I agree to the following policies of Carmel Pediatrics:

Carmel Pediatrics is an immunizing pediatric office. All Families accepted into the practice at Carmel Pediatrics agree to comply with the vaccination schedule as recommended by the Academy of Pediatrics.

Once accepted into the practice of a physician at Carmel Pediatrics, families may not transfer to the practice of another physician at Carmel Pediatrics. Similarly, patients in the same family may not be split between different physicians at Carmel Pediatrics.

Failure to arrive for an appointment, or failure to cancel an appointment at least 24 hours in advance will result in a failed appointment fee of $50.

Failure to comply with these policies may result in dismissal from Carmel Pediatrics.

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Signature:_____ Date:_____

carmel pediatrics
Independent Pediatricians Who Care

Acknowledgement of Receipt of Notice of Privacy Practices

(Federal HIPAA Privacy Regulations)

By signing below, I am acknowledging that this office has provided me with a copy of their Notice of Privacy Practices.

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

Child's Name: _____DOB: _____

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

A copy of this form must be kept in the patient's chart.

Financial Payment Policy for Carmel Pediatrics

The purpose of this form is to clarify to you our stand on filing insurance, completing health forms, transferring records and collecting payments on your account.

REGARDING INSURANCE: Our office participates with many insurance companies, should your insurance be with one or more of these companies, we will bill your insurance along the guidelines of our contract. **A current copy of your insurance card(s) must be on file to submit a claim.** If the correct insurance information is not given to Carmel Pediatrics and your medical claim is denied you will be responsible for payment in full for services rendered and/or for a $25.00 fee to re-file to the correct insurance company. *Insurance information submitted to us past the timely filing date, will be your full responsibility.*

The party which seeks medical care and signs the financial policy is considered the "guarantor" and financially responsible for payment, regardless of any divorce decree or court order. This includes services rendered to minors who may be covered by another parent's insurance under a custody agreement.

REGARDING BALANCES DUE ON ACCOUNT: The balance due after the insurance company has paid their portion is due within 30 days. If you are unable to make payment in full you will need to call the office and make payment arrangements. *Your account may be assessed $20.00 per month for every month we send a statement 30 days after the insurance company has paid.* After 60 days you risk your account being sent to the collection agency.

REGARDING ACCOUNTS THAT GO TO COLLECTIONS: If your account goes to the collection agency your child(ren) will be seen for 30 days, only for urgent care. You will need to find a new physician to care for your family. In the event your account is submitted for collection, you will be charged a fee of $15.00 to collect for services, and any additional fees required for court judgment or otherwise.

REGARDING TRANSFER OF RECORDS: There is a charge of $15.00 per chart to transfer records. This will need to be paid prior to the transfer.

REGARDING HEALTH FORMS: There is a $10.00 fee per health form. You are required to complete your portion of the health form before you bring it to the office for completion. It takes 5-7 business days to complete a health form. Should you need to have the form completed within 24 hours there is a fee of $20.00 per form.

NON-SUFFICIENT CHECKS/CLOSED ACCOUNTS: Your account will be charged $35.00 for a check returned for non-sufficient funds, closed account, etc. You are still responsible for the amount of the check and if payment is not made, your account may be subject to collection process as defined above.

ADDITIONAL FEES:

- There may be a $50.00 fee for any appointments not kept without at least a 24 hour cancellation.
- There is an additional fee if your child is seen for urgent care on a date that we do not have normal office hours. (i.e. holidays)

Financial Hardship: There are times when making payment can be a financial hardship. It may be necessary to set up a payment plan for the parent who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your visit. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered. Co-pays not paid at the time of visit are subject to $10.00 late penalty.

Notice of Privacy Practices

Carmel Pediatrics, LLC
13450 North Meridian St. Suite 260, Carmel, IN 46032

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your child's paper or electronic medical record
- Correct your child's paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your child's information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your child's privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your child's condition
- Provide disaster relief
- Include your child in a hospital directory
- Provide mental health care
- Market our services and sell your child's information
- Raise funds

Our Uses and Disclosures

We may use and share your child's information as we:

- Treat your child
- Run our organization
- Bill for your child's services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your child's health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your child's medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about your child. Ask us how to do this.
- We will provide a copy or a summary of your child's health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your child's medical record

- You can ask us to correct health information about your child that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your child's care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your child's health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your child's health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your child's health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your child's rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your child's information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your child's care
- Share information in a disaster relief situation
- Include your child's information in a hospital directory

If you are not able to tell us your preference, for example if you are unable to be reached in an emergency, we may go ahead and share your child's information if we believe it is in your child's best interest. We may also share your child's information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your child's information unless you give us written permission:

- Marketing purposes
- Sale of your child's information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your child's health information?

We typically use or share your child's health information in the following ways.

Treat your child

We can use your child's health information and share it with other professionals who are treating your child.

Example:We may share information to other doctors who may be treating your child, or to a doctor to whom your child has been referred to ensure that the necessary information is available to diagnose and treat your child.

Run our organization

We can use and share your child's health information to run our practice, improve his or her care, and contact you when necessary.

Example: We use health information about your child to manage his or her treatment and services.

Bill for your services

We can use and share your child's health information to bill and get payment from health plans or other entities.

Example: We give information about your child to your health insurance plan so it will pay for his or her services.

How else can we use or share your health information?

We are allowed or required to share your child's information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your child's information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about your child for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your child's information for health research.

Comply with the law

We will share information about your child if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about your child with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about your child:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about your child in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your child's protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your child's information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your child's information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date July 1, 2016
- The privacy official for Carmel Pediatrics, LLC is the office manager, who may be reached at 317-582-7257 or 317-582-7360.
- Carmel Pediatrics, LLC will never market or sell personal information.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.