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Authorization for Release of Information

By completing this document, you hereby authorize the use or disclosure of your individually identifiable health information, as described below. In executing this authorization, you acknowledge that you do so voluntarily. Unless otherwise stated in our Privacy Notice, you have the right to revoke this authorization at any time.

Patient Name: ______________________________

DOB: ____________________ **SS#:** ____________________

Mailing Address:____________________ **City/State/Zip:** ____________________

Home Phone:____________________ **Cell Phone:** ____________________

Requesting Records From : ______________________________

Phone# : ____________________ **Fax# :** ____________________

Send Records To : ______________________________

____

____

Change of Doctor:______________ **Specialist:** ______________ **Other:** ______________

For patients transferring records out, there is a $25.00 charge for printed copies of record.

Authorization Signature: ______________________________ **Date:** ______________

I understand that the records and information to be released may contain and include information of a personal and confidential nature. This authorization is subject to revocation at any time by notifying this office in writing. Without revocation, authorization will automatically expire in 90 days from the date thereof.

703 Verdae Blvd.
Greenville, SC 29607
Tel: 864.288.5402
Fax: 864.234.7961

112 Commons Blvd.
Piedmont, SC 29673
Tel: 864.295.8811
Fax: 864.295.0806

307 North Main St.
Simpsonville, SC 29681
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Fax: 864.228.8050

841 South Buncombe Rd.
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First: __________ **Middle:** __________ **Last:** ____________ **Sex:** __ **DOB:** ___/___/___ **SS#:** ____-____-______

First: __________ **Middle:** __________ **Last:** ____________ **Sex:** __ **DOB:** ___/___/___ **SS#:** ____-____-______

First: __________ **Middle:** __________ **Last:** ____________ **Sex:** __ **DOB:** ___/___/___ **SS#:** ____-____-______

First: __________ **Middle:** __________ **Last:** ____________ **Sex:** __ **DOB:** ___/___/___ **SS#:** ____-____-______

How did you hear about our practice?

☐ **Facebook** ☐ **Friend/Family** ☐ **Web** ☐ **Other**

Patient Mailing Address: ____________________ **City/State/Zip:** ____________________

Home Phone: ____________________ **Email:** ____________________

Mother: ____________________ **Father:** ____________________
SS#: ____________________ **SS#:** ____________________
Cell: ____________________ **Cell:** ____________________
DOB: ____________________ **DOB:** ____________________

Other than Parent:

Emergency Contact Name: ____________________ **Emergency Contact Number:** __________

Address: ____________________ **Relationship to Patient:** __________

In the event of an emergency situation and the clinic is unable to reach the above legal guardians I or we Grant my or our permission for emergency care, treatment, transportation, hospitalization or any other physicians to be called in connection with the care needed for the above listed child(ren).

Signature of Guardian: ______________________________

Pharmacy Name: ______________________________
Pharmacy Number: ______________________________
Pharmacy Address: ______________________________

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Person Responsible For The Bill Is The Person Who Brings In The Child

Name of Person Responsible: ______________________________

DOB: ______________________ **SS#:** ______________________

Mailing Address: ______________________ **City/State/Zip:** ______________________

Home Phone: ______________________ **Cell Phone:** ______________________

Insurance Information

Primary Insurance: ______________________________

Effective Coverage Date: ______________________________

Group #: ______________________ **Policy/Subscriber #:** ______________________

Insurance Address: ______________________ **City/State/Zip:** ______________________

Policy Holder's Name: ______________________________

Policy Holder's DOB: ______________________ **SS#:** ______________________

Employer: ______________________ **Phone #:** ______________________

Home Address (if different from above): ______________________________

City/State/Zip: ______________________________

**** I authorize the release of any medical information necessary to process claims ****

Signature: ______________________________ **Date:** ______________

**** I authorize payment of medical benefits to services described above ****

Signature: ______________________________ **Date:** ______________

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HIPAA Consent Form

Patient Name: ____

DOB: ______________________ **SS#:** ______________________

Mailing Address:______________________ **City/State/Zip:** ______________________

Home Phone:______________________ **Cell Phone:** ______________________

In accordance with HIPAA regulations, we require consent to provide treatment, release account information and discuss any healthcare operations in your absence. Listed below are the people I give permission for your office to speak with and receive information requested. Please **CHECK** the information below that you authorize Children's Medical Center to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

- ☐ Results of lab test/x-rays
- ☐ Appointment Information
- ☐ Billing Information
- ☐ Medical Information

Name : ______________________ **Relationship:** ______________________

Name : ______________________ **Relationship:** ______________________

The people listed below DO NOT have the permission to receive any information regarding my child's healthcare or any account information. (If a parent is listed to not receive any information regarding your child's health or any other information we require court documentation on file to honor this request.)

Name : ______________________ **Relationship:** ______________________

Name : ______________________ **Relationship:** ______________________

Signature: ______________________ **Date:** ______________________

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Financial Policy

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

Payment for Service: We require that you pay your deductible, co-payment, and/or any charges not covered by insurance. As a courtesy to you, we will file your insurance if you provide us with a copy of your current insurance card.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $35.00 service charge will be added on all checks returned to us for insufficient funds.

Forms Fee: There will be a $15.00 fee charged for all forms (sports, physical, camp, etc.) to be completed when not needing a scheduled office visit.

Copies of Medical Records: There may be a charge for completion of this service (SC Sec. 44-7-325 for Health Care Facilities):

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Plus actual postage

No Show Appointments: A fee of $25.00 may be charged for missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify your home office of any cancellations during normal office hours.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. If you are unable to pay your balance promptly, please call the billing office at 864-752-0510 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded to a collection agency.

Signatures: I have read and understand these financial policies:

Guarantor Signature: ____

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In my absence, the following people have permission to bring my child for medical care at Children's Medical Center, P.A.

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

I consent to my child receiving regularly scheduled immunizations at Children's Medical Center, P.A.

Signature: ______________________ **Date:** ______________________

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Children's Medial Center Web Portal

We have a web portal to help with all of our patient needs. It can be accessed on our website, **www.cmc-pa.com**, and is available to serve our patients. There is no charge for this service. Through the portal, you will be able to access the following:

Demographics
Statements
Immunization Records
Medical Records
Make Future Appointments for Physicals
Email questions to our nurse
Email your physician questions
Forms
Prescription Refills

Date: ___________________________

Signature:___________________________

Email address: ___________________________

☐ **Check here if you do not wish to have access to the web portal.**

☐ **Check here if you already have your login and password.**

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,________________________________, understand that as a part of my healthcare, Children's Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. **I understand that this information serves as:**

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. **I understand that I have the following rights and privileges:**

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purpose, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Children's Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Children's Medical Center reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Children's Medical Center change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that it may be necessary for Children's Medical Center to contact my house from time to time concerning treatment, payment or other healthcare observations, and I consent to voice mail messages being left if necessary.

I fully understand and accept the terms of this consent.

____ ______________________________

Patient's Signature **Date**

FOR OFFICE USE ONLY

☐ Consent refused by patient, and treatment refused as permitted. ☐ Consent added to the patient's medical records on ____________.

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