



****This form is for your personal use only and is a tool to help you understand your personal health benefits****

Call your insurance company (phone number on the back of your insurance card) and ask them to send you a summary of benefits for your (or your child's) current plan.

Insurance company name: _____

Customer Service #: _____

Policy ID #: _____ Group #: _____

Effective Date: _____ Renewal Period: _____

Policy holder name: _____ Policy holder date of birth: _____

Do I have to choose a Primary Care Physician? Yes No

If yes, is that the physician listed on my card? Yes No

If it is not, call your insurance company and have them change the Children's Medical Center to one of Children's Medical Center physicians.

Individuals covered under this plan: _____

Deductible Amount: \$ _____ /Individual & \$ _____ /Family

Out of pocket max: \$ _____ /Individual & \$ _____ /Family

General Office Visit: Copay \$ _____ Co-Insurance \$ _____ Deductible \$ _____

Specialist visit: Copay \$ _____ Co-Insurance \$ _____ Deductible \$ _____

Hospital: Copay \$ _____ Co-Insurance \$ _____ Deductible \$ _____

Prescription*: Copay \$ _____ Co-Insurance \$ _____ Deductible \$ _____

Radiology: Copay \$ _____ Co-Insurance \$ _____ Deductible \$ _____

**Prescription benefits may have different levels of coverage (tiered)*

Questions to ask your insurance company specifically how they process wellness visit charges:

1. How many wellness visits can my child have between the age of newborn and 4? _____
2. At what age is my child limited to one wellness visit per year? _____
3. Is that per calendar year or from last wellness visit? _____
4. How does my plan pay for routine immunizations? _____
5. Do I have co-insurance or a deductible to meet for immunizations? _____
6. Is there a wellness maximum amount that my insurance company will pay? _____
7. If so, what is that amount? _____
8. Who is my preferred lab? _____

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@CMCGreenville

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Tel: 864.228.8010
Fax: 864.228.8050

841 South Buncombe Rd.
Greer, SC 29650
Tel: 864.877.1220
Fax: 864.877.7731



First: _____ Middle: _____ Last: _____ Sex: ___ DOB: ___/___/___ SS#: ___-___-___

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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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Children's Medical Vaccine Policy

Children's Medical Center believes that vaccines are the most important intervention we offer to our patients. We join the American Academy of Pediatrics (AAP) and the Center for Disease Control (CDC) in supporting the recommended vaccine schedule. This schedule has been rigorously studied for efficacy and safety.

While alternative schedules have gained in popularity, we firmly discourage families from using these schedules. Alternative schedules are poorly studied and their efficacy and safety have not been adequately demonstrated. Delaying vaccines puts children at risk for preventable diseases. If parents choose to "spread out" vaccinations, parents must decide which vaccines they will delay. Our providers recommend following the traditional vaccine schedule.

As of January 7, 2019, CMC only accepts new patients committed to vaccination. We are happy to develop a catch-up schedule for any patient that is behind on vaccines. This policy applies to vaccines which are required for daycare and school attendance. Certain vaccines such as HPV are exempt from our policy.

This policy also does not affect patients who were previously established with our practice. If you are transferring into our practice and have not previously been vaccinated, we will help you to set up a catch up schedule. This catch up schedule should begin within 60 days of your first visit. Failure to comply with this policy may result in the physician recommending that you seek another pediatrician.

Medical exemptions for vaccines will only be given to children with documented qualifying health conditions/reactions. Medical exemptions will NOT be given based on parental refusal to vaccinate.

If parents insist on refusing vaccination for their child despite our recommendations and overwhelming scientific data to support immunizations, we reserve the right to terminate the doctor-patient relationship. We do not maintain a list of practices that accept unvaccinated patients.

Many parents have questions regarding vaccines and we welcome these discussions. We want our families to feel well informed. Finding reliable vaccine information can be a challenge for families. We recommend families refer to **cdc.gov**, **aap.org**, or **chop.edu/centers-programs/vaccine-education-center**.

Patient's Name: _____ **DOB:** ____/____/____
First Middle Last

Parent's Name (please print): _____

Parent's Signature: _____ **Date:** ____/____/____



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:** _____



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:** _____