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.

First: ______________ **Middle:** ______________ **Last:** __________________ **Sex:** _____ **SS#:** _____-_____-_____

First: ______________ **Middle:** ______________ **Last:** __________________ **Sex:** _____ **SS#:** _____-_____-_____

First: ______________ **Middle:** ______________ **Last:** __________________ **Sex:** _____ **SS#:** _____-_____-_____

First: ______________ **Middle:** ______________ **Last:** __________________ **Sex:** _____ **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: ____

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

3455 Highway 153
Piedmont, SC 29673
Tel: 864.295.8811
Fax: 864.295.0806

307 North Main St.
Simpsonville, SC 29681
Tel: 864.228.8010
Fax: 864.228.8050

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

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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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: ____

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:** ______________________

cmc-pa.com ChildrensMedicalCenterPA @CMCGreenville

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