First: _____ Middle: _____ Last: _____ DOB: __/__/__ Sex: ____ SS#: _____-_____-_____

First: _____ Middle: _____ Last: _____ DOB: __/__/__ Sex: ____ SS#: _____-_____-_____

First: _____ Middle: _____ Last: _____ DOB: __/__/__ Sex: ____ SS#: _____-_____-_____

First: _____ Middle: _____ Last: _____ DOB: __/__/__ 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: _____

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:** _____

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:** _____

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 _____.

Payment Policy

Proof of Insurance:
All patients must provide a copy of a current, valid insurance card for proof of insurance. If you fail to provide us with the correct insurance information at the time of service, you are responsible for the balance of your account.

Non-Covered Services:
Please be aware that some and perhaps all of the services you receive may not be covered by your insurance company. Since all insurance plans are different, please contact your insurance for detailed information about what is covered or not covered including Well Child Visit Maximums, Labs associated with Well Visits, After-Hours fees and Immunizations, etc. You will be billed and responsible for all Non-Covered services.

Co-Payments and Balances Due:
All co-payments and balances due, including deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Not collecting co-payment at the time of service is considered fraud. Co-pays, deductibles, and any outstanding balance are due at the time of service.

Filing Your Claim:
As a courtesy to our patients, we will file claims to your insurance provider and assist you in any way we reasonably can to help get your clean paid. It is your responsibility to contact your insurance if the claim is denied.

Self-Pay Patient:
Payment is expected at the time of service; however, you may be billed for additional charges if not paid at the time of service. We do offer a 20% discount of all patients in good standing with CMC.

Newborn Insurance:
In order to file insurance for your newborn, a parent must add the baby to the insurance policy within 30 days of the date of birth. Once added, please notify our office in order to have the patient's charges filed in a trimly manner.

I understand Children's Medical Center payment policy.

Responsible Party 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: _____

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:** _____

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

6527 State Park Rd.
Travelers Rest SC 29690
Tel: 864.610.2108
Fax: 864.610.2900

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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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:** ___/___/_____

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Credit Card On File Agreement

We have an optional system allowing us to maintain your Credit Card information securely on file which would be accessed only under the terms you specify below. This is completely optional and for your convenience regarding payment of services rendered.

By providing Children's Medical Center, PA with your credit card information on this form, you are giving us permission to automatically charge your credit card on a weekly, monthly, or as needed basis for the amounts due for services rendered to your child and family. These amounts match the patent responsibility amounts as determined by your insurance company and are reflected on the explanation of benefits (EOB's) from your insurance company.

Any canceled or missed appointments without a 24-hour notice, will result in the credit card on file being charged the late cancellation or no-show fee of $25.00 for an office visit, $50.00 for a consult.

If the credit card on file changes for any reason, you must notify Children's Medial Center, PA as soon as possible. If you have any questions concerning a charge please notify us within 30 days. After 60 days, all charges will be assumed to be correct.

We will maintain a clear record of all payments and charges.

I HAVE READ AND UNDERSTAND THE CREDIT CARED ON FILE AGREEMENT ABOVE AND AUTHORIZE CHILDREN'S MEDICAL CENTER, PA TO CHARGE MY CREDIT CARD AS STATED ABOVE.

Patient Name: _____

Type of Credit Card: _____ **Card Number:** _____

Expiration Date: _____ **Security Code or CVC/CID#:** _____

Full Name on Card: _____

Billing Address on Card: _____

How would you like to receive your receipts? _____

Guardian Printed Name: _____ **Date:** _____

Guardian Signature: _____

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