18+ CHILDREN'S MEDICAL GROUP, P.C. 18+

PATIENT'S NAME____ DOB ___/___/____GENDER ______
LAST FIRST MIDDLE

ADDRESS ____
STREET APT # CITY STATE ZIP

EMAIL ADDRESS ______________________________ OCCUPATION ______________________

CELL PHONE ____________________ HOME or WORK PHONE ___________________________

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY) ______________________________

EMAIL ADDRESS FOR BILLING STATEMENTS ______________________________________

BILLING ADDRESS ____
(IF DIFFERENT THAN ABOVE) STREET APT # CITY STATE ZIP

EMERGENCY CONTACT ______________________ PHONE________________ RELATIONSHIP__________

PRIMARY PROVIDER YOU SEE AT CHILDREN'S MEDICAL GROUP ___________________________

PREFERRED PHARMACY__________________________ PHONE _____________________

STREET/CITY ____

RACE:
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ HISPANIC
- ☐ OTHER

ETHNICITY: HISPANIC OR LATIN _______ NOT HISPANIC OR LATIN _______

PREFERRED LANGUAGE: ____________________

AUTHORIZATION TO LEAVE MEDICAL INFORMATION and/or MESSAGE

In accordance with HIPAA Privacy Rule, individuals have the right to request a restriction on uses and disclosures of their protected health information (PHI). We at Children's Medical Group, P.C., must have your authorization as to where we may leave messages. We need to know in writing what phone number(s) we may call to speak with you or with whom we may leave a message. It is our office policy to NOT release confidential and/or unauthorized information by home, cell, or work telephone or by answering machine or voicemail. Whenever returning telephone calls and the answering machine picks up, we will NOT leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We will simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize Children's Medical Group providers and/or staff to leave medical information pertaining to my care with household members/answering machines/voicemail, by the following methods and will assume responsibility to notify them whenever this information changes. In addition, staff may provide information concerning appointment confirmation, rescheduling, lab results, vaccine information or nurse follow-up calls. **Please provide numbers that we have permission to use and check appropriately for permission you are authorizing.**

Phone # ______________________

Phone # ______________________

O Leave message with appointment, time & date
O Leave message regarding lab results, vaccines
O Leave medical info and/or nurse return calls
O Leave message to call office
O Do not leave message

SMS Communication to cell? **Yes** _____ **No** _____
Number provided at time of need
Fax Communication to work **Yes** _____ **No** _____
Number provided at time of need
Fax Communication to school **Yes** _____ **No** _____
Number provided at time of need

Mail to home address on file **Yes** _____ **No** _____

Email address for appointment reminders: ____________________@____________________

PLEASE SEE REVERSE SIDE

THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicaid, private insurance, or other health plans, to this practice. I understand it is my responsibility to pay any copayment, deductible, or co-insurance amount and that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize Children's Medical Group to release and receive my health information for evaluation and treatment of care.

Children's Medical Group, P.C.'s Notice of Privacy Practices is available at www.cmg-pc.com. A hard copy will be provided upon my request.

I hereby agree to payment of an Annual Administrative Fee of $10.00, per individual patient, if any forms need to be completed.

Children;s Medical Group, P.C. has permission to take/store my photo in their Electronic Medical Record (EMR) system for identification purposes.

SIGNATURE: **DATE:**

Due to privacy concerns and regulations, **no video recording, photographing, and/or audio recordings are allowed in our offices**. This is in line with our policy of securing the privacy and protection of our patients and staff.

Health Information Exchanges: I understand that Children's Medical Group may participate in one or more health information exchanges (HIEs) and I consent to Children's Medical Group electronically sharing the patient's health information including but not limited to, information related to infectious or contagious disease (Including HIV and/or AIDS), drug or alcohol abuse or treatment, genetic testing, and/or psychiatric or psychological conditions, for treatment, payment and/or healthcare operations purposes with other participants in the HIEs. I agree that if I do not want the patient's information shared with any HIE in which Children's Medical Group participates, I must opt-out by filling out a form obtained from Children's Medical Group patient representatives or found online at https://www.cmg-pc.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss medical information, request prescriptions, vaccine information, medical records, results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's written consent. If you wish to have any of your medical information released to family members you must fill out and sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

I, ______________________________, Date of Birth ______________________,

(Print your Name)

Authorize representatives of Children's Medical Group, P.C. to share and/or release information to:

1) ______________________ Relationship ______________________

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines

O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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2) ______________________ Relationship ______________________

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines

O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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3) ______________________ Relationship ______________________

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines

O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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I understand that I have the right to change this authorization, in writing, at any time by sending a written notification to this office.

Patient Name (Print)______________________ **Date**______________________

Signature of Patient ______________________

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

Children's Medical Group, P.C.
Management