THE CHILDREN'S CLINIC
1003 WEST MEETING STREET
LANCASTER, SC 29720

Date:____________ **TCC Account# __________________**

Patient's First Name:_________________Middle____________Last_________________

Street Address ___________________ City____________State_________Zip_________

Patient's Date Of Birth ______________ SS#______________ Male______ Female________

Relation to Pt. (Mom) ________ (Dad) _______ (Foster Parent) _______(Guardian)_______

Home Number __________________________ **Cell Number ________________________**

★★

Mother/Guardian Full Name ___________________________Date of Birth______________

Street Address ___________________ City____________State_________Zip_________

SS# ____________________ Employer_______________________

Home Phone_________________ Work Phone ____________________

★★

Father/Guardian Full Name ___________________________Date of Birth______________

Street Address ___________________ City____________State_________Zip_________

SS# ____________________ Employer_______________________

Home Phone_________________ Work Phone ____________________

★★

Name of Insurance Company (1) ______________________________

Name of Policy Holder ___________________________________

Address of Policy Holder _________________________________

Name of Insurance Company (2) ______________________________

Name of Policy Holder ___________________________________

Address of Policy Holder _________________________________

PRIMARY INSURANCE WILL BE LISTED AS NUMBER 1!!!!!!!!!

I VERIFY THAT THE ABOVE INFORMATION IS CORRECT. I GIVE MY PERMISSION FOR TREATMENT, IMMUNIZATIONS, AND MEDICATIONS AS DEEMED NECESSARY BY THE MEDICAL STAFF OF THIS OFFICE NO MATTER WHO BRINGS CHILD IN FOR TREATMENT.

SIGNED ________________________________DATE________________WITNESS________

Revised 01/22

THE CHILDREN'S CLINIC

Please read all of the following before signing below
Statement of Financial Responsibility

It is the policy of this practice to collect payment for services as services are rendered. This allows us to control our costs and to keep fees at a reasonable level. Payments may be made by cash, check, or debit card.

We will be happy to bill your insurance for you. If, at the time of service your carrier will assume responsibility for payment of your services, we will accept payment from them. If your carrier later refuses payment for any reasons, we will bill you directly for services rendered. You are always responsible for your co-pay at each visit. Medicaid billing will follow appropriate Federal and State billing guidelines.

Private patients who wish to make payment arrangements other than payments in full at the time services are rendered must request an alternate payment plan prior to being treated at this clinic.

I, UNDERSIGNED, HAVE READ THE ABOVE STATEMENT AND ACCEPT FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED AT THIS CLINIC.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, authorize the release of any information necessary to process claims relating to this account. I hereby authorize the above referenced clinic to apply for benefits on my behalf from covered services rendered. I request that payment from my insurance company be made to The Children's Clinic. I certify that the information I have reported with regard to my insurance coverage is correct.

I, the undersigned, hereby authorize any direct payment to the clinic above for medical/surgical benefits. Otherwise, payment to me under the terms of insurance.

CONSENT FOR EVALUATION AND TREATMENT

I, Hereby, authorize The Children's Clinic, their physicians, employees or agents to perform a physical examination and/or any medical treatment deemed necessary by the treating physician. This includes, but is not limited to any required medical examination procedures or treat ordered by the physician to be carried out by the designed staff.

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I, Hereby acknowledgement that I received a paper copy of The Children's Clinic Notice of Privacy Practices which sets forth the way in which any protected health information may be used or disclosed by The Children's Clinic and outlines my rights with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patients behalf.

By signing below, I acknowledge that I have read and consent to all articles listed above.

PATIENT/PARENT/GUARDIAN SIGNATURE_____ DATE_____

RELATIONSHIP TO PATIENT_____ WITNESS_____

Revised 2017

Dear Parent/Guardian:

Please list the people that are allowed to bring your child in for treatment at The Children's Clinic P.A.

By signing this form, you are granting permission for the providers to treat your child in the best way they see fit, including in SOME INSTANCES, giving immunizations.

_____ _____

SIGNATURE **DATE**

PERSON ALLOWED TO BRING CHILD IN:

1._____

2._____

3._____

4._____

5._____

Child's Name(s) **Date Of Birth**

_____ _____

_____ _____

_____ _____

_____ _____

EFFECTIVE IMMEDIATELY

I, AS A PATIENT AND/OR PARENT, UNDERSTAND THAT IF MEDICAID COVERAGE BECOMES INELIGIBLE, I WILL NO LONGER BE UNDER MEDICAID FEDERAL AND STATE BILLING GUIDELINES. THEREFORE, I WILL BE CONSIDERED "SELF-PAY" AND WILL BE FULLY RESPONSIBLE FOR ALL OFFICE CHARGES.

SIGNATURE:_____

DATE:_____

WITNESS:_____

Revised 2017

THE CHILDREN'S CLINIC, P.A.
1003 WEST MEETING STREET
LANCASTER, SC 29720
PHONE: 803-289-5437
FAX:803-289-5440

Request for Confidential Communication of Protected Health Information

It is frequently necessary for personnel at this practice to communicate lab results, radiology reports, instructions, information about treatment and other items of Protected Health Information with our patients. It is frequently not possible to speak personally or face to face with the patient. In the event that our staff is not able to speak with you (the patient) directly, please give us instructions about communicating with you.

1. Messages may be left at my:

Home Answering Device **Number** _____

Work Voicemail **Number**_____

Cell Phone **Number**_____

My home answering device does not identify me by name, but it is appropriate to leave messages for me there.
(circle one) yes or no

2. Prescriptions, drug samples, written and verbal instructions for treatment or other messages and items of Protected Health Information may be given to:

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please list each Child's Name AND Date Of Birth below

Name: _____ **Date Of Birth** _____

Name: _____ **Date Of Birth** _____

I hereby release, discharge, and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid for one year from this date of signature, unless otherwise revoked in writing.

Signature of Parent/Guardian _____ **Date**_____

Witness _____ **Date**_____

EFFECTIVELY IMMEDIATELY

DUE TO INSURANCE COMPANIES AND MEDICAID NOT COVERING SPORTS PHYSICAL CHARGES, EACH PATIENT WILL BE CHARGED $35.00 AT THE TIME OF THE VISIT.

PATIENT NAME _____

SIGNATURE _____

DATE_____

WITNESS _____

Revised 2017

THE CHILDREN'S CLINIC

Missed Appointment Policy

After the first missed appointment within a calendar year, the parent or guardian will be notified by letter of our office policy. The appointment may be rescheduled.

If a second scheduled appointment is missed within a calendar year, letter #2 is sent, reiterating our policy. The appointment may be rescheduled.

If a third scheduled appointment is missed within a calendar year, it will be necessary to terminate our professional relationship with the patient and family. A termination letter is sent.

Parent/Guardian Signature:_____

Date: _____

Witness: _____

Please list all children	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ACKNOWLEDGEMENT OF OFFICE POLICY

I have read The Children's Clinic, P.A. office and financial policies in full and I understand and agree to this policy. I acknowledge full financial responsibility for services rendered. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-payments. I understand that payment of co-payments is expected at the time of service, as well as any prior balance I owe. I understand the policy regarding missed appointments.

_____ _____

Patient Full Name **Date of Birth**

_____

Parent or Guardian

Revised 2017

EXPLANATION OF OUR POLICIES

Office Hours
Our office in Lancaster is open to patients Monday-Friday, 7:30am-6:00pm and Saturdays 8:00am-12:00pm, except for holidays. Our satellite office in Indian Land is open to patients Monday-Friday, 8:30am-5:00pm.

Waiting Room
Please check-in with the receptionist when you arrive for your appointment. We request that you supervise young children. Children cannot be left unattended in the waiting room. Due to limited waiting space, we do request that no more than 2 additional persons attend with the patient. Smoking is not permitted anywhere in our office building.

"No Show" and Cancellation Policy
A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients and to our providers. We therefore request that patients who are unable to keep their scheduled appointments notify us at least 4 hours in advance, so the time might me made available to someone else. One of the ways that we strive to meet your healthcare needs is to provide appointments with our physicians in a timely manner, many times appointments can be made within the same day. In order to provide these same day appointments, we have the following "No Show" policy:

- For established patients, a missed appointment will be rescheduled once upon request. You will receive a letter after each missed appointment.
- Three (3) "No Show" appointments within a calendar year may result in you and your family being dismissed as patients from our clinic.

Telephone
We encourage you to call with any questions concerning your child's medical care. Please understand that when you call, the doctor or nurse is usually with a patient. It would be unfair to the other patients under examination if we were to interrupt the examination to answer every telephone call. We do have a nurse triage line open during normal business hours located in the Lancaster office. If you are unable to speak directly with the nurse, please leave a detailed message including the patient's name and date of birth. Your call will be answered at our earliest opportunity. Please note that most calls are answered in the late morning and late afternoon. The after hours answering service is intended solely for urgent matters that cannot wait until the next normal business day.

Prescriptions and Shot Records
All prescription refills and shot records should be requested during regular office hours, when your medical records are available to the doctors or nurses. If you would like your prescription refill telephoned to your pharmacy, please leave that information when requesting the refill. We have included an option in our telephone service dedicated to prescription refills.

Please call for refills a few days before your prescription runs out rather than waiting until the last moment. Routine prescription refills and shot record requests will generally be ready within 48 hours of your request. However, prescriptions for antibiotics, narcotic pain and behavior medications will not routinely be given without a recent examination by the physician, in order to ensure that your child receives medication appropriate for their condition. Any narcotic or behavior medication must be picked up and signed for in our office (by someone on your child's pickup list), these will not be called into the pharmacy.

Telephone prescriptions for pain medications, antibiotics or behavior will not be given after office hours or on weekends. Any requests left during weekend hours will be received on the following business day.

Insurance
As a courtesy, our office will bill your insurance of the services you receive. We cannot bill your insurance company unless you give us the correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. We can often help with providing information to help get your claim paid. It is our policy to bill the patient for any amounts due after insurance payments, and the patient guarantor has the financial responsibility to pay these amounts. We will provide the patient with monthly statements for any balance due after insurance payments. Unpaid balances may be sent to an outside collection agency. The patient will be responsible for any collection expenses associated with the collection efforts.

If you do not have insurance, a portion of the payment is due at the time of visit. A 25% discount may be given to self-pay patients if the visit is being paid in full on the same day as the visit. A payment plan can be arranged if the full payment cannot be paid at the time of the visit.

Co-payments, Deductibles and Fees
All co-payments are due at the time services are rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.

We accept cash, personal checks, VISA, and MasterCard. There will be a charge of $35 for any check that is returned by your bank for any reason. This will be in addition to any charges applied by your bank. This fee cannot be charged to your insurance.

THE CHILDREN'S CLINIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS T OTHIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

UNDERSTANDING YOUR CHILD'S MEDICAL/HEALTH INFORMATION

As you child's healthcare provider, we will maintain a record of your child's visits that contain his/her symptoms, reports of immunizations, test results, diagnosis, treatments, correspondence with other providers and and plans for future care or treatment.

YOUR CHILD'S HEALTH INFORMATION RIGHTS

Your child's health record is the physical property of this practice; however, the information it contains belong to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

a. Request Restrictions: You have a right to request restrictions on the use of your child's information.
b. Obtain a paper copy of this notice
c. You have a right to inspect and receive a copy of your child's health information. If you request a copy of your child's information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
d. You have the right to request that we amend your child's health information.
e. You have the right to request an accounting of certain disclosures of information that have been made about you child. This listing includes disclosures of your child's information for other than treatment, payment, or healthcare purposes and is within a specified period for up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may one charged a reasonable fee for additional requests made within a twelve month period.
f. You have the right to request that you receive communications regarding your child's information in a certain manner or at a certain location.
g. You have the right to revoke an authorization for disclosure of information that was previously given.

OUR RESPONSIBILITIES

a. Maintain the privacy of your child's health information.
b. We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about your child.
c. Abide by the terms of the notice.
d. We will notify you if we are unable to agree to a requested restriction of your child's information.
e. We will accommodate reasonable requests that you may have to communicate health information by alternate means or alternate locations. We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your child's health information without you authorization, except as described in this notice.

FOR MORE INFORMATION

a. If you have a question or would like additional information, you may contact our Privacy Officer.
b. If you have a concern about the the privacy of your information, you may contact our Privacy Officer. Your concern will be responded by our practice, buy you may also file a complaint with the Secretary of Health and Human Services in the U.S. Office of Civil Rights. The Privacy Officer will supply information about this procedure.

SAMPLES OF DISCLOSURES OF INFORMATION

a. We will use your child's health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your child's health record and used to determine the best treatment for your child. Members of the healthcare team will be document your child's treatment goals, actions taken, and clinical procedure.
b. We will provide your child's other healthcare provider with copies of various reports that will help them to treat your child for any subsequent condition that may arise
c. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies too and/or your child, your child's diagnosis, treatments, and supplies used.
d. The physicians and members of your child's healthcare team may use the information to evaluate the quality of care your child received as well as the care received by the other similar to your child. This information will be used to improve the effectiveness of healthcare operations.
e. There are some services provided through contracts with business associates. As an example, we contact with a company that provides information for the computer system we operate. When these services are contracted, we may disclose your child's health information to this business associate so that they can perform the work we require. To protect our child's health information, the business associate must appropriately safeguard your child's information.
f. We may disclose intimation to notify or assist in notifying a family member, personal representative, or other persons responsible for your child's care, information about your child's general condition.
g. We will use good judgement in disclosing to a family member or any other person you identify, health information or payment, relevant to that person involvement in you child's care.
h. We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.
i. We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
j. If your child is an organ donor, we may disclose your child's information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.
k. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
l. We may contact you as part of a fund-raising effort.
m. We may disclose to FDA health information relative to adverse events with respect to food, supplements, product, and product defect or post-marketing surveillance information to enable product recalls, repairs, or replacement.
n. In accordance with state law, we may disclose health information as is required for processing a claim under Worker's Compensation.
o. Under SC law, we may disclose your child's health information to the health department in order to prevent control disease ,injury, or disability.
p. If your child is an inmate of a correctional institute, we may disclose the institution or its agents, health information that is needed for you child's health or the health and safety of other individuals.
q. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
r. Federal and state laws make provisions for your child's health information to be released to appropriate health authorities provided that a member of your staff or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers, or the public.
s. All other uses and disclosures of your child's health information will only be made with your written authorization. If you have authorized us to use or disclose information about your child: you may revoke this authorization at any time.

KEEP FOR YOUR RECORDS

HIPAA AUTHORIZATION FORM

Patient Name_____ D.O.B_____

I authorize_____ to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____ Appointments _____Restrictions ____ Medications ____Released from care

_____ Date of visit _____Reason for visits ____ Diagnosis

Entity or person(s) authorized to receive this information:

_____ School/Daycare/Preschool _____ Camp _____ Employer_____ Social Worker

_____ Personal Representative's Employer_____ Truant Officer _____ Parole Officer

_____ Family/ Friends

This PHI is being used or disclosed for the following purposes:

_____ Work/School Excuse_____ To verify restrictions _____ Verify return to work/school

This Authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

_____ No longer in school _____ Employment terminated _____ Released from care

_____ Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at **The Children's Clinic, P.A., 1003 West Meeting St., Lancaster, SC 29720**. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization my be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Personal Representative's Authority

(Provide a signed copy of this form to the patient.) created 06/19/17 qc