**Today’s Date:**

**PATIENT INFORMATION:**

First: MI: Last: DOB:

Physical Address: City: State: Zip:

Mailing Address: City: State: Zip:

Primary Phone #: ( ) Alternate Phone #: ( ) SSN:

Gender: Race: **Ethnicity** (circle): Hispanic/Non-Hispanic/Declined **Preferred Language:**

Preferred Pharmacy & Location:

Please list all other children who have been seen in our practice along with their Date of Birth

**PARENT/GUARDIAN INFORMATION:**

**Contact 1** Circle One: Mother / Father / Other - Specify Relationship Lives with Patient? Yes / No

First: MI: Last: DOB:

Address: City: State: Zip:

Primary Phone #: ( ) Alternate Phone #: ( ) SSN:

Email Address: If NO email, please list cell phone carrier:

**Contact 2**

Circle One: Mother / Father / Other - Specify Relationship Lives with Patient? Yes / No

First: MI: Last: DOB:

Address: City: State: Zip:

Primary Phone #: ( ) Alternate Phone #: ( ) SSN:

Email Address: If NO email, please list cell phone carrier:

**EMERGENCY CONTACT INFORMATION:** (to be used in the event parent/guardian cannot be reached)

Name: Phone: ( )

Address: Relationship:

**INSURANCE INFORMATION:** (Insurance card must be presented at each visit.)

**Primary Insurance Name**: Policy #:

Policy Holder Name: DOB:

Policy Holder SSN: Relationship to the Patient:

**Secondary Insurance Name**: Policy #:

Policy Holder Name: DOB:

Policy Holder SSN: Relationship to the Patient:

**How did you First hear about us?** (Circle one)

|  |  |  |  |
| --- | --- | --- | --- |
| * Family Member or Friend
 | * Google Search
 | * Public Event
 | * Walk-In
 |
| * Sibling or Returning Patient
 | * Facebook
 | * Child’s School
 | * Insurance Referral
 |
| * Hospital Personnel
 | * Billboard
 | * Flyer
 | * Other:
 |

**CONSENT FOR MEDICAL TREATMENT**

By signing below, I (for above named patient) do hereby give permission for Children’s International and its physicians, nurse practitioners, and/or their designee(s) to examine and treat my child as necessary in their judgement. I also consent to procedures including but not limited to medical testing, vaccinations, diagnostic evaluation and/or other forms of necessary treatment.

**\_\_\_\_\_\_\_\_\_**

**INITIAL**

**PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.**

Payments are due prior to the patient being seen by the physician/nurse practitioner. This includes copayments, coinsurance, deductibles, payments for noncovered services, as well as any outstanding account balances. Any other payment arrangements should be discussed and agreed upon prior to your appointment. Please note when making payment arrangements that some insurance/Medicaid settlements may not be final, and you may receive additional bills. Health insurance is an agreement between the cardholder and insurance company, and it is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. Although we make every effort to verify coverage and estimate what your insurance company may pay, this is not a guarantee of payment and it is the insurance company that makes the final determination of eligibility. You are fully responsible for any and all charges that your insurance company refuses to pay. Examples of noncovered services may include but are not limited to wart removal, ear irrigation, vaccines, strep test, flu test and urine dips or on occasion preventative medicine visits. It is strongly recommended that the cardholder verify coverage limitations prior to appointment date. Account balances older than 120 may be turned over to an outside collection agency and additional fees will apply.

There are circumstances that might result in a credit to your account**. Please check one below:**

**[ ] I agree OR [ ] I do not agree (check one only) that any refund due back to me for services provided to my child/children, will be allocated to cover my co-pays/deductible in future visits for any patients in which I am responsible for**

**\_\_\_\_\_\_\_\_\_**

**INITIAL**

Prescription refill request will only be addressed during normal office hours and will be sent directly to your pharmacy upon receipt of an electronic request. For nonemergent medical assistance, you may call (985) 768-1253 to reach the nurse on call. In addition, Medicaid and most insurance companies offer 24-hour nurse advice that can be reached by calling the phone number located on your insurance card. In the event of a serious or life-threatening emergency call 911 or proceed to the nearest emergency facility.

By signing below, I acknowledge that I have read, understand and agree to abide by all the above. I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, email, and/or Postal Service including the diagnosis, treatment or examination rendered to my child during the period of treatment for the processing of insurance claims, or to satisfy requirements of managed care organizations of which I am a member. I also authorize the payment of medical benefits directly to Children’s International Medical Group, its physicians, and/or supplier for services rendered all payments for the medical services rendered to my child. I authorize Children’s International to leave or send appointment reminder messages on voicemail, text or email. I also authorize Children’s International to utilize any email address provided to them as a form of communication.

SIGNATURE: DATE:

OFFICE STAFF WITNESS: DATE:

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

We keep a record of health care services we provide to you. You may request to see and receive a copy of that record. You may also ask for correction of that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may request to review your record or get more information about it by contacting our privacy officer, Brittany Frost (985) 646-1580 ext.1007. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices (Revision: 06/15/2017).

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**PERMISSION TO TREAT FOR ALTERNATE CAREGIVERS**

Please complete the section below if you give permission for someone other than the parent(s) or guardian(s) and emergency contact listed above to bring your child to any future appointments and authorize them to make any decisions necessary to have your child treated by Children’s International Medical Group in office or by telephone.

I, , I hereby give my consent to the individuals listed below to discuss and authorize medical treatment in office or over the telephone for my child, . I understand the caregiver will be required to make payments due for each visit. I also understand it is my responsibility to notify Children’s International in writing for any caregiver changes.

Name: Relationship:

Name: Relationship:

Name: Relationship:

Name: Relationship:

By signing below, I acknowledge that I have read, understand, and agree to abide by the above statement.

SIGNATURE: DATE:

OFFICE STAFF WITNESS: DATE:

**PATIENT MEDIA RELEASE**

I, the undersigned, hereby grant Children’s International Medical Group, its representatives and employees, the right to take photographs of me and my child/family. I give permission to Children’s International Medical Group and its affiliates to use my/my child’s name, picture and/or likeness in any manner and in any media for any lawful purpose including but not limited to website entries, Facebook, or other electronic media without payment or any other consideration. I agree that I will not hold Children’s International Medical Group responsible for any liability resulting from the use of my/my child’s name, picture and/or likeness in the manner described above.

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**PATIENT PORTAL**

Our patient portal lets established patients communicate more easily with us but is not intended for ‘Web Visits’ or new problems. Instead, it will make regular communication and access to health information more flexible. The portal uses encryption to keep messages and information secure and can only be accessed by someone who knows the right password to log into the portal site. Usage is voluntary and free of charge. DO NOT SEND ANY MESSAGES REQUIRING URGENT ATTENTION USING THE PATIENT PORTAL, and if experiencing an emergency, dial 911 or go to the nearest Emergency facility.

I acknowledge that I have read and fully understand this consent form. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the patient portal.

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