CHILDREN'S MEDICAL GROUP, P.A.

NEW PATIENT INFORMATION FORM

Appointment Date: _____Time: _____Chart #: _____

Patient's Full Name: _____
Address: _____
_____
City State Zip
Primary Phone #: _____ Date of Birth: _____
Sex: M ____F ____ Ethnic Origin: _____
Birth Hospital: _____ Birth Wt: _____Lgth: _____

Father's Name: _____ SS#: _____
Employer: _____ Employer Ph#:_____
Mother's Name: _____ SS#: _____
Employer: _____ Employer Ph#:_____
Father's Cell #: _____ Mother's Cell #:_____
Contact Email: _____

Responsible Party/Bill to (Parent/Guardian):_____
Address/Phone# (if different from patient's): _____
_____
Primary Insurance Carrier: _____
Claims Address:_____
_____ Phone #: _____
Insured's Name:_____ Date of Birth:_____
ID#:_____ Group #: _____
Secondary Insurance Carrier: _____
Claims Address:_____
_____ Phone #: _____
Insured's Name:_____ Date of Birth: _____
ID#:_____ Group #: _____

Other Children at Home Under 18 Yrs. _____
_____
_____
_____

For record keeping purposes, please indicate which office and which doctor you will primarily use:
_____Jackson location Physician_____
_____Clinton location Physician_____
_____Madison location Physician_____

X_____
Signature of Patient/Parent/Legal Guardian

Appointment Reminder Text Messaging: (only 1 number allowed per family)
Text **CMGMS** to **622622** to receive appointment reminders via text message.
Cell number used: _____

GENERAL CONSENT FOR MEDICAL CARE, TREATMENT AND TESTING:

I do hereby voluntarily consent to such care encompassing diagnostic and therapeutic procedures and medical treatment as may be ordered by my/my child's physician or designees, as is necessary in their judgment. I understand that I am free to ask questions at any time, and that I may discuss my questions and receive answers in language I understand and to my understanding prior to receiving any such treatment.

MEDICARE AND/OR MEDICAID:

I hereby request that payment of authorized Medicare/Medicaid benefits to me or on my behalf for services furnished to me in or by Children's Medical Group, P.A., if applicable, be made to Children's Medical Group, P.A. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that certain services may not be covered under the Medicare/Medicaid program and that I may be responsible for the entire charge incurred for such services. I also understand all deductibles/copays are due unless they have been met within the period specified by Medicare.

INSURANCE:

I hereby assign to Children's Medical Group, P.A. all rights, benefits and interest under any insurance policy, health plan, Workers' Compensation or other third party liable to me, in consideration for services rendered by Children's Medical Group, P.A. I hereby authorize payment directly to Children's Medical Group, P.A. of all third-party liability insurance coverage, third party payor health plan, and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury, or illness for which I received treatment at Children's Medical Group, P.A.

RELEASE OF INFORMATION:

I authorize Children's Medical Group, P.A. as holders of medical or other information about me/my child to release to insurance companies, health plans, Medicare or Medicaid, agencies or representatives of any companies handling my/my child's claims any information needed for this or any other claims.

PATIENT RESPONSIBILITY:

I understand that I am financially responsible to Children's Medical Group, P.A. for all physician fees, tests, x-rays, and other such treatment ordered by the physician and further agree to pay any collection or attorney fees which may occur as a result of non-payment for treatment rendered by Children's Medical Group, P.A. I understand that payment is due when services are rendered.

I also understand that Children's Medical Group, P.A. shall bill all insurance companies and third-party payers if they are contractually obligated to do so. If my insurance fails to pay for any services provided to me/my child, I hereby acknowledge that I am responsible for any unpaid balances that are deemed my responsibility by Medicare, Medicaid, or other third-party payers. Furthermore, I understand I am responsible for any co-payment, co-insurance amounts and/or deductibles.

REFERALS:
I understand that if my insurance requires a referral that Children's Medical Group, P.A. will need at least twenty-four (24) hours to complete my referral.

NO SHOW FEE:
I understand that if I miss a scheduled appointment, I will be charged a $25 "no show" fee. I also understand that the "no show" fee will not be billed to my insurance and that I will be financially responsible for paying the fee.

MEDICAL RECORDS FEE:
I understand that if I want copies of my/my child's medical records or there may be a fee unless they are being sent to another physician.

FORMS FEE:
I understand that there is a $5.00 processing fee for the completion of patient forms (immunization/121, camp physicals, sports physicals, etc.) outside of a normal office visit.

** A person 18 years old or younger is considered a minor. If you are under 18 years old or younger, this form must be signed by your parent or legal guardian.

I hereby certify that I have read and understand this form and I accept all its terms.

_____ **X**_____
Date Signature of Patient

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

Address of Parent/Legal Guardian _____
Street City State

_____
Zip Code Phone #

_____ _____
Clinic Record No. Email address

PATIENT AUTHORIZATION
FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

By signing this authorization, I authorize Children's Medical Group, P.A. ("CMG") to use and/or disclose certain protected health information (PHI) about me/my child to or for the party or parties listed below:

_____

_____

_____

I understand this authorization is at my request and this authorization permits CMG to disclose to my designee the following individually identifiable health information. I understand this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel) (please initial all that apply):

Release these records: (Check only one)	**Initials**
1. Only records generated by CMG (not including records from other sources)	_____
2. All medical records at CMG including records from other clinics/doctors	_____
3. Only some portion of records maintained at CMG (date of treatment, etc. or specify below)	_____

For #3 above, please indicate dates of treatment for which medical information is needed for release, or specific forms (ex. Vaccinations, camp health forms, sports participation, school or work excuses, school medication administration forms, or college health admission forms if under 17 years of age)

_____

_____

_____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize CMG to release the information specified to the individual who I have indicated above, with the **exception** of: (PLEASE INITIAL EXCEPTION)

_____ Substance abuse, if any
_____ AIDS/HIV, if any _____ Other (please specify) _____

This authorization will expire on patient's 18th birthday unless otherwise noted.

When my or my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CMG has acted in reliance upon this authorization. My written revocation must be submitted to Children's Medical Group, P.A.'s Privacy Officer at 1867 Crane Ridge Drive, Suite 101-B, Jackson, Mississippi 39216.

_____ _____
Person Authorized to Sign for Patient (Print Name) Relationship to Patient
(If patient is 18 years or older, he/she must sign this form.)

_____
Phone #

X_____ _____
Signature of Authorized Person Date

For more information on Patient Authorizations, see the Children's Medical Group, P.A. Patient Notice. The Children's Medical Group, P.A. Patient Notice is subject to change. The Children's Medical Group, P.A. Patient Notice can be obtained from the Clinic Manager, any Children's Medical Group P.A. location or online at www.childrensmedicalgroup.net.

PERMISSION FOR TREATMENT FORM

I give the following people listed below permission to seek medical attention for my child.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

X_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Clinic Record Number

PATIENT NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Children's Medical Group is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Children's Medical Group is required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice in the clinic waiting room and will make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will securely store your medical information on a computer for use as part of rendering patient care. For example, your medical information may be used by the health care professional treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality and appropriateness of the care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- 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.
- We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination or the Clinic's compliance with relevant laws.
- Unless you object, we may disclose to family members, other relatives or close personal friends the medical information directly relevant to such person's involvement with your care.

- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.
- We may disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
- We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.
- We may disclose your medical information for law enforcement purposes or other specialized governmental functions.
- We may disclose your medical information to a coroner, medical examiner or a funeral director.
- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
- We may disclose your medical information for certain research purposes.
- We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to you medical information.

- The right to request restrictions on certain uses and disclosures of your medical information. We are not required to agree to your requested restriction, but if we do, we will honor it. We are, however, required to agree to your request to restrict the disclosure

of medical information from your insurance company if that medical information relates to treatment or services for which you have paid us out-of-pocket, in full.

- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information in the six years prior to your request, except for disclosures for treatment, payment or clinic operational purposes, and for certain other specific disclosure types. If we maintain your medical information in an electronic format, you also have the right to obtain an accounting of the disclosures for treatment, payment, or clinic operational purposes that have occurred in the prior three (3) years.
- The right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- The right to complain to the Privacy Officer of the clinic and/or to the United States Department of Health and Human Services if you believe that the clinic has violated your privacy rights. If you choose to file a complaint you will not be retaliated against in any way.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact our administrator at:

CHILDREN'S MEDICAL GROUP, P.A.
1867 CRANE RIDGE DRIVE
SUITE 101B
JACKSON, MS 39216
(601) 362-8776

THIS NOTICE IS EFFECTIVE AS OF 07/01/2012.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE / PRIVACY POLICY

I, (patient / parent / legal guardian) _____,

do hereby acknowledge that I have received a copy of the Patient Notice / Privacy Policy of Children's Medical Group, P.A.

[Must be 18 years or older to sign]

_____ _____
Patient Name Date

X_____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient