Columbus Regional Health Network

Advanced Pediatrics & Family Care
36 McNeill Plaza
Whiteville, NC 28472
(P) 910-640-4064 • 910-641-8660 • (F) 910-640-4063

FAMILY INFORMATION FORM

Patient Name:
First Middle Last Nickname Date of Birth Social Security # Gender (Circle one)

_____ Boy / Girl

Child's Address: _____
PO Box or / Street Address City State Zip Code

Main Adult Contact for Child	Alternate Adult Contact for Child
Name:	Name:
Relation to Child: ☐ Mother ☐ Father ☐ Other:	Relation to Child: ☐ Mother ☐ Father ☐ Other:
Address: ☐ Same as child's address Street Address: _____ City: State: Zip Code:	Address: ☐ Same as child's address Street Address: _____ City: State: Zip Code:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Social Security#: Date of Birth:	Social Security#: Date of Birth:
Email:	Email:
Employer:	Employer:
Work Phone:	Work Phone:

Pharmacy: _____

Race: _____

Foster Child? ☐ Yes ☐ No Foster Guardian: _____

DSS Custody? ☐ Yes ☐ No Assigned Contact: _____

Custody or Legal Documents in place? ☐ Yes ☐ No (Please Provide)

Hospital child was born: _____

The Child's parents are:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Living together, not married ☐ Widowed ☐ Unknown ☐ Child is adopted

CASE OF EMERGENCY, THE OFFICE SHOULD CALL: _____ Phone #: _____
(Name & Relationship)

As a parent, I understand that I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Advanced Pediatrics.

If I cannot come with my child, I agree to let _____
(Name & Relationship) (Phone#)

and/or _____ seek medical treatment for my child.
(Name & Relationship) (Phone #)

(Examples of persons to name here may be stepparent, grandparent, sitter, etc.)

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature giving permission for treatment.

Are there any court orders of legal documents involving your child that we should know about? ☐ Yes ☐ No

Signature of adult completing this form: _____ Print Name: _____

CHILD'S NAME:_____ DATE: _____

PATIENT AND FAMILY HISTORY

1. What medical problems does the child have? What medical problems do people in the child's family have?

Medical Problems:	**Who has the medical problem** (please circle):
Birth Defects	Child Mother Father Other:
Obesity (Overweight)	Child Mother Father Other:
Congenital Hearing Loss / Hearing Problems	Child Mother Father Other:
Mental Retardation	Child Mother Father Other:
Migraine Headaches	Child Mother Father Other:
Allergies	Child Mother Father Other:
Asthma (Trouble Breathing)	Child Mother Father Other:
Heart Disease or Heart Problems (Murmur, Hole in Heart)	Child Mother Father Other:
Sudden Death of Infant / Baby	Child Mother Father Other:
Arthritis (Pain in the Joints)	Child Mother Father Other:
AIDS	Child Mother Father Other:
Cancer	Child Mother Father Other:
Thyroid Problems	Child Mother Father Other:
Diabetes (Sugar)	Child Mother Father Other:
Muscular Dystrophy	Child Mother Father Other:
Cystic Fibrosis	Child Mother Father Other:
Anemia (Low Iron in the Blood)	Child Mother Father Other:
Sickle Cell Disease	Child Mother Father Other:
Epilepsy (Seizures)	Child Mother Father Other:
Crohn's Colitis (Stomach or Bowel Problems)	Child Mother Father Other:
ADD / ADHD (Have trouble paying attention or sitting still)	Child Mother Father Other:
Skin Problems (Acne, Flaking, Rashes)	Child Mother Father Other:
Cerebral Palsy	Child Mother Father Other:
Other (Please List):	Child Mother Father Other:

If other please specify

2. Check all the people that the child lives with:

❒ Mother ❒ Father ❒ # Brothers _____ ❒ # Sisters _____

❒ Other family members (list: _____)

❒ Friends or other people (list: _____)

❒ Animals: ❒ Dogs ❒ Cats ❒ Other animals (list: _____)

ABOUT MOM WHEN PREGNANT

The next questions are about the mother of the child during pregnancy and birth.
If you do not know about the pregnancy of the mother, check here ❒.

12. Did the mother use any of the following **during pregnancy**?
    - ❒ Cigarettes
    - ❒ Alcohol
    - ❒ Illegal drugs (which ones? _____)
    - ❒ Prescription drugs (which ones? _____)
    - ❒ None of these were used by the mother during pregnancy.

13. Did the mother have any of these **conditions or problems during pregnancy**?

    ❒ Preeclampsia (High Blood Pressure) ❒ Diabetes (Sugar)

    ❒ Emotional Stress ❒ Injury or Serious Illness

    ❒ Unexpected Bleeding or Spotting ❒ Other _____

14. **Was the birth:**
    - ❒ On the due date
    - ❒ Before the due date (by how much _____)
    - ❒ After the due date (by how much _____)

15. Was the baby born by C-Section (Surgical cut in the tummy)? ❒ Yes ❒ No

16. Were there any **problems during the birth**? ❒ Yes ❒ No

    If yes, please explain: _____

17. Siblings? ❒ Yes ❒ No Which provider would you prefer? _____

    If yes,

Names (Please list)	DOB:
_____	_____
_____	_____
_____	_____

18. Patient Portal Access:

    email address: _____

    Zip code (temporary password): _____

Columbus Regional Health Network

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

Thank you for choosing Columbus Regional Health Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare cost as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the Mastercard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles, & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. If you arrive without your card, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Columbus Regional Health Network participate with **Traditional Medicare (Part A & Part B)** and a limited number of private fee-for-service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for -Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductible and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co--pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will your claim

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

Columbus Regional Health Network

Acknowledgement Form

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____

Relationship to Patient: _____ Self_____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

Acknowledgement Form
Documento De Reconocimiento De Columbus Regional Health Network

Numero de Registro Medico _____

Nombre del Paciente: _____ Fecha de Nacimento ____/____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____

Relacion al Paciente: _____ Misco _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Fixmar: _____

_____

Columbus Regional Health Network - Pediatrics

Authorization for Consent to Medical Treatment of Minor Child
Consent for Communication for Involvement of Care

I, the understand, do hereby consent and request that Columbus Regional Health Network communicate with or release health information concerning me, if communication is in my best interest and is only information that is directly relevant to designed individual's involvement with my health care and treatment decisions.

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Name, Address, Phone #: _____

1. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to patient: _____

Address: _____

Phone #: _____

2. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to patient: _____

Address: _____

Phone #: _____

3. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to patient: _____

Address: _____

Phone #: _____

_____ _____

Signature of Patient or Authorized Party/Date **Name Printed**

* I **DO** grant consent for the above persons to be given information regarding patient's health care or treatment. I also consent for all medical and/or surgical treatment that may be required for our child during our absence.

_____ _____

Signature of Patient or Authorized Party/Date **Name Printed**

* I do **NOT** consent for the above persons to be given information regarding patient's health care or treatment unless required by law. I do **NOT** consent for all medical and/or surgical treatment that may be required for our child during our absence.

Staff Signature/Witness: _____ Date: _____

Columbus Regional Health Network - Pediatrics

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per From)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: ( ) _____

Email Address: _____

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s))	_____ (Name of facility, person, company) (Relationship)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

Purpose of Release (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment Dates: From _____ To _____
Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (Check all that may apply):
- ☐ Hospital Summary
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Laboratory Reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology Reports
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Other _____
- ☐ Entire Record (Not including psychotherapy notes)

Office/Clinic (Check all that may apply):
- ☐ Office/Clinic Summary
- ☐ Office Visits
- ☐ Physical Exam
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Other _____
- ☐ Entire Record (Not including psychotherapy notes)

FORMAT:
- ☐ CD
- ☐ Email Address noted above, where permitted
- ☐ Paper Copy (charges may apply)
- ☐ Other _____

DELIVERY METHOD
- ☐ Reg. US Mail ☐ Pick-up ☐ Fax, where permitted
- ☐ Overnight/Express Mail Service, where permitted
- ☐ Secure email
- ☐ Other _____ IF MORE THAN 25 PAGES, PLEASE MAIL

PATIENT'S RIGHTS - I understand that:
- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- CRHS will not share or use my health information without my permission other than by ways listed in CRHS's Notice of Privacy Practices or as required by law. The Notice of Privacy is available at crhealthcare.org.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here : _____

Signature: _____ Print Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May Be Requested):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney In Fact ☐ Spouse ☐ Parent
☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ Print Name: _____ Date: _____

Authorization given to patient / Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____ ☐ ID Verified ☐ DL/Other ID _____

CRHS Employee Name & Title: _____ **CRHS Employee Signature:** _____ **DAte:** _____