Today's Date:____________________

Who is filling out this form?

☐ Mother ☐ Father

☐ Other Guardian:____________________
(explain relationship to child)

☐ Other (please explain____________________

Southeast Pediatrics
Columbus Regional Health Network

FAMILY INFORMATION FORM

Please list all your dependent children on this form.

CHILDREN'S NAMES:

FIRST	MIDDLE	LAST	NICKNAME	DATE OF BIRTH	SOCIAL SECURITY #	GENDER Circle One
						Boy / Girl
						Boy / Girl
						Boy / Girl
						Boy / Girl
						Boy / Girl

CHILD'S ADDRESS: ____
STREET ADDRESS CITY STATE ZIP CODE

The child's parents are:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Living together, not married ☐ Widowed ☐ Unknown ☐ Child is adopted

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:	Address: ☐ Same as child's address Street Address: ____________________ City: State: Zip:
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:

CASE OF AN 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 Southeast Pediatrics.

I cannot come with my child, I agree to let ____________________ **and/or** ____________________
(Name & Relationship) (Name & Relationship)
I've permission for any treatment including shots.

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 or legal documents involving your child that we should know about? ☐ **Yes** ☐ **No**

Signature of adult completing this form: ____________________ **Print Name:** ____________________

CHILD'S NAME: ______________________ DATE OF BIRTH: ____________

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	Brother/Sister	Grandparent
Obesity (Overweight)	Child	Mother	Father	Brother/Sister	Grandparent
Congenital Hearing Loss / Hearing Problems	Child	Mother	Father	Brother/Sister	Grandparent
Mental Retardation	Child	Mother	Father	Brother/Sister	Grandparent
Migraine Headaches	Child	Mother	Father	Brother/Sister	Grandparent
Allergies	Child	Mother	Father	Brother/Sister	Grandparent
Asthma (Trouble Breathing)	Child	Mother	Father	Brother/Sister	Grandparent
Heart Disease or Heart Problems (Murmur, Hole in Heart)	Child	Mother	Father	Brother/Sister	Grandparent
Sudden Death of Infant / Baby	Child	Mother	Father	Brother/Sister	Grandparent
Arthritis (Pain in the Joints)	Child	Mother	Father	Brother/Sister	Grandparent
AIDS	Child	Mother	Father	Brother/Sister	Grandparent
Cancer	Child	Mother	Father	Brother/Sister	Grandparent
Thyroid Problems	Child	Mother	Father	Brother/Sister	Grandparent
Diabetes (Sugar)	Child	Mother	Father	Brother/Sister	Grandparent
Muscular Dystrophy	Child	Mother	Father	Brother/Sister	Grandparent
Cystic Fibrosis	Child	Mother	Father	Brother/Sister	Grandparent
Anemia (Low Iron in the Blood)	Child	Mother	Father	Brother/Sister	Grandparent
Sickle Cell Disease	Child	Mother	Father	Brother/Sister	Grandparent
Epilepsy (Seizures)	Child	Mother	Father	Brother/Sister	Grandparent
Crohn's Colitis (stomach or bowel problems)	Child	Mother	Father	Brother/Sister	Grandparent
ADD / ADHD (have trouble paying attention or sitting still)	Child	Mother	Father	Brother/Sister	Grandparent
Skin Problems (Acne, Flaking, Rashes)	Child	Mother	Father	Brother/Sister	Grandparent
Cerebral Palsy	Child	Mother	Father	Brother/Sister	Grandparent
Other (Please List):	Child	Mother	Father	Brother/Sister	Grandparent

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

☐ Mother ☐ Father ☐ Brothers and Sisters (how many? ________)

☐ Other family members (list:______________________________)

☐ Friends or other people (list:____________________________)

☐ Animals: ☐ Dogs ☐ Cats ☐ Other animals (list:________________)

3. Has your child ever been a **patient in a hospital** (other than a few days after birth)?
   - ☐ No (Go to Question #5)
   - ☐ Yes (Explain why and when below):

My child was in the hospital because:	When:
Example: *Bike Accident*	*5 Years Old*

4. Is your child taking any **prescription medicines**?
   - ☐ Yes – Please list the child's medicines below or ☐ I brought my child's medicines
   - ☐ No, my child does not take any prescription medicines. (Go to Question #6)

Name of Medicine	Amount / size of pill	How many pills or doses does your child take at:
Example: *Dexedrine*	*10 mg*	_1_ morning ___ noon ____ dinner ____ bedtime
		___ morning ___ noon ____ dinner ____ bedtime
		___ morning ___ noon ____ dinner ____ bedtime

5. What **over-the-counter** medicines does your child take?
   - ☐ Vitamins
   - ☐ Herbal Medicines (Please list:______________________________)
   - ☐ Other (Please list:______________________________)
   - ☐ None – my child does not take any over-the-counter medicines.

6. Does you child have any **allergic reactions (bad effects)** from any of the following? Check all that apply:
   - ☐ Outdoor or Indoor allergies (for example: grass, pollen, cats, bee stings....)
   - ☐ Food Allergies (for example: milk, peanuts, wheat....). Please list below.
   - ☐ Medicines or shots (immunizations). Please list below.
   - ☐ No, my child has no allergies that I am aware of. (Go to Question #8)

Medicine or food that child is allergic to:	What happens when the child eats that food or takes that medicine?
Example: *Penicillin*	*Big red spots on skin (Hives)*

7. Does the child go to **school or daycare**?
   - ☐ No
   - ☐ Yes (Name of school or daycare facility: ______________________________)

8. Does the child live with anyone who smokes? ☐ Yes ☐ No

9. Does the child smoke? ☐ Yes ☐ No

10. What type of water is used in the child's house? ☐ City Water ☐ Well Water

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 ☐.

11. 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

12. Did the mother have any of these **conditions or problems during pregnancy**?
    - ☐ Preeclampsia (High Blood Pressure)
    - ☐ Emotional Stress
    - ☐ Unexpected Bleeding or Spotting
    - ☐ Diabetes (Sugar)
    - ☐ Injury or Serious Illness
    - ☐ Other ____________________

13. **Was the birth:**
    - ☐ On the due date
    - ☐ Before the due date (by how much ______________________)
    - ☐ After the due date (by how much ______________________)

14. **Was the baby born by C-Section** (surgical cut in the tummy)? ☐ Yes ☐ No

15. Were there any **problems during the birth**? ☐ Yes ☐ No

    If yes, please explain: ____

Consent for Communication for Involvement of Care

I, the undersigned, do herby consent and request that Southeast Primary Care communicate with or release health information concerning me, if communication is in my best interest and is only information that is directly relevant to designated individual's involvement with my health care and treatment decisions.

Patient's Name ______________________________ DOB ____________

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 Printed Name

I do not grant consent for anyone to be given information regarding my health care or treatment except required by law.

____________________________ ______________________

Signature of Patient or Authorized Party/Date Printed Name

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: ____________________
(Patient or Authorized Representative)

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 Nacimiento _____/_____/_____
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: ________________________________
(Paciente o Representante Autorizado)

Relacion al Paciente: ________ Mismo _________ Esposo (a) __________ Otro ____________

Razon Por la Cual El Paciente No Puede/No Desea Firmar: _______________________________

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 costs 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 deductibles 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 file 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.

MEDICAID may not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have insurance coverage.** Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient Guardian Name ____

Patient Guardian
Signature ________________________________ Date ________________

COLUMBUS REGIONAL HEALTHCARE SYSTEM-SOUTHEAST PEDIATRICS
612-36 Jefferson Street Whiteville, North Carolina 28472
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Phone: 910-640-4064
Fax: 910-640-4063

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

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ Last 4 numbers of SSN: ______________________

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

Email address: ______________________

Release Information From:

____

(List applicable Facility(s) and/or Practice(s)

____

____

(Phone number) (Fax number)

Release Information To:
SOUTHEAST PEDIATRICS
612-36 JEFFERSON STREET
WHITEVILLE NC 28472

910-640-4064 910-640-4063

(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 (charges may apply)
☐ 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: ______________

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 Practices 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:** ______________