Coastal Children's Clinic

New Bern
Havelock
Maysville

Verified Initial and Date	Chart #

FAMILY INFORMATION SHEET

MOTHER'S NAME (last, first, maiden) _____ SOC SEC # _____

RACE _____ Preferred Language _____ Date of Birth _____

MAILING ADDRESS: _____ (Street or P. O. Box) _____ (City) _____ (State) _____ (Zip Code)

PHYSICAL ADDRESS: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)
(If different)

HOME PHONE #: _____ CELL# _____ WORK PHONE #: _____

EMAIL _____ PREFER APPT CONFIRM BY Phone Text (circle choice)

FATHER'S NAME (last, first, middle) _____ SOC SEC # _____

RACE _____ Preferred Language _____ Date of Birth _____

MAILING ADDRESS: _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip Code)

PHYSICAL ADDRESS: _____
(If different)

HOME PHONE#: _____ CELL# _____ WORK PHONE #: _____

EMAIL _____ PREFER APPT CONFIRM BY Phone Text (circle choice)

EMERGENCY CONTACT PERSON
OTHER THAN PARENT OR GUARDIAN: _____ RELATIONSHIP TO CHILD/REN: _____

MAILING ADDRESS: _____ (Street or P.O. Box) _____ (Apt. #) _____ (City) _____ (State) _____ (Zip Code)

HOME PHONE #: _____ CELL OR WORK PHONE#: _____

Children's Full (First Middle Last) Name	Date of Birth	SS #	Race	Sex	

I also give the person/s listed below my full permission to seek medical care from a Coastal Children's Clinic physician including, but not limited to: injections, laceration repair, prescriptions, general medical care, and emergency medical care for my children as the situation warrants. (This allows the named grandparents, baby sitters, etc. to bring in your child.)

_____ _____ _____

_____ _____ _____

PLEASE READ AND SIGN REVERSE PAGE

PATIENT CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

[as required by HIPAA Regulation]

With my consent, **Coastal Children's Clinic, Inc.** may use and disclose protected health information about my child / children to carry out treatment, payment and healthcare operations. Please refer to Coastal Children's Clinic, Inc.'s Notice of Privacy Policies for a more complete description of such uses and disclosures.

The Notice of Privacy Practices has been made available to me and I have the right to a copy if I so desire. Coastal Children's Clinic, Inc. reserves the right to revise its Notice of Privacy Policies Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Coastal Children's Clinic, Inc., Privacy Officer, 703 Newman Road New Bern, NC 28562.

With my consent, Coastal Children's Clinic, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Coastal Children's Clinic, Inc. may mail my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Coastal Children's Clinic, Inc. may email or text my appointment reminder cards and patient statements. I have the right to request that Coastal Children's Clinic, Inc. restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I hereby assign to Coastal Children's Clinic, Inc. all payments for medical services rendered to myself or to my dependents. I understand I am responsible for any amount not paid by my insurance company (ies). I am responsible for all services performed by the medical staff. I am responsible for all services deemed not covered or denied by my insurance company. Any copayment or deductible is due at the time of the visit. I authorize the use of a photocopy of this assignment in lieu of the original by my signature below. If for any reason it becomes necessary to send the financial balance on the account for collections, the expense incurred will be charged to the patient's account.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Coastal Children's Clinic, Inc. may decline to provide treatment to me.

_____ _____

Print Name of Mother or Legal Guardian | Print Name of Father or Legal Guardian

_____ _____

Signature of Mother or Legal Guardian | Signature of Father or Legal Guardian

Date _____ Date _____