PATIENT REGISTRATION

Dr. Karen Harum, M.D., FAAP

Attached is necessary paperwork to start you and your child's process at the Clinic for Special Children. We ask that you pay close attention to the following instructions so that we can make sure this process is appropriately and efficiently handled! Please make sure that all the following information is filled in:

-Be sure all **demographics** are filled in (names, addresses, date of birth).
-Be sure to add **contact information** (numbers, emails, etc.) so that we can contact you.
-Be sure to complete all **bolded questions** (email, zip codes, contact information).
-Please provide us with your **Medicaid/Insurance** information, so that we are able to verify it prior to your scheduled appointment.
-Be sure to fill out **pharmacy / zip code** and **primary care physician.**
-Be sure to **sign all** of the important documents.

Thank you for choosing the Clinic for Special Children with Dr. Karen Harum M.D., FAAP.

Please contact our office if you have any further questions or concerns at

(910)319-7744

Or

csc@clinicforspecialchildren.net

Pediatric Patient Registration

Patient ..... Sex ❑ M ❑ F DOB..... SS#.....

Mother ..... DOB ..... SS#.....

Address ..... Home # ..... Cell # .....

City/State/Zip..... **Email**.....

Employer ..... Work #.....

Father ..... DOB ..... SS#.....

Address ..... Home # ..... Cell # .....

City/State/Zip..... **Email**.....

Employer ..... Work #.....

Children live with: ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other .....

Primary Care Physician..... Phone #.....City.....

Pharmacy.....Phone **#** .....**Zip Code**.....

Emergency Contact..... Relation..... Phone # .....

How did you hear about our practice? .....

Insurance Information

Name of Insured..... DOB .....Relation.....

Primary ..... Claim Address.....

Policy #..... Group#.....Co-pay .....

Secondary ..... Claim Address.....

Policy #..... Group#.....Co-pay .....

Authorization of Treatment and Assignment of Benefits

I authorize Dr. Karen Harum, MD-FAAP, to treat my child. I further authorize release of medical information necessary for the completion of insurance forms. I authorize payment directly to Clinic for Special Children for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following individuals; _____. I understand that if my child's physician, or any person employed by or under the direction or control of my child's physician, is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines of the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's bodily fluids.

....
Parent/Guardian Signature Relationship Date

....
Witness Signature Date

Clinic for Special Children

Developmental Questionnaire

Child's name:..... Sex: ❑ M ❑ F Date of Birth:___/___/_____
Address:..... Phone: .....
City/State/Zip: ..... Cell: .....
.....
Person answering questions: ..... Relationship to patient:.....
Address (*if different*): ..... Phone: .....
City/State/Zip: ..... Cell: .....
.....
Why are you seeking help for this child?.....
.....
.....
.....
Who referred you to our service?.....
What kind of services are you seeking for this child (e.g.: *diagnosis, medication management, change of school placement, therapy, psychological testing, custody, evaluation, etc.*)?.....
.....
.....
.....
Mother's Name:..... Stepmother? ❑ Yes ❑ No
Address (*if different*): ..... Phone: .....
City/State/Zip: ..... Cell: .....
Occupation: ..... Employer: .....
Highest grade/degree completed: .....
Father's Name: ..... Stepfather? ❑ Yes ❑ No
Address (*if different*): ..... Phone: .....
City/State/Zip: ..... Cell: .....
Occupation: ..... Employer: .....
Highest grade/degree completed: .....
Does this child have any other parent(s) Stepparents(s)? ❑ Yes ❑ No
Address (*if different*): ..... Phone: .....
City/State/Zip: ..... Cell: .....
Occupation: ..... Employer: .....
Highest grade/degree completed: .....
With what adults does this child live?.....
How long in current living situation?..... Child's primary caregiver?.....
If primary caregivers work outside the home, please provide the following information:
Who cares for this child when caregivers are gone?.....
How many hours per day is this child in a child-care setting?.....
Has this child ever experienced any parental separations, divorces, or death? ❑ Yes ❑ No
If yes, when? ..... Child age at the time?.....

Please describe the circumstances:.....
If parents are separated or divorced who has custody of this child?.....
How often does the other parent see this child? ❑ Weekly or more often
❑ Once or twice a month ❑ Few times a year ❑ Never
Please list all brothers and sisters, and any other children living with the family:

Age	Gender	Relationship to this child	Living at home?

How does this child get along with brother(s) and /or sisters? .....
.....

I. Family Relations

Check the activities in which this child often participates with the family:
❑ Movies ❑ Meals ❑ Conversations ❑ Visits with relatives
❑ Church ❑ Games ❑ Sports ❑ Trips ❑ Television
❑ Other .....

How frequently does this child see grandparents?
❑ Weekly or more often ❑ Once or twice a month ❑ Few times a year ❑ Never
No grandparents living ❑ Yes ❑ No
What do you find most difficult about raising this child? .....
.....
.....
What would you like this child to be when he/she grows up? .....
.....

What level of education do you hope this child will complete?
❑ High School ❑ College ❑ Technical or vocational school
Who is mainly in charge of discipline in the home?.....
Do all caregivers agree on discipline?.....
Describe discipline techniques:.....
.....
.....

Friendship
Please indicate how this child relates to other children.
Has problems relating to our playing with other children? ❑ No ❑ Yes
If yes, describe: .....
Fights frequently with playmates ❑ No ❑ Yes
Prefers playing with younger children ❑ No ❑ Yes
Has difficulty making friends ❑ No ❑ Yes
Prefers to play alone ❑ No ❑ Yes

Are there children in the neighborhood with whom this child could play? ❑ No ❑ Yes
What role does this child take in peer group games (for example: aggressor, leader, victim, etc.)?

.....

Recreation / Interests
What activities does this child enjoy?
Sports:.....
Hobbies: .....
Other:.....
Has this child's interest in participating in these activities declined recently? ❑ No ❑ Yes
If yes, describe: .....

Behavior / Temperament
Please indicate whether this child exhibits any of the following behaviors:

Is easily over stimulated in play:	❑ No	❑ Yes	Seems overly energetic in play:	❑ No	❑ Yes
Has a short attention span:	❑ No	❑ Yes	Seems impulsive:	❑ No	❑ Yes
Lacks self-control:	❑ No	❑ Yes	Overreacts when facing problems:	❑ No	❑ Yes
Seems unhappy most of the time:	❑ No	❑ Yes	Uncomfortable meeting new people:	❑ No	❑ Yes
Hides feelings:	❑ No	❑ Yes	Requires a lot of parental attention:	❑ No	❑ Yes
Withholds affection:	❑ No	❑ Yes	What makes this child angry?		
Has fears:	❑ No	❑ Yes	Describe:.....		

.....

Adaptive Skills
Please indicate whether this child has the following skills:

Dresses self:	❑ No	❑ Yes	Bathes self:	❑ No	❑ Yes
Helps with household chores:	❑ No	❑ Yes	Has good table manners:	❑ No	❑ Yes
Buys gifts or presents for others	❑ No	❑ Yes	Can get help or find home if lost:	❑ No	❑ Yes
Says "please" and "thank you"	❑ No	❑ Yes	Tells time accurately:	❑ No	❑ Yes
Receive an allowance:	❑ No	❑ Yes	If yes, how does he/she spend it?		

.....

II. Educational History

Preschool
Does or did this child attend preschool? No Yes At what age?.....
School:..... Teacher:.....
Amount of time per day: ..... Days per week:.....

Elementary / High School
Please indicate whether this child has had any of the following school experiences:
Has changed schools for reasons other than normal academic progression? ❑ No ❑ Yes
Has repeated a grade? ❑ No ❑ Yes If yes, when and why?.....
.....
Has skipped a grade in school? ❑ No ❑ Yes If yes, when and why?.....
.....
Has difficulty with reading? ❑ No ❑ Yes If yes, describe: .....
.....
Has difficulty with math? ❑ No ❑ Yes If yes, describe: .....

Gets poor grades? ❑ No ❑ Yes
Describe most recent report card results: .....
Been tested for special education? ❑ No ❑ Yes If yes, when .....
Currently in special education class? ❑ No ❑ Yes
If yes, what type of class? ..... Hours per day: .....
Other services (OT, SPT, PT) ❑ No ❑ Yes Which? .....
Date of last revised IEP:.....
Dislikes going to school? ❑ No ❑ Yes
Is absent from school frequently? ❑ No ❑ Yes If yes, why? .....
If in high school, when will this child graduate? .....
Do you have any concerns about the quality of this child's school or teachers? ❑ No ❑ Yes
If yes, describe: .....

III. Development

At what age did this child first do the following? Indicate age / year / month.

Turn over: ..... Sit alone:.....
Crawl: ..... Stand alone: .....
Walk alone: ..... Walk up stairs:.....
Walk down stairs:..... Show interest in or attraction to sound:.....
Understand first words: ..... Speak first words:.....
Speak in sentences:.....
Was this child breast-fed? ❑ No ❑ Yes When weaned? .....
Was this child bottle-fed? ❑ No ❑ Yes When weaned? .....
When was this child toilet trained? Days:..... Nights: .....
Has this child experienced any of the following problems? If yes, please describe.
Walking difficulty ❑ No ❑ Yes .....
Unclear speech ❑ No ❑ Yes .....
Feeding problem ❑ No ❑ Yes .....
Underweight problem ❑ No ❑ Yes .....
Overweight problem ❑ No ❑ Yes .....
Colic ❑ No ❑ Yes .....
Sleep problem ❑ No ❑ Yes .....
Difficulty with sleep onset ❑ No ❑ Yes Difficulty with sustained sleep? ❑ No ❑ Yes
Duration of sleep? ❑ No ❑ Yes Sleep schedule? .....
Difficulty learning to ride bike ❑ No ❑ Yes .....
Eating disorder ❑ No ❑ Yes .....
Learning to skip ❑ No ❑ Yes .....
Learning to throw/catch ❑ No ❑ Yes .....
During this child's first 4 years, were any special problems noted in the following areas?
If yes, please describe.
Eating ❑ No ❑ Yes .....
Motor skills ❑ No ❑ Yes .....
Sleeping too much ❑ No ❑ Yes .....
Temper tantrums ❑ No ❑ Yes .....
Sleeping to little ❑ No ❑ Yes .....
Failure to thrive ❑ No ❑ Yes .....
Separating from parents ❑ No ❑ Yes .....

Excessive crying ❑ No ❑ Yes .....
Other (throwing, etc.)? ❑ No ❑ Yes .....
Has this child been forced to change writing hand? ❑ No ❑ Yes

IV. Pregnancy

Was this child a planned pregnancy? ❑ No ❑ Yes Was the mother under a doctor's care? ❑ No ❑ Yes
Number of previous pregnancies / miscarriages: .....
Check any of the following complications that occurred during the pregnancy.
❑ Difficulty in conception ❑ Emotional problems ❑ Anemia
❑ Excessive swelling ❑ Toxemia ❑ Flu
❑ Abnormal weight gain ❑ Vaginal bleeding ❑ High blood pressure
❑ Other (Rh incompatibility, vaccines, fillings, etc.).....
Maternal injury: ❑ No ❑ Yes Describe:.....
Hospitalization during pregnacy.: ❑ No ❑ Yes Reason .....
Medications during pregnancy: ❑ No ❑ Yes Frequency .....
Cigarettes during pregnancy: ❑ No ❑ Yes Frequency.....
Other drugs used during pregnancy: ❑ No ❑ Yes Type.....
Frequency.....
At this child's birth, what was the mother's age? ..... Father's age? .....
Mother's age at birth of first child?.....
Was this child born in the hospital? ❑ No ❑ Yes If no, where?.....
Length of pregnancy..... weeks Length of labor ..... hours
Birth weight:.....lbs.....ozs
Apgar score ..... Child's condition at birth.....
Mother's condition at birth.....
Check any of the following complications that occurred during birth.
❑ Forceps used ❑ Breech birth ❑ Labor induced ❑ Caesarean delivery
Other deliver complications: ❑ No ❑ Yes Describe.....
.....
Incubator: ❑ No ❑ Yes How long? .....
Jaundiced: ❑ No ❑ Yes
Bilirubin lights: ❑ No ❑ Yes If yes, how long? .....
Breathing problems right after birth: ❑ No ❑ Yes If yes, how long? .....
Anesthesia used during delivery: ❑ No ❑ Yes If yes, what kind? .....
Length of stay in hospital: Mother .....days Child .....days

V. Medical History

Childhood illnesses / injuries:
Please circle the illnesses this child has had an indicate age (year/month).
❑ Chicken pox ..... ❑ Scarlet fever .....
❑ Rheumatic fever..... ❑ Meningitis .....
❑ Encephalitis..... ❑ Anemia.....
❑ Fever above 104° .....
Head injury: ❑ No ❑ Yes Describe.....
Coma or loss of consciousness: ❑ No ❑ Yes Describe.....
Sustained high fever: ❑ No ❑ Yes Describe.....
Please describe other serious illnesses or operations:

Illnesses/Operations	Age	Illness/Operation	Age
.....		.....	

....

Has this child ever been on long-term medications (more than 6 months)? ❑ No ❑ Yes

If yes, when ..... What kind? .....

If yes, when ..... What kind? .....

Respiratory

Please indicate whether this child currently has any of the following problems. If yes, describe how often.

Frequent colds: ❑ No ❑ Yes .....

Asthma: ❑ No ❑ Yes .....

Sinus condition: ❑ No ❑ Yes .....

Chronic cough: ❑ No ❑ Yes .....

Hay fever: ❑ No ❑ Yes .....

Cardiovascular

If yes, please describe:

Shortness of breath or dizziness with physical exertion: ❑ No ❑ Yes .....

Activity limitation due to heart condition: ❑ No ❑ Yes .....

Heart murmur: ❑ No ❑ Yes .....

Gastrointestinal

Excessive vomiting: ❑ No ❑ Yes .....

Frequent diarrhea: ❑ No ❑ Yes .....

Constipation: ❑ No ❑ Yes .....

Describe stool and pattern of elimination: .....

Stomach pain: ❑ No ❑ Yes .....

Reflux/heart burn: ❑ No ❑ Yes .....

Dietary history:

Food sensitivities? ❑ No ❑ Yes .....

Food cravings? ❑ No ❑ Yes .....

Food aversions? ❑ No ❑ Yes .....

List foods most commonly eaten: .....

Genitourinary

Urination in pants/bed: ❑ No ❑ Yes .....

Pain while urinating: ❑ No ❑ Yes .....

Excessive urination: ❑ No ❑ Yes .....

Strong odor to urine: ❑ No ❑ Yes .....

Musculoskeletal

Muscle pain: ❑ No ❑ Yes .....

Clumsy walk: ❑ No ❑ Yes .....

Poor posture: ❑ No ❑ Yes .....

Other muscle problems? ❑ No ❑ Yes Describe.....

Skin

Frequent rashes: ❑ No ❑ Yes .....

Bruises easily: ❑ No ❑ Yes .....

Sores: ❑ No ❑ Yes Describe.....

Severe acne: ❑ No ❑ Yes .....

Itchy skin (eczema): ❑ No ❑ Yes .....

Irregular skin flushing: ❑ No ❑ Yes Describe.....

Fever blisters: ❑ No ❑ Yes .....

Neurological

Seizures/convulsions: ❑ No ❑ Yes Describe.....
Speech defects: ❑ No ❑ Yes .....
Accident prone: ❑ No ❑ Yes .....
Bites nails: ❑ No ❑ Yes .....
Sucks thumb: ❑ No ❑ Yes .....
Grinds teeth: ❑ No ❑ Yes .....
Has tics / twitches: ❑ No ❑ Yes .....
Bangs heard: ❑ No ❑ Yes .....
Rocks back and forth: ❑ No ❑ Yes .....
Toe walking: ❑ No ❑ Yes When?.....
Self-injury: ❑ No ❑ Yes How? .....
Bowel movements in pants/bed: ❑ No ❑ Yes .....
Has this child ever taken medication to increase activity? ❑ No ❑ Yes .....
If yes, when? ..... What medication: .....
Has child ever taken tranquilizing medication? ❑ No ❑ Yes
If yes, when? ..... What medication: .....
Brain scan obtained? ❑ No ❑ Yes .....
Brain wave study (EEG) obtained? ❑ No ❑ Yes .....

Allergies

Allergy to medicine: ❑ No ❑ Yes Describe.....
Allergy to food: ❑ No ❑ Yes Describe.....
Other allergies: ❑ No ❑ Yes Describe.....
Adverse reactions to vaccines? ❑ No ❑ Yes Describe.....

Hearing

Ear infections: ❑ No ❑ Yes Describe.....
Hearing problems: ❑ No ❑ Yes Describe.....
Ear tubes: ❑ No ❑ Yes Describe.....
Date of most recent hearing exam:.....

Vision

Vision problems: ❑ No ❑ Yes Describe.....
Wears glasses/contacts: ❑ No ❑ Yes
Date of most recent vision exam: .....

Medical Care

Child's Physician: .....
Telephone:..... Fax:.....
Address:.....
How often does this child see a doctor:..... Date of last visit: .....
Child currently on medication? ❑ No ❑ Yes
If yes, indicate type and reason: .....
.....
.....
.....
List nutritional supplements, if any:
.....
.....
Has this child ever had psychological counseling or therapy? ❑ No ❑ Yes

If yes, counselor's name.....
Telephone:..... Fax:.....
Address:.....
Type of counseling.....
When?.....
Has this child ever had a neurological exam? ❑ No ❑ Yes
If yes, neurologist's name .....
Address.....
Date of exam .....
Reason .....
Has this child ever had a psychological or psychiatric exam? ❑ No ❑ Yes
If yes, doctor's name .....
Address.....
Reason for exam.....

VI. Family Health

Has any family member had any of the following? *If yes Please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.*

❑ Cancer.....
❑ Cystic fibrosis.....
❑ Diabetes .....
❑ Heart disease.....
❑ High blood pressure.....
❑ Kidney disease.....
❑ Migraine headaches .....
❑ Multiple sclerosis.....
❑ Physical handicap .....
❑ Stroke.....
❑ Tuberculosis.....
❑ Alzheimer's disease.....
❑ Hemophilia .....
❑ Huntington's chorea.....
❑ Muscular dystrophy .....
❑ Parkinson's disease.....
❑ Sickle-cell anemia.....
❑ Tay-Sachs disease.....
❑ Tourette's syndrome.....
❑ Birth defect .....
❑ Cerebral palsy.....
❑ Alcohol / drug abuse.....
❑ Behavior disorder.....
❑ Emotional disturbance .....
❑ Mental illness.....
❑ Mental retardation .....
❑ Nervousness.....
❑ Seizures or epilepsy.....
❑ Reading problem.....
❑ Other learning disability .....
❑ Speech or language problem.....
❑ Food allergies/hayfever .....
❑ Severe head injury .....
❑ Other: Describe.....

.....
Describe father's present health .....
Describe mother's present health .....
Has anyone in the family ever been in special education?.....
If yes, who? .....
What type of class? .....

Additional Comments

.....
.....
.....

Clinic For Special Children
TREATING THE WHOLE CHILD

Financial Policy

Please check below and initial beside the applicable statements as they apply to the *patient* being seen:

❑ **If primary insurance** is through a private carrier like ***Aetna, BlueCross/BlueShield, Cigna, Medcost, Tricare, United Heathcare***, etc. I understand that by accepting service from Dr. Karen Harum at the Clinic for Special Children (CSC) that I am *responsible for payment in full at the time services are rendered*.

I am also aware of the following:

_____ Fees for the initial developmental evaluation (approximately 1½ - 2 hours) can run between $350-550. Follow-up visits can range from $85-350 depending on the extent and complexity of the appointment. Extended and/or complicated visits will incur an additional $150.

_____ I am responsible for filing for reimbursement through my insurance carrier. CSC *does not* file claims for me nor does CSC routinely complete claim/reimbursement forms.

_ Clinic for Special Children is considered an "out-of-network provider" and reimbursement typically falls under my out-of-network benefits. These benefits usually carry a higher annual deductible and greater out-of-pocket expense for me.

_____ I am responsible for verifying my out-of-network benefits and eligibility (customer service # can usually be found on the back of my insurance card).

_____ CSC will provide me with the procedure codes and other pertinent information so I can file for reimbursement. CSC staff is available for consultation if I need assistance.

_____ I am responsible for follow-up with my insurance carrier for any denied claims or otherwise unpaid reimbursement.

_ Lab kits and testing are separate from Dr. Harum's fees and are usually billable through my insurance company. Lab work fees/deposits will be discussed with me prior to ordering/performing suggested tests.

_ CSC's protocol is to retain my credit/debit card number securely on file to expedite account settlement. I can provide this information when I schedule my initial evaluation.

_____I understand that payment is due in full at time of service and that I will receive the following if my account becomes PAST DUE:

30 days: 2nd statement mailed/emailed

60 days: 3rd statement and service suspension notice mailed/emailed

90 days: 4th statement and notice of service suspension, including prescription refills, until account settled

❑ **If primary insurance** is through ***NC Health Choice*** or ***NC Medicaid***, I am aware of the following:

_____ CSC will file claims on my behalf.

_____ I am responsible for any co-pays *at the time services are rendered*.

_____ CSC will require Carolina Access authorization from my primary care physician and I will request authorization from my primary care provider for this purpose, if necessary.

❑ **If secondary insurance** is through ***NC Medicaid***, I am aware of the following:

_____ All private carrier procedures still apply (see above).

_____ I am responsible for forwarding a copy of my Explanation of Benefits from my primary carrier to CSC so they can file a secondary claim to NC Medicaid.

_____ Medicaid typically does NOT reimburse for services provided by a provider who is *non-participating* with my primary insurance plan.

Patient Name _____

Guarantor's Signature _ Date_____

Clinic For Special Children
TREATING THE WHOLE CHILD

16-Nov-2013

Office Policy Notifications

Please initial beside each statement:

_____**No Show Appointments:** A $50.00 fee will be billed directly to the patient for all "no show" appointments.

_____**Late Cancellations:** A $50.00 fee will be billed directly to the patient for appointments cancelled without one full business day of notice.

_____**Phone Consultations, Web Consults (eg Skype), Research, and Document Review Outside the Scope of Routine Clinical Care:** Charges range from $35-$175 depending on the amount of time spent on the phone with Dr. Harum the complexity of the subject matter and whether or not research is required. *A credit card number is required up front for these services*.

_____**Email Policy:** A minimum charge of $25 may be billed directly to the patient for an email consultation. This charge will vary depending on the time needed to answer questions.

_____**Parent Consultation:** From time to time a parent may want to have a consultation without the child present. Although we are happy to accommodate the parents' wishes for this consultation, in most cases insurance *will not pay for this type of office visit*.

_____**Letter/Form Policy:** In most cases, charges for letters requested by the parents are $35 to $50 and vary depending on the amount of time required to do research and write the letter. There is no charge for school forms if you bring it with you to your appointment. Otherwise, there will be a $25 charge for school forms.
Please allow at least one week for letters to be written and forms to be filled out and mailed. *A credit card number for prepayment is required up front for these services*.

_____**Medical Records/Lab Results Copying Policy:** We are happy to provide copies of your current lab results while you are at your appointment. Providing medical records up to 13 pages is a minimum charge of $10. The maximum fee for each request shall be seventy five cents per page for pages 14 through 25, fifty cents per page for pages 26 through 100, and twenty-five cents for each page in excess of 100 pages. The total charge will vary depending on the size of the chart. *A credit card number is required up front for these services*.

_____**Prescription Refill Policy:** Written prescriptions that need to be mailed will require a one week notice to renew. All other prescriptions may take up to 48 hours to renew. To expedite refills, please have your pharmacy fax a request to 910-319-7754.

_____**Returned Checks:** There will be a $35.00 processing fee for all returned checks. This includes checks returned due to NSF or stopped payment.

_____**Past Due Accounts:** Payment IN FULL is due at time of service.

30 days past due: second statement mailed/emailed

60 days past due: third statement and service suspension notice mailed/emailed

90 days past due: fourth statement and notice of service suspension, including prescription refills, until account settled

Patient Name _____

Guarantor's Signature_ Date_____

HIPAA Authorization Statement

Please complete the following so that we may contact you properly and securely.

- Please list family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

  Name .....
  Phone.....
  Name .....
  Phone.....

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN EMERGENCY.

  Name .....
  Phone.....
  Name .....
  Phone.....

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

  .....
  .....

- Please print the telephone number where you want to receive phone calls about your appointments, lab and x-ray results, or other health care information if other than your home telephone number.

  .....
  .....

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL ❑ Yes ❑ No

- Can confidential messages (i.e. appointment reminders) Be left on your telephone answering machine or voicemail? ❑ Yes ❑ No

.....
Patient Name *print* (parent / guardian, if under 18 years old)

....
Patient Signature (parent / guardian, if under 18 years old) Date

Notes

.....
.....
.....

Clinic For Special Children
TREATING THE WHOLE CHILD

Patient Consent

For Use and Disclosure of Protected Health Information

(As required by HIPAA)

With my consent, *Clinic for Special Children*, may use and disclose protected health information about my child/children to carry out treatment, payments and healthcare operations. Please refer to *Clinic for Special Children'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. *Clinic for Special Children* reserves the right to revise its Notice of Privacy Policies Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Clinic for Special Children*, Privacy Officer, 5725 Oleander Drive · Suite C1, Wilmington, NC 28403.

With my consent *Clinic for Special Children* 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 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 *Clinic for Special Children* may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment remainder cards and patient statements.

With my consent, *Clinic for Special Children* may fax or e-mail my appointment reminder cards, patient records, and patient statements. I have the right to request that *Clinic for Special Children* restricts 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.

By signing this form, I am consenting *Clinic for Special Children* to use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures or reliance upon my prior consent. **If I do not sign this consent, *Clinic for Special Children* may decide not to provide treatment to my child.**

_____

Print Name of Patient

_____

Signature of Parent or Legal Guardian

Date_____

Clinic For Special Children
TREATING THE WHOLE CHILD

Authorization for Disclosure of Health Information

I hereby authorize:

.....

.....

.....

.....

To share with/receive records from:

Clinic for Special Children
5725 Oleander Drive · Suite C1
Wilmington, NC 28403
910-319-7744 · 910-319-7754 (fax)

Patient: ..... DOB:.....

Address: .....

Phone:.....

Medical record release dates covering: (from).....(to).....

Parent/Guardian understands that by signing this document that they are enabling the providers listed above to discuss, exchange, and disclose information pertaining to their child's treatment. Parent/Guardian understands that this will include information relating to (check if applicable):

- ❑ **Medical care and treatment**
- ❑ **Education/academic planning and service records**
- ❑ **Behavioral health service/psychiatric care**
- ❑ **Treatment for alcohol and/or drug abuse**
- ❑ **Developmental history/evaluation and treatment**
- ❑ **Other**.....

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, even or condition one year from date signed. The facility, its employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

....
Parent/Guardian signature Date

.....
Relationship to patient

....
Witness signature Date