WILMINGTON HEALTH

Pediatric Patient Information (Patient less than 18 years old)

Account No. ____________________

Doctor's No. ____________________

PLEASE ANSWER ALL QUESTIONS

NAME: LAST ____________________ FIRST ____________________ MIDDLE ____________________

BIRTHDATE ____________ SS# ____________

HOME PHONE ____________________

CELL PHONE ____________________

EMAIL ADDRESS ____________________

SEX ☐M ☐F

RACE ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ American Indian/Alaskan

ETHNIC ORIGIN ☐ Hispanic ☐ Non-Hispanic

Language ____________________

ADDRESS ____________________ ADDRESS 2 ____________________

CITY ____________________ STATE ____________________

ZIP CODE ____________ 4 DIGIT ____________ COUNTY ____________________

COUNTRY ____________________ MARITAL STATUS ____________________

EMPLOYER ____________________ ADDRESS ____________________

WORK PHONE ____________ EXT ____________ PRIMARY CARE DOCTOR ____________________

RESPONSIBLE PARTY

NAME ____________ BIRTHDATE ____________ HOME PHONE ____________ CELL PHONE ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ SS# ____________

EMPLOYER ____________ RELATIONSHIP ____________ MARITAL STATUS ____________ SEX ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ PHONE ____________

MOTHER

NAME ____________ BIRTHDATE ____________ HOME PHONE ____________ CELL PHONE ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ SS# ____________

EMPLOYER ____________________ MARITAL STATUS ____________ SEX ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ PHONE ____________

FATHER

NAME ____________ BIRTHDATE ____________ HOME PHONE ____________ CELL PHONE ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ SS# ____________

EMPLOYER ____________________ MARITAL STATUS ____________ SEX ____________

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________ PHONE ____________

INSURANCE INFORMATION

1) INSURANCE CO ____________________ 2) INSURANCE CO ____________________

ADDRESS ____________________ ADDRESS ____________________

CITY ____________ STATE ________ ZIP ________ CITY ____________ STATE ________ ZIP ________

MEDICARE/ID# ____________________ MEDICARE/ID# ____________________

GROUP # ____________________ GROUP # ____________________

POLICY HOLDER INFO **POLICY HOLDER INFO**

NAME ____________________ NAME ____________________

RELATIONSHIP TO PATIENT ____________________ RELATIONSHIP TO PATIENT ____________________

SS# ____________________ SS# ____________________

DATE OF BIRTH ____________________ DATE OF BIRTH ____________________

EMPLOYER ____________________ EMPLOYER ____________________

ADDRESS ____________________ ADDRESS ____________________

CITY ____________ ST ________ ZIP ________ CITY ____________ ST ________ ZIP ________

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health. This assignment covers any and all benefits under medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health.

Patient Signature ____________________ Date/Time ____________________

Responsible Party Signature ____________________ Date/Time ____________________

FORM #307 (Revision 08-2010)

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Name:

____

Address: ____

Account Number: ____________________ Social Security Number: _____________________

Date of Birth: ______________________ Telephone: ________________________________

Section B: Protected Health Information to Be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ Psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

☐ Specific information (please describe): ____

____

Entities Authorized to Use or Disclose: Wilmington Health

Families, Friends and Other Authorized to receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.

☐ At the request of the individual

☐ Other:____

SECTION E: Expiration

This authorization will expire (complete one):

☐ Until I revoke permission in writing

☐ On the occurrence of the following event:____

☐ 2 Years after my death

☐ Future Date ____/____/

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701 **Fax:** (910) 772-1307 **Address:** 1202 Medical Center Drive, Wilmington, NC 28401 **E-mail:** privacy @wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Voicemail and Text Message Notifications

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine please complete the section below.

Wilmington Health may leave a message regarding my medical information on the answering machine at this number (_______)________-___________

**Wilmington Health may send appointment reminders via text message to the following number (________)_______-______________

☐ Wilmington Health may not communicate appointment reminders via text message

** Text messaging is an offered service, however not required for appointment reminder notification. Note Text messaging charges may apply, based on your service contract with your service provider.

I acknowledge that I have been made aware of Wilmington Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Wilmington Health Notice of Privacy Practices.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: ______________________________________Date: _________________________

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, ______________________________, of ____________________ County, State of __________, am the custodial parent having legal custody of ______________________________________, a minor child, age ________, born ___________________________. I authorize ______________________________ of ____________________ County, State of _____________, to do any acts which may be necessary or proper to provide for the health care of the minor child, including but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including the administration of anesthesia, x-ray examination, performance of operations, or other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing.

By signing here I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and assign the health care decision covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

______________________________ (Custodial Parent's Signature)

______________________________ (Date)

STATE OF ______________________________

COUNTY OF ____________________________

On this _________ day of ________________________, 20____, personally appeared before me the named ____________________________________, to me known and known to me to be the person described in and who executed to foregoing instrument and that person acknowledges that he or she executed the same and being duly sworn to me, made oath that the statements in the foregoing instrument are true.

____, Notary Public

My Commission Expires: ______________________

(OFFICIAL SEAL)

Medical Record # _________________________