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	WILMINGTON HEALTH
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WILMINGTON HEALTH

Pediatric Patient Information (Patient less than 18 years old)

Account No.	

Doctor's No._____

		ANSWER AL	D QUDDITIOND		
NAME: LAST		FIRST		MIDDLE	
BIRTHDATE	SS#	SEX	RACE		ETHNIC ORIGIN
HOME PHONE		М	White/Caucasian	Black/African American	Hispanic
				Native Hawaiian or Pacific Islander	Non-Hispanic
EMAIL ADDRESS	21 - 121 - 211 - 21 - 21 - 21 - 21 - 21		Other Race	American Indian/Alaskan	ш
			Language		
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	4 DIGIT				
		MARITAL STATUS			
EMPLOYER		ADDRESS			
WORK PHONE					
	Server State Stat	ESPONSIBLE	DADTV		
NAME				CELL PHONE	
	BIRTHDATE CITY				
NEW COMPLEXED AND ADD CONTRACTOR (2012)	RELATIONSHIP		Contraction of Assessment The Case of the		
		51111 2			
		MOTHER			
	BIRTHDATE				
	CITY				
ADDRESS	CITY	STATE	ZIP	PHONE	
		FATHER			
NAME	BIRTHDATE	HOME P	HONE	CELL PHONE	
ADDRESS	CITY	STATE	ZIP	SS#	
ADDRESS	CITY	STATE _	ZIP	PHONE	
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1) INSURANCE CO	1100				
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ACTIVE CARDEN CONTRACTOR AND CARDEN AND CARDEN	STATE ZIP				
GROUP #		GROUP			
	HOLDER INFO			CY HOLDER INFO	
NAME		NAME_			
	TV				
DATE OF BIRTH		DATE O	F BIRTH		
ADDRESS		ADDRES	SS		
OTTO I	ST ZIP	OITV		CT 71D	

(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 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 _____ 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):

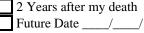
Entities Authorized to Use or Disclose: Wilmington Health

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	2 Years after my deat 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 Email: 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.

HIPPA Form 1 (revised 11/14/2014)

Page 2 of 2 Pages



AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

1,, of	County, State of
am the custodial parent having legal custody of _	, a minor child
age, born	. I authorize 0
County, State of	, to do any acts which may be necessary or prope
to provide for the health care of the minor child, in	cluding but not limited to, the power (i) to provide for suc
health care at any hospital or other institution, or	the employing of any physician, dentist, nurse, or othe
person whose services may be needed for such h	ealth care, and (ii) to consent to and authorize any healt
care, including the administration of anesthesia,	x-ray examination, performance of operations, or other
procedures by physicians, dentists, and other med	ical 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			
			, personally appeared before me
			and known to me to be the person cknowledges that he or she executed
		A SECONDER TRANSPORTATION AND A SECOND	he foregoing instrument are true.
			. *
		, Notary Public	
My Commission Expl	res:		(OFFICIAL SEAL)
Medical Record #			