The Children's Group, PC

604 N Fifth Street

Hartsville, SC 29550

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ M or F _____ Race _____ Social Security # _____

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ M or F _____ Race _____ Social Security # _____

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ M or F _____ Race _____ Social Security # _____

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ M or F _____ Race _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Pharmacy _____ City of Pharmacy _____

Email _____

PARENTS/GUARDIAN INFORMATION

Father:_____ Mother:_____

Date of Birth: _____ Date of Birth:_____

Social Security # _____ Social Security:_____

Cell phone:_____ Cell phone:_____

Siblings Names:_____

In Case of Emergency Contact _____

Relationship to child_____ Phone ( )_____

INSURANCE

Primary Insurance _____

Policy Holder Name _____ Date of Birth _____

Policy ID # _____ Group ID # _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. All co-pays are payable at the time of service.

I hereby authorize The Children's Group, PC to furnish insurance companies or their representatives information concerning my (my dependants) illness and treatments and I hereby assign to The Children's Group, PC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I agree that the above information is true and correct to the best of my knowledge.

Print Name (patient or parent if minor) _____

Signature (patient or parent if minor)_____

Relationship to Above Patient _____ Date _____

CONSENT FOR TREATMENT OF MINOR CHILD

I, being the parent or guardian of _____

_____

do hereby request and authorize *The Children's Group, PC physicians and staff* to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

_____
_____
_____
_____
_____
_____
_____

Signature of Parent/Guardian _____

Witness _____

Date _____

CONSENT FOR SERVICES

AUTHORIZATION FOR TREATMENT: I authorize The Children's Group, PC to provide treatment to myself or my dependents.

NOTICE OF PRIVACY PRACTICES: I have been given a copy of The Children's Group, PC Privacy Practices in compliance with the HIPAA legislation.

ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay and hereby assign directly to The Children's Group, PC all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES: I understand that The Children's Group, PC utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to The Children's Group, PC providing demographic information as necessary for billing purposes.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize release of copies of pertinent medical records to providers outside of The Children's Group, PC who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

NON-VIOLENCE POLICY: I understand that The Children's Group, PC is committed to providing its employees with a safe, non-violent workplace and reserve the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

AUTHORIZATION FOR REVIEW OF PRESCRIPTION HISTORY: I authorize The Children's Group, PC to access my electronic records of previously prescribed medications through the external electronic prescribing network.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

Parent/Guardian Signature _____ Date _____

PATIENT PORTAL

The Children's Group, PC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) the secure message must reach the correct email address, and
2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Parent/Guardian Signature _____ Date _____