CHILDREN'S MEDICAL GROUP, P.C.

LIST ALL CHILDREN SEEN BY OUR OFFICE

IF ALL REQUESTED INFORMATION DOES NOT APPLY TO ALL CHILDREN, PLEASE REQUEST A SEPARATE INFORMATION SHEET.

CHILD'S NAME____ DOB ____/____/_____ GENDER _______
LAST FIRST MIDDLE

CHILD'S NAME____ DOB ____/____/_____ GENDER _______
LAST FIRST MIDDLE

CHILD'S NAME____ DOB ____/____/_____ GENDER_______
LAST FIRST MIDDLE

CHILD'S NAME____ DOB ____/ ____/ _____ GENDER_______
LAST FIRST MIDDLE

ADDRESS ____
STREET APT # CITY STATE ZIP

PARENT NAME ____ DOB____/_____/______ GENDER______

EMAIL ADDRESS ___________________________________ OCCUPATION _________________________

CELL PHONE _________________________ HOME or WORK PHONE _______________________________

PARENT NAME ____ DOB ____/___/______ GENDER ______

EMAIL ADDRESS __________________________________ OCCUPATION ___________________________

CELL PHONE __________________________ HOME or WORK PHONE ______________________________

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY) ____

EMAIL ADDRESS FOR BILLING STATEMENTS ____

BILLING ADDRESS ____
(IF DIFFERENT THAN ABOVE) STREET APT # CITY STATE ZIP

EMERGENCY CONTACT ____________________________ PHONE________________ RELATIONSHIP__________

PRIMARY PROVIDER YOUR CHILD SEES AT CHILDREN'S MEDICAL GROUP ____________________________________

PREFERRED PHARMACY______________________________________ PHONE _________________________

STREET/CITY ____

RACE:
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ HISPANIC
- ☐ OTHER

ETHNICITY: HISPANIC OR LATIN _______ NOT HISPANIC OR LATIN _______

PREFERRED LANGUAGE: ___________________________

IF YOU ARE A NEW PATIENT, HOW DID YOU HEAR ABOUT OUR PRACTICE? _________________________________

PLEASE SEE REVERSE SIDE

AUTHORIZATION TO LEAVE MEDICAL INFORMATION and/or MESSAGE

In accordance with HIPAA Privacy Rule, individuals have the right to request a restriction on uses and disclosures of their protected health information (PHI). As the parent/guardian of your child(ren), we at Children's Medical Group, P.C., must have your authorization as to where we may leave messages. We need to know in writing what phone number(s) we may call to speak with you or with whom we may leave a message. It is our office policy to NOT release confidential and/or unauthorized information by home, cell, or work telephone or by answering machine or voicemail. Whenever returning telephone calls and the answering machine picks up, we will NOT leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We will simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize Children's Medical Group providers and/or staff to leave medical information pertaining to the care of my child(ren) with household members/answering machines/voicemail, by the following methods and will assume responsibility to notify them whenever this information changes. In addition, staff may provide information concerning appointment confirmation, rescheduling, lab results, vaccine information or nurse follow-up calls. **Please provide numbers that we have permission to use and check appropriately for permission you are authorizing.**

Health Information Exchanges: *I understand that Children's Medical Group may participate in one or more health information exchanges (HIEs) and I consent to Children's Medical Group electronically sharing the patient's health information including but not limited to, information related to infectious or contagious disease (Including HIV and/or AIDS), drug or alcohol abuse or treatment, genetic testing, and/or psychiatric or psychological conditions, for treatment, payment and/or healthcare operations purposes with other participants in the HIEs. I agree that if I do not want the patient's information shared with any HIE in which Children's Medical Group participates, I must opt-out by filling out a form obtained from Children's Medical Group patient representatives or found online at https://www.cmg-pc.com*

Phone # ______________________________

Phone # ______________________________

O Leave message with appointment, time & date

O Leave message regarding lab results, vaccines

O Leave medical info and/or nurse return calls

O Leave message to call office

O Do not leave message

Email address for appointment reminders:

____________________________@____________________

SMS Communication to home **Yes** _____ **No** _____

Number provided at time of need

Fax Communication to work **Yes** _____ **No** _____

Number provided at time of need

Fax Communication to school/daycare

Number provided at time of need **Yes** _____ **No** _____

Mail to home address on file **Yes** _____ **No** _____

Other than parents, the following individuals have my permission to receive medical information about my child(ren)

NAME	RELATIONSHIP	TELEPHONE NUMBER

THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicaid, private insurance, or other health plans, to this practice. I understand it is my responsibility to pay any copayment, deductible, or co-insurance amount and that I am financially responsible for all charges whether or not paid by said insurance.

*****I hereby authorize Children's Medical Group to release and receive my health information for evaluation and treatment of care.*****

Children's Medical Group, P.C.'s Notice of Privacy Practices is available at www.cmg-pc.com. A hard copy will be provided upon my request.

I hereby agree to payment of an Annual Administrative Fee of $10.00, per individual patient, if any forms need to be completed.

SIGNATURE: ____________________________________ **DATE:** ____________________

Due to privacy concerns and regulations, no video recording, photographing, and/or audio recordings are allowed in our offices. This is in line with our policy of securing the privacy and protection of our patients and staff.