Carteret Clinic for Adolescents and Children
312 Commerce Avenue • Morehead City, NC 28557
(252) 726-0511 • Fax: (252) 726-7441
www.carteretclinic.com

FOR OFFICE USE ONLY
rec'd by _____ / _____
completed by _____ / _____

FAMILY INFORMATION SHEET

CHILD BEING SEEN TODAY (if 18 years old or older, please list your phone #)

Child's Full Name: _____
First Middle Last Suffix Phone #

Child's Mailing Address: _____
Street City / State / Zip

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race**: Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: ❑ Both Natural Parents ❑ Mother ❑ Father ❑ Other (step- or grand parents, etc) _____

Biological Father Name_____ Biological Mother Name _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____Secondary Insurance Co.: _____

Father/Legal Guardian: _____
FULL Name First Middle Last Suffix

Social Sec. No.: _____

Date of Birth: _____

Mailing Address: _____

Physical Address: _____

City: State: Zip: _____

Phone (H): _____ (W): _____

Mobile: _____ (other) _____

E-Mail: _____

Employer / Occupation: _____

Mother/Legal Guardian: _____
FULL Name First Middle Last

Soc. Sec. No.: _____

Date of Birth: _____

Mailing Address: _____

Physical Address: _____

City: State: Zip: _____

Phone (H): _____ (W): _____

Mobile: _____ (other) _____

E-Mail: _____

Employer / Occupation: _____

Please list any step parents or others involved in this child's care

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please complete this section if there is a court ordered custody agreement. We will need a copy of this documentation.

If parents are separated, divorced or not married, who has custody? FATHER / MOTHER / JOINT / OTHER _____

Are there any **LEGAL** restrictions for either parent that would keep them from consenting to medical treatment for child? YES or NO

(If yes please explain) _____

Emergency Contacts (local and NOT a parent)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Relationship to patient: _____

Print Name: _____ Date: _____

REV 6/2023

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FINANCIAL POLICY AND AGREEMENT TO PAY FOR TREATMENT

We are pleased that you have chosen us to provide health care for your child. In order to avoid any misunderstanding, we ask that you carefully read and sign this financial statement. If you have any questions, please do not hesitate to ask one of our staff members.

1. The person who brings the child to our office is expected to pay for that day's visit. We accept cash, personal check, and Mastercard / Visa. All copayments are required to be paid at the time of service, including telehealth services. For patients not covered by insurance (self pay) we offer a **30% discount** if the charges are **paid in full** at the time of service. There are times when it is not possible to pay in full at the time of each visit, and in such cases, you must speak with the account manager to discuss payment options.

2. We are contracted with Blue Cross/Blue Shield, Medcost, Cigna, Aetna, United Healthcare and Atlantic Integrated Health. We are in network with Tricare and are Tricare Prime managers for those patients assigned to our clinic. Mental Health services vary between insurance companies, so please check with your insurance company for detailed information regarding what is covered under your policy. We also accept patients covered by NC Medicaid/Health Choice, as well as all the Medicaid Managed Care plans offered in North Carolina. We will file your insurance claims under these carriers as well as most other major insurance carriers as a courtesy. You must verify your insurance coverage at every visit. We will be happy to assist you in filing your own insurance claims with your carrier if necessary.

3. If your child is covered by any Medicaid Plan, you must bring the card to every appointment. Without proof of coverage, we cannot perform services under the Medicaid program, and you will be responsible for payment of all charges. If the child is covered by other insurance in addition to Medicaid, it is VERY important that we get this information. Please make sure you choose Carteret Children's Clinic for your Primary Health Provider (PHP) or Carolina Access provider. If another physician or office is selected, they will have to authorize services we provide. Our insurance department will discuss any questions you may have regarding insurance coverage and our policies.

4. It is important that you understand that our financial relationship is with you, not your insurance company. For certain carriers, we file claims as a courtesy, however, the parent or responsible party is ultimately responsible for the bill. It is always your responsibility to understand the coverage your insurance program provides and its referral process. It is your responsibility to secure proper authorization if your plan requires prior approval to make an appointment with us. Visitors should be especially aware of this if they are members of an HMO or preferred care plan. If your insurer refuses to pay for services or you do not have authorization for our services, you are responsible for non-covered charges.

5. The person who brings the child, or has a telehealth appointment with our office, is expected to make a payment on that day of service. However, when a relative or other caretaker brings the child, the charges can be applied to that child's account if previous arrangements have been made and the account is in good standing. In cases where the parents are separated or divorced, the parent bringing the child to our office is responsible for payment. Only one parent can be billed, therefore both parents have the responsibility to communicate with each other to ensure that their child's account does not become delinquent.

6. Collection procedures: Established accounts will receive monthly statements reflecting the balance due on the account after insurance has been filed and all insurance payments have been received. Should no payment be received on the account for 60 days, additional mail and phone reminders will be made in an attempt to collect the debt. Our policy is to help those with outstanding balances understand their account and reach an agreement on payment options. After 90 days of nonpayment or if a payment agreement is breached, an unpaid account may be turned over to an outside collection agency with an additional 35% fee to cover costs involved in the collection process.

7. A $25 charge is made for all checks returned for non-sufficient funds.

8. Overpayments on your account will be refunded within 90 days of overpayment, or upon request.

I have read the above financial policy of Carteret Clinic for Adolescents and Children and understand completely my responsibilities under this policy. I agree to pay all charges submitted by this office during the course of treatment.

Responsible party (please print): _____ Signature: _____

Patient(s) Name:_____

Date(s) of Birth:_____

Today's Date: _____

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AUTHORIZATIONS

Please read each authorization section carefully and sign at the bottom. If you have any questions, please ask for clarification. One must be signed for EACH patient. The following authorizations shall remain in effect until specifically revoked in writing.

Full Name of Patient (please print):_____Date of Birth _____

Certification of Authority to Consent
I certify that I am the Patient or the legal guardian of the Patient and, if the Patient is a minor, I certify that I am a parent of the minor Patient, or if living separate and apart or divorced, the custodial parent or authorized non-custodial parent of the minor Patient (collectively the "Patient or Legal Guardian") and that I have full authority to give legal and valid consent to the following for the Patient.

Consent for Treatment
I, being the parent or guardian of the Patient, who is a minor child, do hereby request and authorize the staff of Carteret Children's Clinic to perform any and all necessary services for the Patient, including but not limited to immunizations, labwork, and the administration of anesthetics which are deemed advisable by the provider, whether or not I am present at the actual appointment when the treatment is rendered. Any photos taken of the patient will be used for purposes of identification in the medical record. I understand that I have the right to refuse treatment without threat or termination of services except as outlined in the statute ***GS122C-57(d).*** Consent for treatment may be withdrawn at any time, in writing.

Release and Statement to Permit Payment of Private Insurance Benefits to Provider
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic, its agents and employees to release and disclose all or any part of the Patient's medical records to any entity which is, or may be, liable for all or part of the provider's charges for services rendered or items supplied to the Patient. The undersigned Patient or Legal Guardian authorizes the release and disclosure of any and all medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers which may be of assistance, in the opinion of this office, in providing for the treatment of the Patient.

The undersigned Patient or Legal Guardian authorizes the release of records necessary to assist in the reimbursement of benefits to which the Patient or Legal Guardian may be entitled in connection with services rendered or items supplied to the Patient by Carteret Children's Clinic and authorizes this office and/or its employees to release, via fax, electronic or paper format, medical records which are needed in order to provide the Patient with the most appropriate medical care.

The undersigned Patient or Legal Guardian authorizes and requests that payment of any third-party or insurance company benefits be made to Carteret Children's Clinic for any services or items supplied to the Patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

Consent for Protected Health Information Communication
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to communicate with me by my preferred method as well as phone, voice mail, text, postal mail, email and fax regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing issues, and any issues pertaining to the Patient's clinical care, including laboratory results among others. For email, fax, and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email, fax and/or text communication as selected. **If I authorize only my preferred method of communication, I will notify the practice and complete the Communication Restriction form**. I have the right to request that Carteret Children's Clinic restrict how it uses or discloses the Patient's PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Consent for Use and Disclosure of Protected Health Information
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to use and disclose the Patient's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I have been given a copy of and had the opportunity to review Carteret Children's Clinic Notice of Privacy Practices and Patient Rights and Responsibilities prior to signing this consent. I have been notified that release or disclosure of PHI may only occur with a valid consent unless it is an emergency or for other exceptions as detailed in the ***General Statues or in 45CFR 164.512 of HIPAA.***

Patient Rights
The undersigned Patient or Legal Guardian has been informed of their right to treatment, including access to medical care and habilitation, regardless of age, or degree of MH/DD/SA disability. I have been informed and given opportunity to review the Disability Rights NC and Patient Rights which are visibly posted in the patient waiting room.

Treatment plans for counseling services will be reviewed and provided in writing at the follow-up appointment by the counselor within 15 business days. Clinical summaries from a medical visit can be obtained via the patient portal within 3 business days.

(continued on other side)

SIGNATURE REQUIRED ON REVERSE

Revocation of Consent

The undersigned Patient or Legal Guardian has been informed of their right to revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I may inspect the PHI to be disclosed as described in the document. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I have the right to refuse to sign this authorization and that treatment of the patient will not be conditioned on signing.

I have read and understand the above certifications, authorizations, consents and rights. I have had a chance to ask any questions about these items and all my questions were answered to my satisfaction.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Please print name in full: _____ **Relationship to patient:** _____