Patient CONSENT to the Use and Disclosure of Health Information for Treatment, Payment, & Healthcare Operations

To be filled out by a parent or legal guardian ONLY! *Please Print*

Today's Date: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby assign all **Medical Insurance benefits** directly to **Crimson Pediatrics** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my (or patient's) insurance. I understand that I am responsible for all charges even if/when another authorized guardian brings the child to the doctor in my stead. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature (below) on all of my insurance submissions.

I understand that as part of my healthcare, Crimson Pediatrics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, medication history, and any plans for future care or treatment. I understand that this information serves as:

(1) A basis for planning my care and treatment, (2) A means of communication among the many health professionals who contribute to my care, (3) A source of information for applying my diagnosis information to my bill, (4) A means by which third-party payers verify that services billed were actually provided, and (5) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a *Notice of Privacy Policy* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

(1) The right to review the notice prior to signing this consent, (2) The right to object to the use of my health information for directory purposes, and (3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Crimson Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that if I refuse this consent, this organization may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Crimson Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Crimson Pediatrics change their notice, they will send a copy of any revised notice to the address that I have provided.

RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

TO BRING PATIENT TO CLINIC & FOR HEALTH INFORMATION

- I authorize the people listed below to BRING my child (the Patient) to the doctor **ONLY** when I am unable to do so. For the occasions when I may be unable to accompany my child, I consent to and give Crimson Pediatrics my authorization in advance to provide any medical treatment that Crimson Pediatrics deems necessary for the continuing healthcare of my child. If my child is brought in by someone not listed, I understand that the doctor will **NOT** be able to treat my child.
- I also authorize Crimson Pediatrics to discuss and/or release health information and/or medical records to the people that I have listed.

Print Names			
Relationship to Patient			

I understand that as part of this Organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____

Print your name and Relationship to Patient Date Signed

_____

SIGN (**Parent / Legal Guardian** if Patient is under 18 years old)

We can only treat the patient in the company of an adult listed on a current Consent Form.
This Consent Form is valid for ONE year from the signed date.
Form must be renewed yearly.

SOUTHERN SURGICAL ASSOCIATES, LLC / DBA **CRIMSON PEDIATRICS** **Demographics Update**

Date: _____

Patient's Name: _____

Patient's DOB: _____ Gender: _____ Age: _____ SSN#: _____

Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. To get a better idea of health risks you may have and better meet your health needs, we are collecting race and ethnicity information from **all** of our patients. Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record. It is perfectly alright if you do not want to answer the questions, however, this information **does** help us provide better care.

1. Race: _____ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

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Home Address: _____ Apt/Suite/Lot#: _____

City: _____ State: _____ Zip: _____

Primary Cell Phone# _____ **Cell Phone Carrier**: _____
(Example: AT&T, T-Mobile, Verizon, Cricket, Metro, etc.)

Secondary Phone# _____

Email Address (please write **clearly**): _____

Mother's Name: _____ DOB: _____ SS# _____

Father's Name: _____ DOB: _____ SS# _____

Legal Guardian's Name: _____ DOB: _____ SS# _____
(if applicable) *(For Legal Guardian, we will need legal documents to prove guardianship.)*

Please list all siblings that are currently patients here at Crimson Pediatrics so that we may update their accounts.

Sibling's **Name**: _____

Sibling's DOB: _____ Sex: _____ Age: _____ SSN#: _____

1. Race: _____ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

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Sibling's **Name**: _____

Sibling's DOB: _____ Sex: _____ Age: _____ SSN#: _____

1. Race: _____ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

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Sibling's **Name**: _____

Sibling's DOB: _____ Sex: _____ Age: _____ SSN#: _____

1. Race: _____ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

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(If there are more siblings to list, please use the back of this sheet.)

1st Insurance Co.: _____ Insurance Policy# _____ Group# _____

Name of Subscriber (name on card): _____ DOB of Subscriber: _____

2nd Insurance Co.: _____ Insurance Policy# _____ Group# _____

Name of Subscriber (name on card): _____ DOB of Subscriber: _____

Pharmacy of Choice: _____ Phone# _____

Pharmacy Address, City, State, Zip: _____
(There are multiple Walgreens, CVS, Rite Aids, etc... in town and some are also on the same street!!! Please be specific.)

_____

Print: (Parent/Guarantor Name)

_____
Date:

_____

Sign: (Parent/Guarantor Name)

VACCINE POLICY

TO ALL OUR VALUED FAMILIES:

We at Crimson Pediatrics care deeply about the health and safety of the children in our care. One of the most vital steps in keeping them healthy is to be current with their childhood vaccines. Our clinic follows the recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) by encouraging our patients to be immunized according to their published schedule.

Unvaccinated children are at higher risk for becoming ill with a host of preventable diseases that can have very serious and sometimes devastating consequences. In addition, unvaccinated children can potentially spread a preventable disease to another child who may be too young to be vaccinated or whose medical condition prevents them from receiving immunizations. The vaccines our children receive have each been thoroughly tested for safety and effectiveness.

With those important issues in mind, and for the safety of all the children in our care, we are providing our families with The Crimson Pediatrics **VACCINE POLICY**.

EFFECTIVE IMMEDIATELY:

- Crimson Pediatrics does not accept new patients who choose to remain unvaccinated or who are on an alternative vaccine schedule.
- Parents of unvaccinated children ALREADY IN OUR CARE, will be given a 30 day notice in which to enroll with a different primary care physician.
- We will not administer an alternative vaccine schedule for our current patients. Parents of current patients who choose to use an alternative schedule will be asked to find another primary care provider.
- Parents of under-immunized children who would like to start following the AAP and the CDC guidelines for immunizations are encouraged to discuss catch-up immunizations for their child.

We at Crimson Pediatrics look forward to providing your children with the best possible medical care and guidance, and we value your trust and confidence.

PLEASE NOTE

Crimson Pediatrics will continue to see children in our care who have medical conditions, severe documented reactions, or treatments that preclude them from receiving vaccines. These children will be exempt from this policy until they are medically eligible to obtain vaccines.

I have read this Vaccine Policy. I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC Immunization Schedule. My consent also includes visits during which my child is accompanied by an adult that I have listed on the consent form. I understand that should I decide to decline vaccines at any time, I will have 30 days in which to enroll with a different primary care provider.

PRINT: _____ **DATE**: _____

PATIENT Full Name

PRINT: _____ **SIGN**: _____

Parent / Legal Guardian **Parent** / Legal Guardian

Revised 6/26/2019