Greer Pediatric Center
New Family Information Form

Patient(s) Information:

Full Name: _____ Date of Birth: _____ Age: _____ Sex:_____ Insurance ID#_____

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Parent/Guardian(s) Information:

- Name(s): _____
- Relationship to Patient: _____
- Contact Number(s): _____
- Email Address: _____
- Street Address: _____
- City: _____
- State: _____
- Zip Code: _____

Insurance Information:

- Insurance Provider: _____
- Policy Holder Name and DOB_____
- Policy Number: _____
- Group Number: _____

Emergency Contact:

- Name: _____
- Relationship to Patient: _____
- Contact Number: _____

Additional List of person(s) who have your permission to bring your child(ren) to their medical appointments and have access to your child(ren) medical history/records**:**

- _____
- _____
- _____

Additional Information/Comments:

- _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Patient/Gaurdian Communication

I authorize Greer Pediatric Center to call my phone, email, and/or send texts to me to confirm appointments and leave messages on the answering machine at home or on your cell phone.

Consent to Treatment

By signing this document, I am giving Greer Pediatric Center and its personnel permission to deliver medical services to the patient listed at the bottom of this form and I am attesting that I have the authority as the legal guardian of the patient or I have been empowered by the legal guardian to the patient to do so.

Financial Agreement

I understand that I am responsible for all co-pays, deductibles and coinsurances as well as any claims that are denied by my medical insurance company for the patient (s) listed above.

Parent/Guardian's Name_____

Signature_____

Date_____