120 Memorial Dr
Jacksonville, NC 28546

Jacksonville Children's and Multispecialty Clinic, P.A.

Phone (910) 219-TEAM
Fax (910)353-1536

PATIENT INFORMATION

NAME		SS#	BIRTHDATE	LANGUAGE	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP				
DAY OR CELL PHONE #	HOME PHONE #	EMAIL ADDRESS			
PRIMARY CARE PROVIDER IF NOT JCMC	ETHNICITY/ RACE	CONTACT PREFERENCE (circle one) PHONE EMAIL MAIL			

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN)

NAME		SS#	BIRTHDATE	LANGUAGE	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP				
DAY PHONE #	HOME PHONE #	EMAIL ADDRESS			
PERSON(S) AUTHORIZED TO BRING PATIENT TO APPOINTMENT		NAME AND TELEPHONE NUMBER OF EMERGENCY CONTACT			
HOW DID YOU HEAR ABOUT OUR PRACTICE? Circle one: Billboard Insurance Friend Family Social Media Phone Book Other					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			
POLICY NUMBER		IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE	
NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY			
POLICY NUMBER		IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE	
NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

1. PAYMENT AUTHORIZATION: I hereby authorize payment for all services rendered by Jacksonville Children's and Multispecialty Clinic to be made directly to Jacksonville Children's and Multispecialty Clinic from my insurance company or from the proceeds of a personal settlement.
2. TREATMENT AUTHORIZATION: I hereby authorize treatment to be rendered by the doctors and medical staff of Jacksonville Children's and Multispecialty Clinic.
3. RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me/child to release and such information needed to determine these benefits or the benefits payable for related services.

I also acknowledge that I was provided (*last 2 pages of this package*) with the Notice of Privacy Practices of the Jacksonville Children's and Multispecialty Clinic, P.A.

Signature of Patient or Representative: _____ Date: _____

Patient: **DOB:** **Encounter Date:**

Jacksonville Children's Multispecialty Clinic
118 Memorial Dr
Jacksonville, NC 28546
Phone: (910) 353-0581
Fax: (910) 353-1351

NOTICE OF FINANCIAL POLICY

The staff and providers of Jacksonville Children's and Multispecialty Clinic (JCMC) appreciate your choosing us as your provider. A clear understanding of the practice's financial policy is an essential element to any doctor/patient relationship. It is our policy to provide the best care regardless of source of payment.

- We are happy to file your insurance as a courtesy. Please bring your most current insurance card with you for every visit. Medicaid patients are required to show a current Medicaid card each time. Please be prepared to pay your copay, deductible, previous balances, and non-covered services at the time of your visit. Make sure your insurance information, address, phone number, and email are correct at every visit.

- JCMC accepts Visa, MasterCard, Care Credit, personal checks or cash. JCMC reserves the right to reschedule visits if you fail to bring appropriate payment.

- If your insurance requires pre-approval or referral for specialist visits, it is your obligation to assure that the visit/s are approved. Failure to obtain pre-approval or referral may increase the amount you have to pay or lead to the rescheduling of your appointment.

- Outstanding balances over 90 days may be turned over to an outside credit agency. Jacksonville Children's and Multispecialty Clinic reserves the right to add a collection fee.

- Self-Pay Patient – JCMC accepts patients that do not have insurance coverage or choose not to use their insurance coverage. Payment for office visit services is expected at the time of service. Patients **will be billed** for all other tests, procedures, medications, injections, etc. at the discounted rate of 25%.

- Appointment Cancellation Policy - Failure to cancel your appointment without 24 hour notice will result in a **$25 NO SHOW FEE, $50.00 for Specialist**. This fee is NOT covered by your insurance. Any patient having three no shows will be considered for release from our practice.

- NSF (returned) checks – JCMC charges a NSF fee for every returned check written. Multiple returned checks will result in dismissal of the patient.

- The adult accompanying the minor will be the individual responsible for payment of copays, co-insurance, deductibles, non-covered services, and non-participating insurance balances at the time of service. We do not get involved in domestic disputes over balances.

- JCMC may incur a charge, per chart, for medical records printed for and given to an individual. Chart transfers from JCMC to another provider are free of charge. You are responsible for payment at the time you drop off the forms for completion.

- JCMC reserves the right to cancel or reschedule your appointment for unpaid balances, patient non-compliance, inappropriate behavior, or mistreatment of our staff.

Our billing office is available to answer questions regarding our financial policy or setting up a payment plan. Specific coverage issues will need to be addressed by your insurance company member services department.

I have read, understand and agree to the above financial policy:

Printed Patient Name: _____ **DOB:** _____

_____ **Today's Date:** _____
Patient/Parent/Legal Guardian signature

JCMC
Promoting a Healthier Future

JACKSONVILLE CHILDREN'S MULTISPECIALTY CLINIC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: _____

Date of Birth: _____ Phone Number: _____

1. Authorization

I authorize Jacksonville Children's and Multispecialty Clinic, P.A. (JCMC) to use and/or disclose my protected health information (PHI) as described below. I understand this authorization is voluntary.

2. Persons/Entities Authorized to Receive Information (Complete as applicable)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Information to Be Disclosed (Select all that apply)

☐ Medical Records

☐ Lab/Test Results (including X-rays)

☐ Appointment Information

☐ Billing/Financial Information

☐ Other: _____

4. Communication Preferences

Voicemail Messages Regarding Care: Yes ☐ No ☐ Phone Number: _____

Text Message Appointment Reminders: Yes ☐ No ☐ Phone Number: _____

Email Communication: Yes ☐ No ☐ Email Address: _____

Acknowledgment for Email/Text Communication:

I understand that unencrypted email or text messages may carry a risk of unauthorized access. I accept this risk and consent to receive communications as selected above.

5. Additional Authorizations

☐ Photos of patient may be released to patient/legal guardian

☐ Photos taken by staff (e.g., treatment/procedure)

☐ Photos may be used within clinic (e.g., office display)

☐ Photos may be used on website or educational materials

☐ Other: _____

6. Purpose of Disclosure

☐ Continuity of care ☐ Personal use ☐ Insurance/billing

☐ Other: _____

7. Patient Rights and Acknowledgments

• I understand I may revoke this authorization at any time in writing, except to the extent action has already been taken.

• I understand that information disclosed may be subject to redisclosure and may no longer be protected by federal privacy laws.

• I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.

• I have the right to inspect or receive a copy of the information disclosed.

• I acknowledge receipt of the Notice of Privacy Practices.

8. Expiration

☐ Until revoked in writing

☐ Other (specify date/event): _____

9. Signatures

Patient Signature: _____ Date: _____

If signed by Personal Representative:

Name: _____

Relationship: _____

Personal Representative Authority (attach documentation if applicable): _____

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Jacksonville Children's and Multispecialty Clinic, P.A.

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Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Jacksonville Children's and Multispecialty Clinic, P.A. is authorized to release protected health information about the above named patient in the following manner and to persons listed. Please fill out all information; if have any questions please do not hesitate to ask one of our staff. Thank-you!

Who may Receive Information. Check each person/entity that you approve to receive information.	**What information can be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other_____
☐ Other person (s) (provide name and phone number) _____ _____ _____	☐ Financial ☐ Medical ☐ Appointment Reminders
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email 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 and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure 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 my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative (Description of Personal Representatives Authority- Attach necessary documentation)

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Patient Name: _____ Date of Birth: _____

PEDIATRIC/ADOLESCENT PATIENT QUESTIONNAIRE (age <18)

Mother's Name/Date of Birth: _____

Father's Name/ Date of Birth: _____

Our practice can send prescriptions electronically to local pharmacies that are connected to the Pharmacy Health Information Exchange™. Please indicate your preferred pharmacy:

Preferred Pharmacy (Name & Location)_____

Alternate Pharmacy (Name & Location_____

Immunizations:

Do you have a copy of your child's immunization record? □ No, □ Yes, **Please provide us with this document.**

Date of patient's last flu shot? _____ □ None (approximate date is fine)

Medications:

Is the patient currently taking any medications? □ No □ Yes List medication and dosage if known:

_____

_____

Allergies:

Is the patient allergic to anything? □ No □ Yes. If YES list all allergies and reaction(s):

_____

_____

Chronic Illness:

Do you have any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, ADD/ADHD, etc?

□ No □ Yes, please list: _____

_____

Do you have a persistent chronic cough? □ No □ Yes

Past Medical History Has the patient had any prior serious illness? □ No □ Yes, please list including dates if known:

_____

_____

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Patient Name: _____Date of Birth: _____

Has the patient ever been hospitalized? □ No □ Yes, Please explain: _____

_____

Has the patient ever had any surgeries? □ No □ Yes, Please explain: _____

_____

Family History:

Circle if blood relatives have/had any of the following:		Circle if blood relatives have/had any of the following:	
Disease	Relationship to patient	Disease	Relationship to patient
Arthritis, Gout		Heart Disease, Stroke	
Asthma, Hay Fever		High Blood Pressure	
Cancer, Type:_____		Kidney	
Chemical Dependency		Tuberculosis	
Diabetes		Other	

Social History:

Mother's Occupation: _____

Father's Occupation: _____

Parent Relationship: □ Married □ Divorced □ Never Married □ Separated □ Other.

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, potentially toxic fumes?
□ No □ Yes, please list: _____

_____

Are there smokers in the home? □ No □ Yes, please list quantity: _____

Child Care? □ No □ Yes If so how many hours per week? _____

Language spoken at home? _____

Patient's School Name: _____

Patient's grade in school: _____

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Jacksonville Children's and Multispecialty Clinic, P.A.

RELEASE OF MEDICAL INFORMATION

Phone (910) 219-TEAM
Fax (910)353-1536

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

_____

AUTHORIZATION:
I hereby authorize Jacksonville Children's and Multispecialty Clinic to release/disclose the above named individual's health information to. **NOTE if the number of pages is 25 or more than they need to be mailed to**:

RELEASE FROM:
Name (Agency):_____
Address:_____
_____
Phone: ( ) _____
Fax: ( )_____

RELEASE TO:
Name (Agency): JCMC Medical Records
Address: 118 Memorial Drive
Jacksonville, NC 28546
Phone: (910) 353-0581 Option 8 then 2
Fax: (910) 939-5802

Information to be released/ disclosed:
_____ Entire Health Record _____ Office Visits _____ Reports (Labs, X-Ray, etc) _____Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____Fax _____ Pick Up

PURPOSE:
_____ Continuity of Medical Care
_____ Insurance or Other Third Party Reimbursement
_____ Not satisfied with medical care
_____ Other (Specify) _____
_____ Disability
_____ Pending Legal Action
_____ Moving out of the area

I understand that the information in my medical record may include information relating to sexually transmitted disease and/or acquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above. **A fee will be associated with copying/printing documentation from your medical record for personal use.**

RESTRICTIONS:
According to the Federal and State regulations, if the medical information requested relates to AIDS/ HIV treatment or treatment in a federally recognized chemical dependency unit then the information will be accompanied with a statement limiting disclosure to third parties as required by law.
I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I realize that although the Jacksonville Children's and Multispecialty Clinic has the responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and federal privacy laws or regulations may not protect the information. Jacksonville Children's and Multispecialty Clinic will not be held responsible for any subsequent disclosure by the recipient of the health information. I release the Jacksonville Children's and Multispecialty Clinic of any liability, which may arise as a result of any subsequent disclosure of my personal health information by the recipient.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits.
I have read and understand the Jacksonville Children's and Multispecialty Clinic's policy on releasing my personal health information.

DURATION:
This authorization will remain valid until _____. I understand that I have a right to revoke this authorization at any time by submitting a written revocation to Jacksonville Children's and Multispecialty Clinic.

SIGNATURE:
Patient Signature: _____ Date: _____

Personal/ Legal Representative Signature: _____

If signed by Personal/ Legal Representative, relationship to Patient: _____

JCMC Representative: _____ Date: _____

JACKSONVILLE CHILDREN'S MULTISPECIALTY CLINIC

Address:
144 Memorial Court
Jacksonville, NC 28546

Phone:
(910) 353-0581

Website:
www.jcmchealth.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY JCMC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also
- provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this
- information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in
- writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different
- address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree
- with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our
- operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment,
- payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six
- years for the request. One request per year will be provided free of charge. For additional requests we will charge a
- reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

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You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Compliance Officer, Allison Brooks, 144 Memorial Dr, Jacksonville NC 28546, 910-230-2146 and allison.brooks@atlanticmedicalmanagement.com.
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- We do not treat minor patients (under 18) without the parent or guardian present with or without a note unless for the 5 "protected" areas: Mental Health, STD, Birth control, Abuse, substance abuse related visits.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES – For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Health Information Exchange: Your health information may be made available electronically to other healthcare providers outside of our facility who are involved in your care. You can "opt out" of the Health Information Exchange by going to www.coastalconnect.org opt out of NCHIE by going to to https://hiea.nc.gov/documents/opt-out-form-english or by speaking with our Patient Advocate.

Medication History: We may check your medication history electronically through SureScripts to ensure your safety, as well as to prevent diversion and the abuse of prescription medications. You can opt-out by submitting a written request.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.

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- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE – We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website http://jcmchealth.com

JCMC Compliance Officer
Support@jcmcpa.net
910-230-2146

Effective date: 13 August 2018

Revised: September 2025