120 Memorial Dr
Jacksonville, NC 28546

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

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

Informacion del Paciente

Nombre		SS#	Fecha de Nac.	Idioma	Sexo
Direccion Local	Ciudad, Estado, Codigo Postal				
Numero de Telefono Celular	Telefono De Casa	Correo Electronico			
Medico de cabecera si no es JCMC	Etnicidad/Raza	Contacto Preferido (circuleuno) Telefono EMAIL Correo			

INFORMACION DE LA PARTE RESPONSABLE (Padre o Tutor Legal)

Nombre		SS#	Fecha de Nac.	Idioma	Sexo
Direccion Local	Ciudad, Estado, Codigo Postal				
Telefono De Dia	Telefono de Casa	Correo Electronico			
Personas autorizadas de traer al Paciente a las citas		Nombre y Numero de Telefono (Contacto de emergencia)			

Como se entero acerca de nuestra practica? Circule uno: Ca rt ele ra Seguro A m igo F am ilia Internet Directorio Otro

SEGURO MEDICO PRIMARIO

Nombre de la companiadeseguro			
Numero de la Poliza		TRICARE (circule): PRIME STANDARD RETIRADO ACTIVO	
Nombre del Titular de la Poliza o Patrocinador	Fecha de Nac.	SS#	Relacion con el Paciente

SEGURO MEDICO SECUNDARIO

Nombre de la CompaniaDeSeguro			
Numero de La Poliza		TRICARE (circule): PRIME STANDARD RETIRADO ACTIV	
Nombre del Titular de la Poliza o Patrocinador	Fecha de Nac.	SS#	Relacion con el Paciente

1. AUTORIZACION DE PAGO: Por la presente autorizo el pago por los servicios prestados por Jacksonville Children's y Multispecialty Clinic hacerse directamente a Jacksonville Children's y Multispecialty Clinic de mi compania de Seguro o procedente de un acuerdo personal.

2. AUTORIZACION DE TRATAMIENTO: Yo autorizo el tratamineto a ser prestados por los medicos y personal medico de Jacksonville Children's y Multispecialty Clinic.

3. DIVULGACION DE INFORMACION: Por la presente autorizo la divulgación de cualquier información médica necesaria para procesar re de seguros y cualquier titular de información médica sobre mí / hijo para su divulgación y la información necesaria para determinar estos benefi pagaderos por los servicios relacionados.

También reconozco que me proporcionaron (las últimas 2 páginas de este paquete) el Aviso de prácticas de privacidad de Jacksonville Children's and Multispecialty Clinic, P.A.

Firma del Paciente o Representante:_____ Fecha: _____

CLÍNICA MULTIESPECIALIDAD JCMC

CONSENTIMIENTO PARA TRATAMIENTO DE MENOR POR REPRESENTANTE

Información del menor

Nombre: _____ Fecha de nacimiento: _____

Padre/Madre o Tutor Legal

Nombre: _____ Teléfono: _____

Representante Autorizado

Nombre: _____ Relación: _____

código de seguridad de 4 dígitos: _____

AUTORIZACIÓN

Autorizo a la persona indicada a consentir atención médica para mi hijo/a.

ALCANCE

☐ Visitas por enfermedad
☐ Visitas de rutina
☐ Vacunas
☐ Laboratorios / estudios
☐ Medicamentos

Restricciones: _____

DURACIÓN

☐ Una sola visita
☐ Hasta: _____
☐ 12 meses

TÉRMINOS

- Puedo revocar este consentimiento en cualquier momento
- No incluye procedimientos de alto riesgo

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AVISO DE POLIZA FINANCIERA

El personal y los proveedores de Jacksonville Children and Multispecialty Clinic (JCMC) aprecian que nos haya elegido como su proveedor. Una comprensión clara de la política financiera de la práctica es un elemento esencial para cualquier relación médico /paciente. Nuestra política es proporcionar la mejor atención, independientemente de la fuente de pago.

- Estamos encantados de cobrar a su seguro como una cortesía. Por favor traiga su tarjeta de seguro más actual para cada visita. **El Departamento de Salud Mental no es un proveedor de Medicaid.** Los pacientes de Medicaid deben mostrar una tarjeta actual de Medicaid en cada visita. Esté preparado para pagar su copago, deducible, saldos anteriores y servicios no cubiertos al momento de su visita. Asegúrese de que su información de seguro, dirección, número de teléfono y correo electrónico sean correctos en cada visita.
- JCMC accepta Visa, MasterCard, Care Credit, cheques personales o dinero en efectivo. JCMC se reserva el derecho de reprogramar las visitas si no realiza el pago correspondiente.
- Si su seguro requiere aprobación previa o referidos para visitas a especialistas, es su obligación asegurarse de que las visitas sean aprobadas. Si no obtiene la aprobación previa o la referencia, puede aumentar la cantidad que tiene que pagar o llevar a la reprogramación de su cita..
- Los saldos pendientes de mas de 90 dias se pueden entregar a una agencia externa de credito. Jacksonville Children and Multispecialty Clinic se reservan el derecho de agregar una tarifa de recoleccion.
- Paciente que paga por cuenta propia: JCMC acepta pacientes que no tienen cobertura de seguro. El pago por los servicios de visita a la oficina se espera en el momento del servicio. Se facturará a los pacientes todos los demás exámenes, procedimientos, medicamentos, inyecciones, etc. a la tasa de descuento del 25%. El descuento de auto-pago solo se aplica a pacientes sin cobertura de seguro..
- Política de cancelación de citas: si no cancela su cita sin un aviso de 24 horas, se le hara un cobro $25.00 por no presentarse, $50.00 por especialista. Esta tarifa NO está cubierta por su seguro.
- Cheques NFS (devueltos): JCMC cobra una tarifa NSF por cada cheque devuelto que se escriba. Múltiples cheques devueltos resultarán en el despido del paciente.
- El adulto acompanante del menor sera el individuo responsible del pago de copagos, co-seguros, deducibles, servicios no cubiertos y saldos de seguros no participantes en el momento del servicio. No nos involucramos en disputas domesticas sobre saldos.
- JCMC evalua un cargo de $10.00 por expediente, para los registros medicos impresos y entregados a un individuo.
- Las transferencias de expedients de JCMC a otro proveedor son gratuitas. La Clinica Psychiatra cobrara $5.00 por cada carta o formulario. Usted sera responsable de este pago al momento de depositar el document.

- JCMC se reserve el derecho de cancelar or reprogramar su cita por balances no pagos, incumplimiento de paciente, conducta inapropiada or maltrato a nuestros empleados.

Nuestra oficina de facturación está disponible para responder preguntas sobre nuestra política financiera o establecer un plan de pago. Los problemas de cobertura específicos deberán ser abordados por el departamento de servicios para miembros de su compañía de seguros.

He leído, entiendo y acepto la política financiera anterior.:

Nombre del Paciente: _____ **Fecha de Nac:** _____

_____ **Fecha de hoy:** _____

Firma del Paciente/Padre/Tutor Legal

JACKSONVILLE CHILDREN'S MULTISPECIALTY CLINIC

Autorización para el uso y la divulgación de información de salud protegida

Información del paciente

Nombre del paciente: _____

Fecha de nacimiento:_____ Número de teléfono: _____

1. Autorización

Autorizo a Jacksonville Children's and Multispecialty Clinic, P.A. (JCMC) a utilizar y/o divulgar mi información de salud protegida (PHI) tal como se describe a continuación. Entiendo que esta autorización es voluntaria.

2. Personas/Entidades autorizadas para recibir información (Complete según corresponda)

Nombre	Relación	Número de teléfono
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Información a revelar (Seleccione todas las que correspondan)

□ Expedientes médicos

□ Resultados de laboratorio/pruebas (incluyendo radiografías)

□ Información de la cita

□ Información de facturación y financiera

□ Otro: _____

4. Preferencias de comunicación

Mensajes de voz relacionados con la atención: Sí □ No □ Número de teléfono: _____

Recordatorios de citas por mensaje de texto: Sí □ No □ Número de teléfono: _____

Comunicación por correo electrónico: Sí □ No □ Dirección de correo electrónico: _____

Reconocimiento de comunicaciones por correo electrónico/mensajes de texto:

Comprendo que los correos electrónicos o mensajes de texto no cifrados pueden conllevar un riesgo de acceso no autorizado. Acepto este riesgo y doy mi consentimiento para recibir las comunicaciones seleccionadas anteriormente.

5. Autorizaciones adicionales

□ Las fotos del paciente pueden ser entregadas al paciente / tutor legal.

□ Fotos tomadas por el personal (p. ej., tratamiento/procedimiento)

□ Las fotografías podrán utilizarse dentro de la clínica (p. ej., para exhibición en la oficina).

□ Las fotografías podrán utilizarse en el sitio web o en materiales educativos.

□ Otro: _____

6. Finalidad de la divulgación

□ Continuidad de la atención □ Uso personal □ Seguros / Facturación

□ Otro: _____

7. Derechos del paciente y reconocimientos

• Entiendo que puedo revocar esta autorización en cualquier momento por escrito, salvo en la medida en que ya se haya actuado.
• Entiendo que la información divulgada puede estar sujeta a una nueva divulgación y podría dejar de estar protegida por las leyes federales de privacidad.
• Entiendo que el tratamiento, el pago, la inscripción o la elegibilidad para los beneficios no están condicionados a la firma de esta autorización.
• Tengo derecho a inspeccionar o recibir una copia de la información divulgada.
• Acuso recibo del Aviso de Prácticas de Privacidad.

8. Vencimiento

□ Hasta que sea revocado por escrito

□ Otro (especifique fecha/evento): _____

9. Firmas

Firma del paciente:_____ Fecha:_____

Si está firmado por el representante personal:

Nombre:_____

Relación:_____

PAutoridad del representante personal (adjunte documentación, si corresponde): _____

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

Autorización para la divulgación de información

Nombre delPaciente _____ FechadeNac _____

Jacksonville Children's and Multispecialty Clinic, P.A. está autorizado a divulgar información médica protegida sobre el paciente mencionado anteriormente de la siguiente manera y a las personas enumeradas. Por favor complete toda la información; Si tiene alguna pregunta, no dude en preguntar a uno de nuestros empleados.

Quién puede recibir información. Verifiquecadapersona / entidad.Qué informaciónsepuede divulgar.Marquecadaunoquesele puede dar para que usted apruebe recibir información. Persona / entidad (Columna izquierda)

☐ Correo de Voz

☐ Resultados de lab examenex/rayos-X
☐ Recordatorio de citas
☐ Otro_____

☐ Otra persona (s) (provee el nombre y numero de tel)

☐ Financiero
☐ Medico
☐ Recordatorio de Citas

☐ Comunicacion-Proporcionar Correo Electronico
_____

☐ Financiero
☐ Medico
☐ Recordatorio de Citas

*Para que ocurra la communicationporemail,porfavoracepta La notificacion en la parte de abajo.

☐ Comunicacion de texto – Provee el numero *
_____

☐ Recordatorio de citas
☐ Otro:
_____

*:Debe haceptar la siguiente clausura, para recibir texto

☐ Para **email y/o comunicacion de texto** Yo entiendo que si la información no se envía de forma protegida, existe el riesgo de que se pueda acceder de forma inadecuada. Sigo eligiendo recibir correo electrónico y / o comunicaciones de texto según lo seleccionado.

☐ Fotodel paciente recividopor elpaciente (Padres)

☐ Puede ser usado en la oficina

☐ Phototakenbystaff (Example:pre/postprocedure)

☐ Puede ser usado en la pagina del Web
_____

☐ Otro

☐ Otro

DerechosdelPaciente:

- Yo tengo el derecho de revocar estos privilegios en cualquier momento.
- Yo puedo revisar o copier la informacion de salud protegida que va a ser divulgada.
- Revocacion no sera efectivo despues de que la informacion fue divulgada, pero si de ahi en adelante.
- La información de esta autorización puede estar sujeta a una nueva divulgación por parte del destinatario y no puede estar protegida por las leyes federales o estatales.
- Tengo derecho a negarme a firmar esta autorización y a que mi tratamiento no esté condicionado a la firma.

Esta autorización permanecerá vigente hasta que sea revocada por el paciente..

_____ Fecha _____

FirmadelPacienteoPersonalRepresentante

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Nombre del Paciente: Fecha deNac:

Questionario para pacientes Pediatricos/Adolescentes (<18 anos)

NombredelaMadre/FechadeNac:

Nombre del Padre/Fecha de Nac:

Nuestraclinica tiene la habilidad deenviar recetas de manera electronica a las farmacias locales que estan conectadas conPharmacy Health Information Exchange. Pof favor indique su farmacia de preferencia:

Porfavorindique una farmacia alternativa;

Immunizaciones:

Tieneselrecordde vacunas? Porfavorproveerunacopia.

Fechadelaultima vacuna contralainfluenza:

Medicinas:

Elpacientetoma algun medicamento? Por Favor indique cual/es y la dosis.

_____

_____

Alergias:

Elpaciente es alergico a algun medicamento? Por favor indique a cual/es?

_____

_____

Enfermedades cronicas:

Elpaciente tienealgunaenfermedad cronica como: Diabetes, hipertencion, enfermedad cardiaca, asma, Deficiencia de atencion e hiperactividad, etc?

Por favor explique: _____

Tiene tos persistente?

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Nombre del Paciente: Fecha de Nac:

Historia medica previa: El paciente ha tenido alguna enfermedad seria? Por favor explique:

_____

Ha sido hospitalizado alguna vez? Por favor explique:

_____

Historia familiar: Marque las positivas y expecifique que miembro de la familia:

Asthma,alergias:
Gota, artritis:
Cancer:
Dependencia quimica:
Diabetes:
Enfermedades cardiacas, Infartos:
Presion arterial elevada:
Enfermedades renales:
Tuberculosis:
Otros:

Historia Social:

Ocupacion de la Madre: _____

Ocupacion del Padre: _____

Relacion de los padres:

- Casados
- Divorciados
- Separados

Hay algun quimico peligroso para la salud en el hogar, ejemplo: asbestos, plomo? _____

Alguien Fuma en el hogar? Que cantidad? _____

Elpaciente va a un lugar para cuido? _____

Idioma que se habla en el hogar? _____

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Nombre del Paciente: _____ Fecha De Nac _____

FORMULARIODEHISTORIA DE SALUD

Fecha de Hoy: _____ Edad: _____

Date of last physical exam (and/or pap smear): _____

List any known allergies: _____
Date of last flu shot: _____ Date of last tetanus shot: _____ Dateof last pneumonia shot: _____

What is the reason for your visit? _____

Do you have a living will? _____

SYMPTOMS: Check symptoms you currently have or have had in the past year

General
- ▫ Anxiety
- ▫ Bipolar Disorder
- ▫ Chills
- ▫ Depression
- ▫ Dizziness
- ▫ Fainting
- ▫ Fever
- ▫ Forgetfulness
- ▫ Headache
- ▫ Loss of Sleep
- ▫ Loss of Weight
- ▫ Nervousness
- ▫ Numbness
- ▫ Seizure
- ▫ Sweats

Muscle/Joint/Bone
Pain, weakness or numbness in:
- ▫ Arms
- ▫ Back
- ▫ Feet
- ▫ Hands
- ▫ Hips
- ▫ Legs
- ▫ Neck
- ▫ Shoulders

Genito-Urinary
- ▫ Blood in urine
- ▫ Frequent Urination
- ▫ Lack of bladder control
- ▫ Painful Urination

Gastrointestinal
- ▫ Appetite Poor
- ▫ Bloating
- ▫ Bowel Changes
- ▫ Constipation
- ▫ Diarrhea
- ▫ Excessive Hunger
- ▫ Excessive Thirst
- ▫ Gas
- ▫ Hemorrhoids
- ▫ Indigestion
- ▫ Nausea
- ▫ Rectal Bleeding
- ▫ Stomach Pain
- ▫ Vomiting
- ▫ Vomiting Blood

Cardiovascular
- ▫ Chest Pain
- ▫ High Blood Pressure
- ▫ Irregular Heart Beat
- ▫ Low Blood Pressure
- ▫ Poor Circulation
- ▫ Rapid Heart Beat
- ▫ Swelling of ankles
- ▫ Varicose Veins

Eye, Ear, Nose, Throat
- ▫ Bleeding gums
- ▫ Blurred Vision
- ▫ Crossed Eyes
- ▫ Difficulty Swallowing
- ▫ Double Vision
- ▫ Earache
- ▫ Ear Discharge
- ▫ Hay Fever
- ▫ Hoarseness
- ▫ Loss of Hearing
- ▫ Nosebleeds
- ▫ Persistent Cough
- ▫ Ringing in Ears
- ▫ Sinus Problems
- ▫ Vision – Flashes

Skin
- ▫ Bruise Easily
- ▫ Hives
- ▫ Itching
- ▫ Change in Moles
- ▫ Rash
- ▫ Scars
- ▫ Sore that won't heal

Men Only
- ▫ Breast Lump
- ▫ Erection Difficulties
- ▫ Lump in Testicles
- ▫ Penis Discharge
- ▫ Sore on Penis
- ▫ Other

Women Only
- ▫ Abnormal Pap
- ▫ Bleeding between periods
- ▫ Breast Lump
- ▫ Extreme Menstrual Pain
- ▫ Painful Intercourse
- ▫ Vaginal Discharge
- ▫ Other

Date of last period: _____
Date of last pap smear: _____
Have you had a mammogram? _____
Are you Pregnant? _____

(Continue to next page)

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Nombre del Paciente: _____ Fecha de Nac _____

CONDICIONES: Check conditions you currently have or have had in the past year

▫ AIDS	▫ Chemical Dependency	▫ High Blood Pressure	▫ Positive TB Test
▫ Alcoholism	▫ Chicken Pox	▫ High Cholesterol	▫ Prostate Problem
▫ Anemia	▫ Diabetes	▫ HIV Positive	▫ Psychiatric Care
▫ Anorexia	▫ Emphysema	▫ Kidney Disease	▫ Rheumatic Fever
▫ Appendicitis	▫ Epilepsy	▫ Liver Disease	▫ Scarlet fever
▫ Arthritis	▫ Glaucoma	▫ Measles	▫ Stroke
▫ Asthma	▫ Goiter	▫ Migraines	▫ Suicide Attempt
▫ Bleeding Disorders	▫ Gonorrhea	▫ Miscarriage	▫ Thyroid Problems
▫ Blood Transfustion	▫ Gout	▫ Mononucleosis	▫ Tonsillitis
▫ Breast Lump	▫ Heart Disease	▫ Multiple Sclerosis	▫ Tuberculosis
▫ Bronchitis	▫ Hepatitis	▫ Mumps	▫ Typhoid Fever
▫ Bulimia	▫ Hernia	▫ Pacemaker	▫ Ulcers
▫ Cancer, Type _____	▫ Herpes	▫ Pneumonia	▫ Vaginal Discharge
▫ Cataracts		▫ Polio▫ Venereal Disease	

# of Pregnancies: ____ # of Deliveries: ____ # of Miscarriages: ____ # of Abortions ____ Complications: _____

Hospitalizations (Date, Reason, Outcome): _____

Surgeries (Date, Types): _____

_____

Fractures, Serious Injuries: _____

_____

Occupation: _____ Check if exposed to □ Heavy Lifting □ Hazardous Substances □ Stress

Check whichsubstancesyouuse,describethefrequency:

□ Tobacco _____ □Alcohol _____ □Caffeine _____ □ Drugs _____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS

Listmedicationsyouarecurrentlytaking

_____

_____

_____

_____ _____

Patient's Signature Date

Revisado: septiembre de 2025
Revised: September 2025

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Patient Name: _____ Date of Birth _____

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death	Circle if blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer, Type:_____	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney	
					Tuberculosis	
Children					Other	

Other information you feel is important for the doctor to know about you:

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

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Informed Consent & Controlled Medication Use Agreement

Patient Name: _____ Date of Birth: _____

I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.

2. I will take or allow my dependent child to take the medication only as prescribed by my JCMC provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.

3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).

4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:
   _____

5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.

6. Iauthorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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7. I understand that JacksonvilleChildren's andMultispecialty Clinic participates in NorthCarolina Controlled Substances Registry. Patient prescription history will be reviewed and any discrepancies may result in dismissal from the practice.

8. Refills will be given only during office hours with three business-days advance notice. If my controlled medication(s) is/are lost, misplaced or stolen or if I finish them earlier than prescribed, they will not be replaced.

9. I will meet regularly with my provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my medication(s) being filled.

10. I understand that my provider or child's provider, may require specialist evaluation of my condition and treatment and I agree to keep appointments when my provider refers me. New patients who are referred to pain management or psychiatry will have three months to establish care with the specialist.

11. Success in treatment is measured by my ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that my provider may change or discontinue this medication if there is no longer evidence that I am receiving a reasonable therapeutic benefit from the medication or that I am no longer a good candidate to continue the medication(s).

12. I agree to taper my dose of the controlled medication(s) to determine their effectiveness on request of my provider.

13. If I am unable to tolerate any controlled medication(s), or if I wish to request changes in dosage or medication(s), I agree to properly dispose of my medications per regulatory guidelines.

14. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

15. I agree to store my medications in a secure location.

16. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

17. I agree to a blood or urine test for drug analysis at any time it is requested by the provider or child's provider. Random drug and alcohol screens are for my protection. I understand that my use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medication(s).

18. I understand that I am responsible for obtaining the hard copy of my prescription unless an exception is authorized by the prescriber. If another Individual is authorized to pick up a prescription on my behalf, that individual must be listed in my HIPAA documentation and provide a copy of their photo ID to JCMC front desk staff.

19. I agree that I will not give, sellorin any way distribute prescribedmedicationsto others.

20. I agree I will not in any way attempt to forge or alter a prescription.

21. I agree to bring my medication(s) to the office to be counted if requested.

22. I agree that I will not verbally abuse clinic staff.

23. If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from Jacksonville Children's and Multispecialty Clinic.

24. This controlled medication agreement replaces and invalidates all previous controlled medication agreements made for this chronic condition. I understand that by signing this agreement, I must abide by the rules above which are for my or my child's protection and safety, and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of all services from my provider and his or her practice.

25. I understand that JCMC has an on-call provider and an Urgent Care to address urgent concerns about prescribed medications that may arise during non-clinic hours. After-hours access information can also be obtained at www.thejacksonvilleclinic.com.

Additional Conditions and Information for Patients prescribed Opioid (Narcotic) Pain Medications:

a. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

b. I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals my treatment plan. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

c. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

d. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, pseudo non-addiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated does of opioid medication.

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

Phone (910)219-TEAM
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e. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

f. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I think I may be pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

g. I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an acute or subacute condition or for a specific timeframe such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

h. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

i. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient (or Parent/Guardian) Signature	*Date*
Prescriber Signature	*Date*

Staff Please Note: A copy of this agreement should be provided to the patient upon signing.

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RELEASE OF MEDICAL INFORMATION

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**:

RELEASEFROM:
Name (Agency):_ _____
Address:_ _____
Phone: (_____) _____
Fax: (_____)_____

RELEASETO:
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 _____ OfficeVisits _____ Reports (Labs, X-Ray, etc) _____Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____Fax _____ Pick Up

PURPOSE:
_____ Continuity of MedicalCare
_____ Insurance or Other ThirdPartyReimbursement
_____ Not satisfied with medicalcare
_____ Disability
_____ Pending Legal Action
_____ Moving out of the area

_____ Other (Specify) _____

I understand that the information in my medical record may include information relating to sexually transmitteddiseaseand/oracquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental healthservicesandtreatmentforalcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such informationunlessspecifiedotherwiseabove.**A fee will be associated withcopying/printingdocumentationfromyour medicalrecord for personaluse.**

RESTRICTIONS:
AccordingtotheFederalandStateregulations,ifthemedicalinformationrequestedrelatestoAIDS/HIVtreatmentortreatmentinafederally recognizedchemicaldependencyunitthentheinformationwillbeaccompaniedwithastatementlimitingdisclosuretothirdpartiesasrequired by law.
I understandthatifthepersonortheentitythatreceivestheinformationisnotahealthcareproviderorhealthplancoveredbyfederalprivacy regulations,theinformationdescribedabovemayberedisclosedandnolongerprotectedbytheseregulations.However,therecipientmay be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I realizethatalthoughtheJacksonvilleChildren'sandMultispecialtyClinichastheresponsibilitytomaintaintheconfidentialityofthemedical recordsinitspossession,Iunderstandthatoncetheinformationisdisclosedtherecipientmayrediscloseitandfederalprivacylawsorregulatio ns may notprotecttheinformation.JacksonvilleChildren'sandMultispecialtyClinicwillnotbeheldresponsibleforanysubsequentdisclosure by the recipientofthehealthinformation.IreleasetheJacksonvilleChildren'sandMultispecialtyClinicofanyliability,whichmayariseasaresult of any subsequent disclosure of my personal health information by the recipient.
I understandthatImayrefusetosignthisauthorizationandthatmyrefusaltosignwillnotaffectmyabilitytoobtaintreatmentorpayment or my eligibilityof benefits.
I have readandunderstandtheJacksonvilleChildren'sandMultispecialtyClinic'spolicyonreleasingmypersonalhealthinformation.

DURATION:
This authorizationwillremainvaliduntil
_____
_____.IunderstandthatIhavearighttorevokethisauthorizationatanytimebysubmitting a written revocation toJacksonvilleChildren'sandMultispecialtyClinic.

SIGNATURE:
Patient Signature: _____ Date: _____

Personal/ Legal RepresentativeSignature: _____
If signed by Personal/LegalRepresentative,relationshiptoPatient: _____

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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Website:
www.jcmchealth.com

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 www.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 www.jcmchealth.com.

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

Effective date: 13 August 2018

Revision Date: January 2026

120 Memorial Dr
Jacksonville, NC 28546

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

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

AVISO DE POLIZA FINANCIERA

El personal y los proveedores de Jacksonville Children and Multispecialty Clinic (JCMC) aprecian que nos haya elegido como su proveedor. Una comprensión clara de la política financiera de la práctica es un elemento esencial para cualquier relación médico /paciente. Nuestra política es proporcionar la mejor atención, independientemente de la fuente de pago.

- Estamos encantados de cobrar a su seguro como una cortesía. Por favor traiga su tarjeta de seguro más actual para cada visita. **El Departamento de Salud Mental no es un proveedor de Medicaid.** Los pacientes de Medicaid deben mostrar una tarjeta actual de Medicaid en cada visita. Esté preparado para pagar su copago, deducible, saldos anteriores y servicios no cubiertos al momento de su visita. Asegúrese de que su información de seguro, dirección, número de teléfono y correo electrónico sean correctos en cada visita.
- JCMC accepta Visa, MasterCard, Care Credit, cheques personales o dinero en efectivo. JCMC se reserva el derecho de reprogramar las visitas si no realiza el pago correspondiente.
- Si su seguro requiere aprobación previa o referidos para visitas a especialistas, es su obligación asegurarse de que las visitas sean aprobadas. Si no obtiene la aprobación previa o la referencia, puede aumentar la cantidad que tiene que pagar o llevar a la reprogramación de su cita..
- Los saldos pendientes de mas de 90 dias se pueden entregar a una agencia externa de credito. Jacksonville Children and Multispecialty Clinic se reservan el derecho de agregar una tarifa de recoleccion.
- Paciente que paga por cuenta propia: JCMC acepta pacientes que no tienen cobertura de seguro. El pago por los servicios de visita a la oficina se espera en el momento del servicio. Se facturará a los pacientes todos los demás exámenes, procedimientos, medicamentos, inyecciones, etc. a la tasa de descuento del 25%. El descuento de auto-pago solo se aplica a pacientes sin cobertura de seguro..
- Política de cancelación de citas: si no cancela su cita sin un aviso de 24 horas, se le hara un cobro $25.00 por no presentarse, $50.00 por especialista. Esta tarifa NO está cubierta por su seguro.
- Cheques NFS (devueltos): JCMC cobra una tarifa NSF por cada cheque devuelto que se escriba. Múltiples cheques devueltos resultarán en el despido del paciente.
- El adulto acompanante del menor sera el individuo responsible del pago de copagos, co-seguros, deducibles, servicios no cubiertos y saldos de seguros no participantes en el momento del servicio. No nos involucramos en disputas domesticas sobre saldos.
- JCMC evalua un cargo de $10.00 por expediente, para los registros medicos impresos y entregados a un individuo.
- Las transferencias de expedients de JCMC a otro proveedor son gratuitas. La Clinica Psychiatra cobrara $5.00 por cada carta o formulario. Usted sera responsable de este pago al momento de depositar el document.

- JCMC se reserve el derecho de cancelar or reprogramar su cita por balances no pagos, incumplimiento de paciente, conducta inapropiada or maltrato a nuestros empleados.

Nuestra oficina de facturación está disponible para responder preguntas sobre nuestra política financiera o establecer un plan de pago. Los problemas de cobertura específicos deberán ser abordados por el departamento de servicios para miembros de su compañía de seguros.

He leído, entiendo y acepto la política financiera anterior.:

Nombre del Paciente: _____ **Fecha de Nac:** _____

_____ **Fecha de hoy:** _____

Firma del Paciente/Padre/Tutor Legal

JACKSONVILLE CHILDREN'S MULTISPECIALTY CLINIC

Autorización para el uso y la divulgación de información de salud protegida

Información del paciente

Nombre del paciente: _____

Fecha de nacimiento:_____ Número de teléfono: _____

1. Autorización

Autorizo a Jacksonville Children's and Multispecialty Clinic, P.A. (JCMC) a utilizar y/o divulgar mi información de salud protegida (PHI) tal como se describe a continuación. Entiendo que esta autorización es voluntaria.

2. Personas/Entidades autorizadas para recibir información (Complete según corresponda)

Nombre	Relación	Número de teléfono
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Información a revelar (Seleccione todas las que correspondan)

□ Expedientes médicos

□ Resultados de laboratorio/pruebas (incluyendo radiografías)

□ Información de la cita

□ Información de facturación y financiera

□ Otro: _____

4. Preferencias de comunicación

Mensajes de voz relacionados con la atención: Sí □ No □ Número de teléfono: _____

Recordatorios de citas por mensaje de texto: Sí □ No □ Número de teléfono: _____

Comunicación por correo electrónico: Sí □ No □ Dirección de correo electrónico: _____

Reconocimiento de comunicaciones por correo electrónico/mensajes de texto:

Comprendo que los correos electrónicos o mensajes de texto no cifrados pueden conllevar un riesgo de acceso no autorizado. Acepto este riesgo y doy mi consentimiento para recibir las comunicaciones seleccionadas anteriormente.

5. Autorizaciones adicionales

□ Las fotos del paciente pueden ser entregadas al paciente / tutor legal.

□ Fotos tomadas por el personal (p. ej., tratamiento/procedimiento)

□ Las fotografías podrán utilizarse dentro de la clínica (p. ej., para exhibición en la oficina).

□ Las fotografías podrán utilizarse en el sitio web o en materiales educativos.

□ Otro: _____

6. Finalidad de la divulgación

□ Continuidad de la atención □ Uso personal □ Seguros / Facturación

□ Otro: _____

7. Derechos del paciente y reconocimientos

• Entiendo que puedo revocar esta autorización en cualquier momento por escrito, salvo en la medida en que ya se haya actuado.
• Entiendo que la información divulgada puede estar sujeta a una nueva divulgación y podría dejar de estar protegida por las leyes federales de privacidad.
• Entiendo que el tratamiento, el pago, la inscripción o la elegibilidad para los beneficios no están condicionados a la firma de esta autorización.
• Tengo derecho a inspeccionar o recibir una copia de la información divulgada.
• Acuso recibo del Aviso de Prácticas de Privacidad.

8. Vencimiento

□ Hasta que sea revocado por escrito

□ Otro (especifique fecha/evento): _____

9. Firmas

Firma del paciente:_____ Fecha:_____

Si está firmado por el representante personal:

Nombre:_____

Relación:_____

PAutoridad del representante personal (adjunte documentación, si corresponde): _____

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Jacksonville, NC 28546

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Fax (910)353-1536

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

Autorización para la divulgación de información

Nombre delPaciente _____ FechadeNac _____

Jacksonville Children's and Multispecialty Clinic, P.A. está autorizado a divulgar información médica protegida sobre el paciente mencionado anteriormente de la siguiente manera y a las personas enumeradas. Por favor complete toda la información; Si tiene alguna pregunta, no dude en preguntar a uno de nuestros empleados.

Quién puede recibir información. Verifiquecadapersona / entidad.Qué informaciónsepuede divulgar.Marquecadaunoquesele puede dar para que usted apruebe recibir información. Persona / entidad (Columna izquierda)

☐ Correo de Voz

☐ Resultados de lab examenex/rayos-X
☐ Recordatorio de citas
☐ Otro_____

☐ Otra persona (s) (provee el nombre y numero de tel)

☐ Financiero
☐ Medico
☐ Recordatorio de Citas

☐ Comunicacion-Proporcionar Correo Electronico
_____

☐ Financiero
☐ Medico
☐ Recordatorio de Citas

*Para que ocurra la communicationporemail,porfavoracepta La notificacion en la parte de abajo.

☐ Comunicacion de texto – Provee el numero *
_____

☐ Recordatorio de citas
☐ Otro:
_____

*:Debe haceptar la siguiente clausura, para recibir texto

☐ Para **email y/o comunicacion de texto** Yo entiendo que si la información no se envía de forma protegida, existe el riesgo de que se pueda acceder de forma inadecuada. Sigo eligiendo recibir correo electrónico y / o comunicaciones de texto según lo seleccionado.

☐ Fotodel paciente recividopor elpaciente (Padres)

☐ Puede ser usado en la oficina

☐ Phototakenbystaff (Example:pre/postprocedure)

☐ Puede ser usado en la pagina del Web
_____

☐ Otro

☐ Otro

DerechosdelPaciente:

- Yo tengo el derecho de revocar estos privilegios en cualquier momento.
- Yo puedo revisar o copier la informacion de salud protegida que va a ser divulgada.
- Revocacion no sera efectivo despues de que la informacion fue divulgada, pero si de ahi en adelante.
- La información de esta autorización puede estar sujeta a una nueva divulgación por parte del destinatario y no puede estar protegida por las leyes federales o estatales.
- Tengo derecho a negarme a firmar esta autorización y a que mi tratamiento no esté condicionado a la firma.

Esta autorización permanecerá vigente hasta que sea revocada por el paciente..

_____ Fecha _____

FirmadelPacienteoPersonalRepresentante

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Jacksonville, NC 28546

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

Nombre del Paciente: Fecha deNac:

Questionario para pacientes Pediatricos/Adolescentes (<18 anos)

NombredelaMadre/FechadeNac:

Nombre del Padre/Fecha de Nac:

Nuestraclinica tiene la habilidad deenviar recetas de manera electronica a las farmacias locales que estan conectadas conPharmacy Health Information Exchange. Pof favor indique su farmacia de preferencia:

Porfavorindique una farmacia alternativa;

Immunizaciones:

Tieneselrecordde vacunas? Porfavorproveerunacopia.

Fechadelaultima vacuna contralainfluenza:

Medicinas:

Elpacientetoma algun medicamento? Por Favor indique cual/es y la dosis.

_____

_____

Alergias:

Elpaciente es alergico a algun medicamento? Por favor indique a cual/es?

_____

_____

Enfermedades cronicas:

Elpaciente tienealgunaenfermedad cronica como: Diabetes, hipertencion, enfermedad cardiaca, asma, Deficiencia de atencion e hiperactividad, etc?

Por favor explique: _____

Tiene tos persistente?

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Nombre del Paciente: Fecha de Nac:

Historia medica previa: El paciente ha tenido alguna enfermedad seria? Por favor explique:

_____

Ha sido hospitalizado alguna vez? Por favor explique:

_____

Historia familiar: Marque las positivas y expecifique que miembro de la familia:

Asthma,alergias:
Gota, artritis:
Cancer:
Dependencia quimica:
Diabetes:
Enfermedades cardiacas, Infartos:
Presion arterial elevada:
Enfermedades renales:
Tuberculosis:
Otros:

Historia Social:

Ocupacion de la Madre: _____

Ocupacion del Padre: _____

Relacion de los padres:

- Casados
- Divorciados
- Separados

Hay algun quimico peligroso para la salud en el hogar, ejemplo: asbestos, plomo? _____

Alguien Fuma en el hogar? Que cantidad? _____

Elpaciente va a un lugar para cuido? _____

Idioma que se habla en el hogar? _____

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Nombre del Paciente: _____ Fecha De Nac _____

FORMULARIODEHISTORIA DE SALUD

Fecha de Hoy: _____ Edad: _____

Date of last physical exam (and/or pap smear): _____

List any known allergies: _____
Date of last flu shot: _____ Date of last tetanus shot: _____ Dateof last pneumonia shot: _____

What is the reason for your visit? _____

Do you have a living will? _____

SYMPTOMS: Check symptoms you currently have or have had in the past year

General
- ▫ Anxiety
- ▫ Bipolar Disorder
- ▫ Chills
- ▫ Depression
- ▫ Dizziness
- ▫ Fainting
- ▫ Fever
- ▫ Forgetfulness
- ▫ Headache
- ▫ Loss of Sleep
- ▫ Loss of Weight
- ▫ Nervousness
- ▫ Numbness
- ▫ Seizure
- ▫ Sweats

Muscle/Joint/Bone
Pain, weakness or numbness in:
- ▫ Arms
- ▫ Back
- ▫ Feet
- ▫ Hands
- ▫ Hips
- ▫ Legs
- ▫ Neck
- ▫ Shoulders

Genito-Urinary
- ▫ Blood in urine
- ▫ Frequent Urination
- ▫ Lack of bladder control
- ▫ Painful Urination

Gastrointestinal
- ▫ Appetite Poor
- ▫ Bloating
- ▫ Bowel Changes
- ▫ Constipation
- ▫ Diarrhea
- ▫ Excessive Hunger
- ▫ Excessive Thirst
- ▫ Gas
- ▫ Hemorrhoids
- ▫ Indigestion
- ▫ Nausea
- ▫ Rectal Bleeding
- ▫ Stomach Pain
- ▫ Vomiting
- ▫ Vomiting Blood

Cardiovascular
- ▫ Chest Pain
- ▫ High Blood Pressure
- ▫ Irregular Heart Beat
- ▫ Low Blood Pressure
- ▫ Poor Circulation
- ▫ Rapid Heart Beat
- ▫ Swelling of ankles
- ▫ Varicose Veins

Eye, Ear, Nose, Throat
- ▫ Bleeding gums
- ▫ Blurred Vision
- ▫ Crossed Eyes
- ▫ Difficulty Swallowing
- ▫ Double Vision
- ▫ Earache
- ▫ Ear Discharge
- ▫ Hay Fever
- ▫ Hoarseness
- ▫ Loss of Hearing
- ▫ Nosebleeds
- ▫ Persistent Cough
- ▫ Ringing in Ears
- ▫ Sinus Problems
- ▫ Vision – Flashes

Skin
- ▫ Bruise Easily
- ▫ Hives
- ▫ Itching
- ▫ Change in Moles
- ▫ Rash
- ▫ Scars
- ▫ Sore that won't heal

Men Only
- ▫ Breast Lump
- ▫ Erection Difficulties
- ▫ Lump in Testicles
- ▫ Penis Discharge
- ▫ Sore on Penis
- ▫ Other

Women Only
- ▫ Abnormal Pap
- ▫ Bleeding between periods
- ▫ Breast Lump
- ▫ Extreme Menstrual Pain
- ▫ Painful Intercourse
- ▫ Vaginal Discharge
- ▫ Other

Date of last period: _____
Date of last pap smear: _____
Have you had a mammogram? _____
Are you Pregnant? _____

(Continue to next page)

120 Memorial Dr
Jacksonville, NC 28546

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

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

Nombre del Paciente: _____ Fecha de Nac _____

CONDICIONES: Check conditions you currently have or have had in the past year

▫ AIDS	▫ Chemical Dependency	▫ High Blood Pressure	▫ Positive TB Test
▫ Alcoholism	▫ Chicken Pox	▫ High Cholesterol	▫ Prostate Problem
▫ Anemia	▫ Diabetes	▫ HIV Positive	▫ Psychiatric Care
▫ Anorexia	▫ Emphysema	▫ Kidney Disease	▫ Rheumatic Fever
▫ Appendicitis	▫ Epilepsy	▫ Liver Disease	▫ Scarlet fever
▫ Arthritis	▫ Glaucoma	▫ Measles	▫ Stroke
▫ Asthma	▫ Goiter	▫ Migraines	▫ Suicide Attempt
▫ Bleeding Disorders	▫ Gonorrhea	▫ Miscarriage	▫ Thyroid Problems
▫ Blood Transfustion	▫ Gout	▫ Mononucleosis	▫ Tonsillitis
▫ Breast Lump	▫ Heart Disease	▫ Multiple Sclerosis	▫ Tuberculosis
▫ Bronchitis	▫ Hepatitis	▫ Mumps	▫ Typhoid Fever
▫ Bulimia	▫ Hernia	▫ Pacemaker	▫ Ulcers
▫ Cancer, Type _____	▫ Herpes	▫ Pneumonia	▫ Vaginal Discharge
▫ Cataracts		▫ Polio▫ Venereal Disease	

# of Pregnancies: ____ # of Deliveries: ____ # of Miscarriages: ____ # of Abortions ____ Complications: _____

Hospitalizations (Date, Reason, Outcome): _____

Surgeries (Date, Types): _____

_____

Fractures, Serious Injuries: _____

_____

Occupation: _____ Check if exposed to □ Heavy Lifting □ Hazardous Substances □ Stress

Check whichsubstancesyouuse,describethefrequency:

□ Tobacco _____ □Alcohol _____ □Caffeine _____ □ Drugs _____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS

Listmedicationsyouarecurrentlytaking

_____

_____

_____

_____ _____

Patient's Signature Date

Revisado: septiembre de 2025
Revised: September 2025

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Patient Name: _____ Date of Birth _____

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death	Circle if blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer, Type:_____	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney	
					Tuberculosis	
Children					Other	

Other information you feel is important for the doctor to know about you:

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

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Informed Consent & Controlled Medication Use Agreement

Patient Name: _____ Date of Birth: _____

I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.

2. I will take or allow my dependent child to take the medication only as prescribed by my JCMC provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.

3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).

4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:
   _____

5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.

6. Iauthorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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7. I understand that JacksonvilleChildren's andMultispecialty Clinic participates in NorthCarolina Controlled Substances Registry. Patient prescription history will be reviewed and any discrepancies may result in dismissal from the practice.

8. Refills will be given only during office hours with three business-days advance notice. If my controlled medication(s) is/are lost, misplaced or stolen or if I finish them earlier than prescribed, they will not be replaced.

9. I will meet regularly with my provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my medication(s) being filled.

10. I understand that my provider or child's provider, may require specialist evaluation of my condition and treatment and I agree to keep appointments when my provider refers me. New patients who are referred to pain management or psychiatry will have three months to establish care with the specialist.

11. Success in treatment is measured by my ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that my provider may change or discontinue this medication if there is no longer evidence that I am receiving a reasonable therapeutic benefit from the medication or that I am no longer a good candidate to continue the medication(s).

12. I agree to taper my dose of the controlled medication(s) to determine their effectiveness on request of my provider.

13. If I am unable to tolerate any controlled medication(s), or if I wish to request changes in dosage or medication(s), I agree to properly dispose of my medications per regulatory guidelines.

14. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

15. I agree to store my medications in a secure location.

16. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

17. I agree to a blood or urine test for drug analysis at any time it is requested by the provider or child's provider. Random drug and alcohol screens are for my protection. I understand that my use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medication(s).

18. I understand that I am responsible for obtaining the hard copy of my prescription unless an exception is authorized by the prescriber. If another Individual is authorized to pick up a prescription on my behalf, that individual must be listed in my HIPAA documentation and provide a copy of their photo ID to JCMC front desk staff.

19. I agree that I will not give, sellorin any way distribute prescribedmedicationsto others.

20. I agree I will not in any way attempt to forge or alter a prescription.

21. I agree to bring my medication(s) to the office to be counted if requested.

22. I agree that I will not verbally abuse clinic staff.

23. If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from Jacksonville Children's and Multispecialty Clinic.

24. This controlled medication agreement replaces and invalidates all previous controlled medication agreements made for this chronic condition. I understand that by signing this agreement, I must abide by the rules above which are for my or my child's protection and safety, and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of all services from my provider and his or her practice.

25. I understand that JCMC has an on-call provider and an Urgent Care to address urgent concerns about prescribed medications that may arise during non-clinic hours. After-hours access information can also be obtained at www.thejacksonvilleclinic.com.

Additional Conditions and Information for Patients prescribed Opioid (Narcotic) Pain Medications:

a. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

b. I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals my treatment plan. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

c. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

d. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, pseudo non-addiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated does of opioid medication.

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e. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

f. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I think I may be pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

g. I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an acute or subacute condition or for a specific timeframe such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

h. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

i. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient (or Parent/Guardian) Signature	*Date*
Prescriber Signature	*Date*

Staff Please Note: A copy of this agreement should be provided to the patient upon signing.

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RELEASE OF MEDICAL INFORMATION

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**:

RELEASEFROM:
Name (Agency):_ _____
Address:_ _____
Phone: (_____) _____
Fax: (_____)_____

RELEASETO:
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 _____ OfficeVisits _____ Reports (Labs, X-Ray, etc) _____Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____Fax _____ Pick Up

PURPOSE:
_____ Continuity of MedicalCare
_____ Insurance or Other ThirdPartyReimbursement
_____ Not satisfied with medicalcare
_____ Disability
_____ Pending Legal Action
_____ Moving out of the area

_____ Other (Specify) _____

I understand that the information in my medical record may include information relating to sexually transmitteddiseaseand/oracquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental healthservicesandtreatmentforalcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such informationunlessspecifiedotherwiseabove.**A fee will be associated withcopying/printingdocumentationfromyour medicalrecord for personaluse.**

RESTRICTIONS:
AccordingtotheFederalandStateregulations,ifthemedicalinformationrequestedrelatestoAIDS/HIVtreatmentortreatmentinafederally recognizedchemicaldependencyunitthentheinformationwillbeaccompaniedwithastatementlimitingdisclosuretothirdpartiesasrequired by law.
I understandthatifthepersonortheentitythatreceivestheinformationisnotahealthcareproviderorhealthplancoveredbyfederalprivacy regulations,theinformationdescribedabovemayberedisclosedandnolongerprotectedbytheseregulations.However,therecipientmay be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I realizethatalthoughtheJacksonvilleChildren'sandMultispecialtyClinichastheresponsibilitytomaintaintheconfidentialityofthemedical recordsinitspossession,Iunderstandthatoncetheinformationisdisclosedtherecipientmayrediscloseitandfederalprivacylawsorregulatio ns may notprotecttheinformation.JacksonvilleChildren'sandMultispecialtyClinicwillnotbeheldresponsibleforanysubsequentdisclosure by the recipientofthehealthinformation.IreleasetheJacksonvilleChildren'sandMultispecialtyClinicofanyliability,whichmayariseasaresult of any subsequent disclosure of my personal health information by the recipient.
I understandthatImayrefusetosignthisauthorizationandthatmyrefusaltosignwillnotaffectmyabilitytoobtaintreatmentorpayment or my eligibilityof benefits.
I have readandunderstandtheJacksonvilleChildren'sandMultispecialtyClinic'spolicyonreleasingmypersonalhealthinformation.

DURATION:
This authorizationwillremainvaliduntil
_____
_____.IunderstandthatIhavearighttorevokethisauthorizationatanytimebysubmitting a written revocation toJacksonvilleChildren'sandMultispecialtyClinic.

SIGNATURE:
Patient Signature: _____ Date: _____

Personal/ Legal RepresentativeSignature: _____
If signed by Personal/LegalRepresentative,relationshiptoPatient: _____

JCMC Representative: _____
_____ Date: _____

JACKSONVILLE CHILDREN'S MULTISPECIALTY CLINIC

Address:
118 Memorial Court
Jacksonville, NC 28546
Phone:
(919) 230-2146
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.

Address:
118 Memorial Court
Jacksonville, NC 28546
Phone:
(919) 230-2146
Website:
www.jcmchealth.com

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 www.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 www.jcmchealth.com.

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

Effective date: 13 August 2018

Revision Date: January 2026