152 Memorial Court
Jacksonville, NC 28546

Jacksonville Allery Asthma and Sinus
A Division of Jacksonville Children's and Multispecialty Clinic, P.A

Phone (910) 346-3976
Fax (910) 355-5800

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): _____

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.

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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, 919-230-2146 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.

SMS Terms and Conditions

1. JCMC uses SMS texting to send patients SMS messages related to their healthcare needs. Messages may include appointment reminders, reminders for annual wellness checkups, and follow-up messages related to care of chronic conditions.
2. You can cancel the SMS service at any time by texting "STOP" to the short code. After you send the SMS message "STOP" to us, we will send you an SMS message to confirm that you have been unsubscribed. After this, you will no longer receive SMS messages from us. If you want to join again, simply sign up as you did the first time and we will begin sending SMS messages to you again.
3. If you are experiencing issues with the messaging program, you can reply with the keyword "HELP" for more assistance, or you can get help directly at allison.brooks@atlanticmedicalmanagement.com or 919-230-2146.
4. Carriers are not liable for delayed or undelivered messages.
5. Message and data rates may apply for any messages sent to you from us and to us from you. If you have questions about your text plan or data plan, please contact your wireless provider.
6. If you have questions regarding privacy, please refer to the JCMC Privacy Policy https://jcmchealth.com/notice-of-privacy-practices/.

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. Information sharing to subcontractors in support services, such as customer service, is permitted. All other use case categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

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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

Allison Brooks
allison.brooks@atlanticmedicalmanagement.com
919-230-2146

Effective date: 13 August 2018

Revision Date: 29 September 2026