

152 Memorial Court
Jacksonville, NC 28546



Jacksonville Gastroenterology Clinic
A Division of Jacksonville Children's and Multispecialty Clinic, P.A.

Phone (910)353-3200
Fax (910)353-0600

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: _____



Jacksonville Gastroenterology Clinic
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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. **Behavioral Mental Health is not a Medicaid provider.** 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. 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%. The self-pay discount only applies to patients without insurance coverage.
- 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.
- 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 assesses a \$10.00 charge, per chart, for medical records printed for and given to an individual. Chart transfers from JCMC to another provider are free of charge. Behavioral Medicine Clinic will charge \$5.00 per letter or form completion. 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:** _____

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



Jacksonville Gastroenterology Clinic
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Authorization for Release of Information

Name of Patient _____ Date of Birth _____

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

Who may Receive Information. Check each person/entity that you approve to receive information. **What information can be released.** Check each that can be given to person/entity on the left in the same section.

<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays
	<input type="checkbox"/> Appointment reminders
	<input type="checkbox"/> Other _____

<input type="checkbox"/> Other person (s) (provide name and phone number) _____ _____ _____	<input type="checkbox"/> Financial
	<input type="checkbox"/> Medical
	<input type="checkbox"/> Appointment Reminders

<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial
	<input type="checkbox"/> Medical
	<input type="checkbox"/> Appointment reminders
	<input type="checkbox"/> Breach notification

*For email communication to occur, please accept the disclosure below:

<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder
	<input type="checkbox"/> Other: _____

*For text communication to occur, accept the disclosure below:

For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

<input type="checkbox"/> Photo of patient received by patient or legal guardian	<input type="checkbox"/> May be posted in office
<input type="checkbox"/> Photo taken by staff (Example: pre/post procedure)	<input type="checkbox"/> May be posted on website
<input type="checkbox"/> Other	<input type="checkbox"/> Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

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

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

Date _____

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Jacksonville Gastroenterology Clinic
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RELEASE OF MEDICAL INFORMATION

Phone (910)353-3200
Fax (910)353-0600

Patient Name: _____
Address: _____

Date of Birth: _____
Telephone #: _____

AUTHORIZATION:

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

RELEASE FROM:

Name (Agency): _____
Address: _____

Phone: () _____
Fax: () _____

RELEASE TO:

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

Information to be released/ disclosed:

_____ Entire Health Record _____ Office Visits _____ Reports (Labs, X-Ray, etc) _____ Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____ Fax _____ Pick Up

PURPOSE:

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

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

RESTRICTIONS:

According to the Federal and State regulations, if the medical information requested relates to AIDS/ HIV treatment or treatment in a federally recognized chemical dependency unit then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that although the Jacksonville Children's and Multispecialty Clinic has the responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and federal privacy laws or regulations may not protect the information. Jacksonville Children's and Multispecialty Clinic will not be held responsible for any subsequent disclosure by the recipient of the health information. I release the Jacksonville Children's and Multispecialty Clinic of any liability, which may arise as a result of any subsequent disclosure of my personal health information by the recipient.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits.

I have read and understand the Jacksonville Children's and Multispecialty Clinic's policy on releasing my personal health information.

DURATION:

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

SIGNATURE:

Patient Signature: _____ Date: _____

Personal/ Legal Representative Signature: _____

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

JCMC Representative: _____ Date: _____



Patient Name: _____ Date of Birth: _____

HEALTH HISTORY FORM

Today's Date: _____ Age: _____ Date of last physical exam (and/or pap smear): _____

List any known allergies: _____

Emergency contact: _____ Phone: _____ Relationship: _____

What is the reason for your visit? _____

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

Gastrointestinal

- | | | |
|--|---|--|
| <input type="checkbox"/> Appetite Poor | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Gas | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Vomiting Blood |

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

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

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

Hospitalizations (Date, Reason, Outcome): _____

Surgeries (Date, Types): _____

Have you ever had a colonoscopy? (When/Where): _____

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Patient Name: _____ Date of Birth: _____

Have you ever had an endoscopy? (When/Where): _____

Check which substances you use, describe the frequency:

Tobacco _____ Alcohol _____ Caffeine _____ Drugs _____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS (List medications you are currently taking):

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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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our Privacy Officer at the address and telephone number listed below:

120 Memorial Drive
Jacksonville, NC 28546
(910) 219-8333

Effective Date: April 14, 2003 Revised: June 3, 2014

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: <http://jacksonvillechildrensclinic.org>

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. **EXAMPLE:** Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans

- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training health care providers or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- **If required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Legal proceedings:** To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription



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services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. The written request will be given to either a practice manager or the privacy officer who will document and process the request.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions

to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people/organizations who have received your PHI from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact our Patient Advocate/Customer Relations at (910) 219-8323. You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you file a complaint, we will not retaliate against you for filing a complaint.