RELEASE of MEDICAL RECORDS:

OCEANSIDE PEDIATRICS

3701 John Platt Drive
Morehead City, NC 28557
Phone: 252-622-4448 **Fax**: 252-622-4014

I, hereby authorize_____ to release
(Name of Previous Doctor's Office)
copies of the medical records for the following:

1._____
Child's Name Date of Birth
2._____
Child's Name Date of Birth
3._____
Child's Name Date of Birth
4. _____
Child's Name Date of Birth

Previous Office Contact Info:

Phone #: _____ Fax #: _____

Address: _____
City: _____**State**:_____

Please Release:

Complete Record _____ Other **(Please specify)**:_____

Reason for records being released:

Relocation_____ Other **(Please specify)**:_____

Parent's Signature:_____**Date**:_____
Print Parent Name/Relationship to Patient_____

Advance notice must be given to allow our staff ample time to get these records copied. Records must be sent to another physician or the parent/guardian must pick them up. This authorization will expire one year from the date below, unless otherwise specified. I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavior or mental health services and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time except to the extent action has been taken prior to revocation. I understand that if I revoke this authorization, I must do so in writing to the address of the releasing institution. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that received the information in accordance with North Carolina Law. I also understand I may be charged for copies of this information in accordance wit N.C. Law. I understand the matters discussed on this form. I release the provider, and all persons associated with this company from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I understand I do not have to sign this authorization in order to obtain

Oceanside Pediatrics

Patient Information

Patients Full Name:_____ DOB:_____ M or F (**Circle One**)
Who does **CHILD** live with? _____
Address: _____
City & State_____ Zip Code _____
Social Security #: _____

Mother/Step/Guardian (**Circle One**)
Full Name:_____
Social Security #_____ DOB:_____
Address: _____
City & State _____Zip Code_____
Home/Cell #_____
Place of Work _____Phone #:_____
E-Mail: _____

Father/Step/Guardian (**Circle One**)
Full Name: _____
Social Security # _____DOB: _____
Address: _____
City & State _____ Zip Code _____
Home/Cell # _____
Place of Work _____Phone #:_____
E-Mail: _____

Patient's Race: ___ American Indian/Alaska Native ___ Asian ___ White
___ Black/African American ___ Native Hawaiian/Pacific Islander or other

Patient's Ethnicity: ___Hispanic/Latino ___**NOT** Hispanic/Latino

List other siblings: _____
Name of Relative/Friend for Emergency:
Name:_____ Relation to patient: _____
Phone number: _____

Does **CHILD** have Insurance Coverage? Y or N Who is Responsible for Bill? _____
What Insurance provider?_____

We will need a copy of valid insurance in child's chart. You will be asked to bring a current card to **every visit**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Oceanside Pediatrics or insurance company to release any information required to process my claims.

Signature:_____ **Date**:_____

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Your Signature below is an acknowledgement that you have received all of the following procedures, policies & practice of Oceanside Pediatrics and that you have read and understand them.

1. General Information Sheet
2. Referral Policy
3. Financial Policy
4. Authorization of assignment of benefits & release of medical records
5. HIPPA Notice of Privacy Practices

Print Child's Name:_____
Print Parent/Guardian Name:_____
Signature:_____ **Date:**_____

Please State Any Restrictions of information:

☐ **Restrictions** _____
_____
_____

☐ **No Restrictions**

Due to New Laws in place, your child CANNOT be treated by our practice if brought in by anyone other than parent, legal guardian or person listed below. By listing these names you are giving the individual access to medical records and the authority to make medical decisions in your absence.

1. _____ Relationship to Patient:_____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____

PARENTS ONLY must accompany their child to any PHYSICAL or MEDICATION appointments. No Expectations to this. You will be asked to reschedule if the child is not with Parent or Legal Guardian to these types of appointments. Please give 24 hours notice for any changes to appointments due to this office policy.

IMPORTANT NOTICE:

Well Child Annual Exam:

As healthcare providers we are happy that many insurance companies offer 100% coverage for annual exams as this is such an important visit for your children. This visit consists of developmental, vision screening and age appropriate milestones to enable us to evaluate your child's overall health.

Care for Medical problems During The Well Child Exam:

If the provider does find a problem during your child's annual exam, we may or may not be able to treat it during the same visit but it will depend on the complexity of the condition. Please note that most insurance companies will hold you responsible for any additional charges for treatment regardless of whether the care happens during the annual well exam visit or not. The LAW states that we are not allowed to classify care for medical problems as part of the annual well exam. We can not make any exceptions to this LAW.

We can appreciate your frustration regarding this matter but we are under strict contacts with your insurance carrier. These are their regulations not ours.

**Knowingly reporting incorrect or altered information on your claim is considered a criminal act of medical claims fraud, a Class 1 Felony, based on NC False Claims Act.

**We get our charts audited by insurance companies every year. We take this very seriously as we can lose our practicing license.

Screening Tests:

Based on your family history, your provider may recommend certain screening tests; some insurance carriers may not consider them medically necessary even if a positive family history exists. Please ASK your insurance carrier if you have any questions about what is covered under **YOUR POLICY**. We do not have access to that information.

We recommend you review your insurance coverage with your carrier annually.

I have read the above information provided by Oceanside Pediatrics

Signature:_____ Date:_____

New Parents

How to Enroll your child for Health Insurance Coverage:

If you are going to have coverage through your employer, talk to your human resources department to get the appropriate paperwork needed to start the process of adding child to coverage. If you have private coverage, please contact a representative as soon as possible to let them know the baby has been born. Most insurers require that your child be enrolled **within the first 30 days** after giving birth. This is the time frame that most insurers will make coverage retroactive. Any time after this period it is possible that the insurance provider will not cover the care given to your child and you will become responsible for **FULL AMOUNT**.

Please Do Not Wait!

If you are not able to financially provide your child with health insurance coverage, you may be eligible for medicaid coverage through North Carolina. If this is needed, please call your local social services office with any inquiries you may have and to obtain the necessary paperwork to start the process of getting coverage. Even if you have filled out paperwork for this at the hospital already, please call to ensure they do not need further information from you in order to get active coverage.

If your child is going to have coverage through the military please ensure that we are selected as your child's primary care manager or PCM if you plan to have prime coverage. In order to ensure retroactive coverage for your child please contact Defense Enrollment Eligibility Reporting System or DEERS as soon as the birth certificate/social security card has been received. (Paperwork for birth certificate/social security card should have been completed at the hospital at birth before discharged)

If you have any questions about obtaining health insurance coverage for your child please do not hesitate to ask.

Signature:_____ Date: _____