*******This information is needed to file your insurance. Please complete in full.*******

Individual policy (Y__) (N__) If through own business fill in BUSINESS NAME and address (NOT SELF)

Primary Insurance

Insurance Name:________________

Policy or ID #:______________________

Group #:_______________________

Policyholder: _________________

SS#:____________________________

Employer:___________________

Employer Address:_______________

City: _____________ State: _____ Zip: _______

DOB: ___/____/____

Relation to patient: parent stepparent self

Secondary Insurance

Insurance Name:_________________

Policy or ID #:________________________

Group #: __________________________

Policyholder: _________________

SS#:___________________________

Employer:__________________

Employer Address:_______________

City:__________________ State: ____ Zip:_______

DOB: ____/____/____

Relation to patient: parent stepparent self

Ongoing Communication Regarding Your Healthcare

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize the practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service.

From Date of Service: _________________ **To Date of Service:** ________________ **No end date:**_____

Name of Person	Address	Phone	Relationship
_________________________	__________________________	(___)__________________	____________________
_________________________	__________________________	(___)__________________	____________________

An **Authorization to Release Information Form** must be completed for all releases and disclosures not listed in the section below.

Authorization, Assignment of Benefits, and Referral Medical Release

- ☐ I consent to the treatment and allow this practice and their affiliates to use and release my child or my protected health information for treatment, payment, and healthcare options as allowed by HIPAA.
- ☐ I understand that my child or my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and or/ medical care institutions for treatment and payment purposes.
- ☐ I allow payment to be made directly to Charleston Pediatrics and Behavioral Health for all medical benefits.
- ☐ **I understand that I am finically responsible for paying all co-payment, co-insurance, deductibles, and non-covered services (if you are a patient that is 18 years or older and not responsible for the bill please have a parent contact our billing office to confirm their information.)**
- ☐ **A photocopy of this form shall be considered as effective and as valid as the original.**

To the best of my knowledge the information I have given on this form is accurate and true. I know this is my responsibility to keep my physician informed of changes to any of my contact information; a failure to do so may interfere with information concerning my child's healthcare.

Printed Name: ________________________________ **Signature**: ___________________________________ **Date**: ____________