Carolinas HealthCare System

Dear Parent/Guardian,

Thank you for choosing Rock Hill Pediatric Associates as your pediatric practice of choice. It is our goal to provide excellent care and service to both you and your child. Please fill out the enclosed forms and bring them to your first visit. In addition, please plan to arrive 15-30 minutes prior to your first appointment, as we need this time to enter your registration and insurance information.

Our practice locations in Rock Hill and Fort Mill are open:

Monday through Friday, 8 a.m. to 8 p.m.
We offer sick visits at our Fort Mill office Saturday and Sunday, 9 a.m. to 1 p.m.

For after-hours care beyond our availability, call our nurse triage line available 24 hours a day, 7 days a week through our main office numbers. Our office locations and phone numbers are as follows:

Rock Hill
1656 Riverchase Blvd, Suite 3400
Rock Hill, SC 29732
Phone: 803-328-6281

Fort Mill
704 Gold Hill Road, Suite 207
Fort Mill, SC 29715
Phone: 803-802-5900

To schedule an appointment, please call our office. You may also schedule an appointment using the MyCarolinas portal on our website. Visit **RockHillPediatrics.org** for more information.

Thank you for trusting us with your child's care. We look forward to providing excellent care to you and your family for years to come. Rock Hill Pediatric Associates is proud to be your child's medical home.

Sincerely,

Rock Hill Pediatric Associates

Carolinas Physicians Network

Patient Registration-Pediatric

ORG# _____

MRN# _____

	Patient	Parent/Responsible Party- if different Patient Relationship ☐ Parent ☐ Guardian
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Child Lives With	☐ Mother ☐ Father ☐ Grandparent ☐ Guardian	

	Mother / Guardian	Father / Guardian
Name		
Date of Birth		
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact *(Other than Parent/Guardian)*	Reason for visit _____
Name		
Address		
Home Phone		Who referred you? _____
Work Phone		Permission to leave voice mail @ primary phone number?
Mobile Phone		☐ Yes ☐ No

	Primary Insurance	Secondary Insurance
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician		If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Person responsible for payment of bill: ☐ **Mother** ☐ **Father** ☐ **Guardian or Other** _____

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Family Medical History Form

Please place an "X" in any column that applies to the family member listed across the top of the chart. If there are other children that share the same two parents, please list the other children at the bottom of this form.

Patient Name: _____ Patient DOB: _____

Medical Condition	Mother	Father	Sister	Brother	Maternal GM	Paternal GM	Maternal GF	Paternal GF
ADD								
ADHD								
Alcoholism								
Allergies								
Anemia								
Anxiety								
Behavior Problems								
Blood Disorder								
Cancer - Please list type								
Diabetes Type 1								
Diabetes Type 2								
Death < 50								
Depression								
Developmental Delays								
Drug Abuse								
Dysplasia - hip								
Eczema								
Emotional Problems								
Genetic Disorder								
Growth Problem								
Heart Attack								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Problems								
Lupus								
Multiple Sclerosis (MS)								
Seizures								
Sickle cell Anemia								
Sickle Cell Trait								
Stomach Problems								
Thyroid Disease								
Tuberculosis								
Other: Please List								

Siblings Names and DOBs with SAME 2 parents _____

Carolinas HealthCare System

Rock Hill Pediatric Associates
Consent for Immunizations

I wish for my child, _____, to receive all vaccines which are recommended by the Center for Disease Control (CDC) and the American Academy of Pediatrics (AAP) at the time of this and future health maintenance visits at Rock Hill Pediatric Associates. The CDC and AAP may recommend vaccines which are not required for school or daycare facilities.

I understand the Vaccine Information Sheets provided by the CDC for each immunization will be made available to me prior to each vaccine administration, and that I have the opportunity for any of questions to be discussed prior to immunizations.

This consent is valid for all future visits unless it is rescinded by parent or legal guardian.

_____

Parent/Legal Guardian Signature

_____

Relationship to Patient

_____

Date

Carolinas HealthCare System

ACKNOWLEDGEMENT FORM

Medical Record # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date : _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse_____ Other_____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICIANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento ____/____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tembien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciento o Representante Autorizado)

Relacion al Paciente: _____ Mismo_____ Esposo (a)_____ Otro_____

Razon Por la Cual El Paciente No Puede/No Desea Fimar: _____

Carolinas HealthCare System

Instructions for Completing the Authorization for Release of Health Information

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization.

1. **Patient Information:**
   Please fill out all patient information that is listed (Name, Address, City, State, Zip Code, E-mail Address, and Telephone). You may give the last 4 digits of the patient's social security number.

2. **Release Information From/Release Information To:**
   - **A.** Assign what hospital, nursing home, doctors office or other healthcare center(s) will be releasing (copying and sending) the medical records.
   - **B.** List the name, address, fax number and phone number of the organization or person to whom you want the records sent.

3. **Purpose:**
   - **A.** Check the reason you are giving permission for the records to be released.

4. **Records to be released:**
   - **A.** Please list the **dates of service** of the records you want released. (Dates the patient was in the hospital or nursing home or seen at the doctor's office or clinic.)
   - **B.** Please be specific as to what part of the medical record is being requested.
   - **C.** Select the format you prefer to receive the information, paper **or** electronic.
   - **D.** Select the method of delivery to receive records.

5. **Authorize:**
   Read the Patient Rights statements.

   Please print your name, sign, and date the form to confirm the release of the medical information requested. **Please note that a fee may be charged for copying the records.**

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

_____
(Name of facility, person, company) (Relationship)

_____
(Street Address or PO Box, City, State, Zip Code)

_____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐Other_____

Fill in dates of treatment for records to be released:

Treatment dates: From _____ **To** _____

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other_____
☐ Operative Reports _____
☐ Laboratory reports _____
☐ Radiology/X-Ray Reports _____
☐ Pathology reports _____

☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other_____
_____

☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other _____

☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other_____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May Be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:_____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release:_____via ☐Mail ☐Fax ☐Other_____☐**ID Verified** ☐**DL/Other ID**_____
CHS Employee Name & Title: _____**CHS Employee Signature:** _____**Date:**_____

* 9 0 5 *

Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #:

South Carolina Vaccine for Children Program Information

Dear Parents,

It is very important that you contact your insurance company and inquire about your vaccine benefits. The state of South Carolina uses a Vaccine for Children (VFC) program. Children will be eligible to receive a VFC vaccine in our office if they meet the following criteria:

- Medicaid enrolled
- American Indian or Alaskan Native
- Uninsured

Insured patients may only receive vaccine supplied by the state of South Carolina through the VFC program if they meet the following eligibility requirements:

- Insured Hardship – patient has a deductible greater than $2,000 which has not been met and the family cannot afford to pay for privately purchased vaccines.
- A child whose insurance caps vaccine coverage at a certain amount is eligible after the coverage amount is reached. The child is then considered to be in the underinsured category.
- A child whose insurance does not include vaccinations.

Children are not eligible for the VFC program or state supplied vaccine if they have health insurance that covers vaccinations. This includes those with deductible plans that are less than $2,000. If you feel that you meet the above eligibility requirements please make the staff aware prior to the administration of vaccines.

Please complete the two forms – Patient Insured Eligibility Form and the Patient Eligibility Screening Record Form as applicable.

Thank you for your patience and understanding.

Sincerely,

Rock Hill Pediatric Associates

South Carolina Department of Health and Environmental Control

Vaccines For Children (VFC) Program Patient Eligibility Screening Record Form

Purpose:

The purpose of this form is to provide screening and documentation of the eligibility status at each immunization encounter (visit) for the Vaccines for Children (VFC) program for children 18 years of age or younger, prior to administration of vaccine(s). In addition, screening and documenting eligibility status for the state vaccine eligible child through the South Carolina State Vaccine Program at each immunization encounter (visit) is also required. This form captures the documentation for screening all categories of VFC and non-VFC eligible children seen in the VFC provider's office during immunization encounters (visits). Screening and Documentation of eligibility statuses is a requirement for all providers enrolled in the vaccine programs.

General Instructions for Use:

The Vaccines For Children (VFC) Patient Eligibility Screening Record Form will be completed by the parent, guardian, individual of record, or healthcare provider staff **prior** to administration of vaccine(s) for every immunization encounter (visit).

Item-By-Item Instructions:

1. Complete the Child's Name, Child's Date of Birth, Parent/Guardian/ Individual of Record, and Provider's Name.
2. Assess client's eligibility for publicly funded vaccine. Record the date of the immunization encounter (visit).
3. After determination of eligibility category, mark in the appropriate column:

Eligible for VFC Vaccine

- A. Medicaid- Enrolled (VFC Stock)
- B. No Health Insurance (VFC Stock)
- C. American Indian or Alaska Native (VFC Stock)
- D. [1]Underinsured, served by FQHC, RHC or deputized provider (VFC Stock)

Not eligible for VFC Vaccine

- E. Has health insurance that covers vaccines (Private Stock)
- F. [2]SC State Underinsured, served by Non-FQHC/RHC (State Stock)
- G. [3]SC State Insured, Insured Hardship, Vaccine Caps (State Stock)

Office Mechanics and Filing:

Private Provider:

The completed Vaccines For Children (VFC) Patient Eligibility Screening Record Form must be kept for (3) years from most recent date of immunization visit in the providers office.

[1]*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

[2]*SC State Vaccine Program Underinsured: These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an FQHC/RHC or a deputized provider. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

[3]*SC State Vaccine Program - Insured Hardship and Vaccine Caps. These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than **$500.00** per child or **$1000.00** per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded." Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record Form

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: _____ 2. Child's Date of Birth: __ __/__ __/__ __ __ __
Last Name First Name MI

3. Parent/Guardian/Individual of Record:_____
Last Name First Name MI

4. Provider's Name:_____
Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive publicly funded vaccine through the VFC or state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date of Immunization visit	**Medicaid Enrolled** (VFC stock)	**No Health Insurance** (VFC stock)	**American Indian or Alaska Native** (VFC stock)	**VFC [1]Underinsured** served by FQHC, RHC or deputized provider (VFC stock)	**Has health insurance that covers vaccines** (Private stock)	**[2]SC State Underinsured,** Served by Non-FQHC/RHC (State stock)	**[3]SC State Insured,** Insured Hardship, Vaccine Caps (State stock)

[1]*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

[2]*SC State Vaccine Program Underinsured: These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an FQHC/RHC or a deputized provider. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

[3]*SC State Vaccine Program - Insured Hardship and Vaccine Caps: These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than **$500.00** per child or **$1000.00** per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded." Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

South Carolina State Vaccine Program:
Insured Eligibility Form

Instructions for Completing

Purpose:

To provide documentation for non-DHEC healthcare providers enrolled in the South Carolina State Vaccine Program for eligibility of *non- VFC eligible children 18 years of age or younger* to receive State vaccine, prior to vaccine administration.

General Instructions for Use:

The Insured Eligibility Form is to be completed prior to administration of vaccine(s).

Item-By-Item Instructions:

1. Complete the Child's Name, Date of Birth, Insurance Company, Policy Number, and Name and Insurance ID Number of Policy Holder *(this section of form may be completed by parent/guardian/individual of record).*

2. Assess child's eligibility for State vaccine and check appropriate box(es), as applicable.

3. Parent/Guardian/Individual of Record to sign and date form affirming the information they have provided is accurate and authorizing DHEC to verify insurance information given.

4. Healthcare provider or healthcare provider staff authorized to assess eligibility for State Vaccine to sign and date form.

Office Mechanics and Filing:

The completed Insured Eligibility Form must be retained for (3) years.

<u>Note:</u> Children who are eligible for the SC State Vaccine Program are only to be recorded on the Vaccine Usage Log (DHEC1232).

South Carolina State Vaccine Program: Insured Eligibility Form

Child's Name: _____

Date of Birth: _____

Insurance Company _____ Policy Number _____

Name and Insurance ID Number of Policy Holder _____

Insured State Vaccine Eligibility Categories

HPV *vaccine is* ***excluded*** *from the StateVaccine Program.*

Check appropriate box(es) regarding eligibility for State vaccine, as applicable:

Non FQHC/Non RHC Providers:

☐ Insured but coverage does not include vaccines *(Underinsured*);

☐ Insured but coverage only for select vaccines (eligible for State vaccine for non-covered vaccines only) (*Underinsured*);

All Providers: *(This section includes all providers enrolled in the State Vaccine Program)*

☐ Health insurance deductible **>** $250.00 per child OR ≥ $500.00 per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine) **(Insured Hardship)**

☐ Insured but coverage capped at certain amount and cap has been exceeded **(Vaccine Caps)**

NOTE:

Children who are not eligible for Federal VFC or State vaccine programs must be administered privately purchased vaccine.

I hereby acknowledge that the information given herein is true and correct. I authorize DHEC to verify any information contained in this document.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Signature of Healthcare Provider/Designated Staff Date