144 Memorial Court
Jacksonville, NC 28546

Phone (910)353-0680
Fax (910)353-3629

Jacksonville Behavioral and Mental Health
A Division of Jacksonville Children's and Multispecialty Clinic, P.A.

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: _____

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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**. Please be prepared to pay your copay, deductible, previous balances, and non-covered services at the time of your 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.

- You will be responsible for any amount not covered by your insurance. 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 services is expected at the time of service. Self-pay patients' fees will be at the approved CMS Medicare allowed amount.

- Appointment Cancellation Policy - Failure to cancel your appointment without a 24 hour notice will result in a **$50.00 fee**. This fee is NOT covered by your insurance. It must be paid before any future appointment is made.

- 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, or mistreatment of our staff.

- Telemedicine – Behavioral and Mental Health does participate in Telemedicine as a self-pay service for patients. Please indicate your participation in telemedicine as follows:

  _____ I agree to participate in telemedicine services with my BMH Provider and pay the self-pay fee amount.
  _____ I do not agree to participate in telemedicine services with my Behavioral and Mental Health Provider.

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

Revised January 2017

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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.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other_____
☐ Other person (s) (provide name and phone number) _____ _____ _____	☐ Financial ☐ Medical ☐ Appointment Reminders
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ 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.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ 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.

_____Date _____

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

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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: _____

Date of last flu shot: _____ Date of last tetanus shot: _____ Date of last pneumonia shot: _____

What is the reason for your visit? _____

Do you have a living will? _____

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

General
□ Anxiety
□ Bipolar Disorder
□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Nervousness
□ Numbness
□ Seizure
□ Sweats

Muscle/Joint/Bone
Pain, weakness or numbness in:
□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

Genito-Urinary
□ Blood in urine
□ Frequent Urination
□ Lack of bladder control
□ Painful Urination

Gastrointestinal
□ Appetite Poor
□ Bloating
□ Bowel Changes
□ Constipation
□ Diarrhea
□ Excessive Hunger
□ Excessive Thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal Bleeding
□ Stomach Pain
□ Vomiting
□ Vomiting Blood

Cardiovascular
□ Chest Pain
□ High Blood Pressure
□ Irregular Heart Beat
□ Low Blood Pressure
□ Poor Circulation
□ Rapid Heart Beat
□ Swelling of ankles
□ Varicose Veins

Eye, Ear, Nose, Throat
□ Bleeding gums
□ Blurred Vision
□ Crossed Eyes
□ Difficulty Swallowing
□ Double Vision
□ Earache
□ Ear Discharge
□ Hay Fever
□ Hoarseness
□ Loss of Hearing
□ Nosebleeds
□ Persistent Cough
□ Ringing in Ears
□ Sinus Problems
□ Vision – Flashes

Skin
□ Bruise Easily
□ Hives
□ Itching
□ Change in Moles
□ Rash
□ Scars
□ Sore that won't heal

Men Only
□ Breast Lump
□ Erection Difficulties
□ Lump in Testicles
□ Penis Discharge
□ Sore on Penis
□ Other

Women Only
□ Abnormal Pap
□ Bleeding between periods
□ Breast Lump
□ Extreme Menstrual Pain
□ Painful Intercourse
□ Vaginal Discharge
□ Other

Date of last period: _____
Date of last pap smear: _____
Have you had a mammogram? _____
Are you Pregnant? _____

(Continue to next page)

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Patient Name: _____ Date of Birth _____

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

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

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

Hospitalizations (Date, Reason, Outcome): _____

_____

Surgeries (Date, Types): _____

_____

Fractures, Serious Injuries: _____

_____

Occupation: _____Check if exposed to □ Heavy Lifting □ Hazardous Substances □ Stress

Check which substances you use, describe the frequency:

□ Tobacco _____ □ Alcohol _____ □ Caffeine _____ □ Drugs _____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS List medications you are currently taking

_____

_____

_____

_____ _____

Patient's Signature Date

Revised January 2017

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Patient Name: _____ Date of Birth _____

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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CONSENT TO TREAT

I affirm that I, _____, am the **(CIRCLE ONE):** PATIENT / PARENT / LEGAL GUARDIAN and responsible party hereby acknowledge that I authorize and give permission to the staff of **Jacksonville Children's and Multispecialty Clinic (JCMC)** to render treatment and/or services to myself / patient named on page 1 of the Health History Form. I understand that I can withdraw this consent t treatment at any time. A withdrawal of consent must be done in writing and will include the reason for withdrawal. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning care. Because psychotherapy (counseling) is a cooperative effort between patient and therapist, I will not hold JCMC or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws required that my psychiatrist/psychologist/therapist to report all cases in which there exists a specific potential harm to others in cases of reported or suspected physical, sexual and/or neglect of children which are required by law. Dr. Ahlberg's treatment is for medical purposes only and not suitable for forensic purposes.

Electronic Devices and Cell Phones: The use of ANY electronic device used for taking pictures or recordings is prohibited in this facility by Patient Privacy Rules. We also prohibit cell phone conversations in our waiting room. You will be asked to continue your phone call outside; this is to protect your privacy as well those in our waiting room. Failure to follow these rules may result in your appointment being canceled and/or may result in termination from the practice.

Illness: If you have an illness or are exhibiting symptoms, we recommend you cancel and reschedule your appointment.

NO-SHOW POLICY

We require a 24 hour notice of cancellation for all appointments. Failure to cancel your appointment without a 24 hour notice will result in your account being billed a $50 NO SHOW FEE. Patients that no show two times will receive a warning letter. Patients that no show three times or more will be considered by your provider for the possibility of being discharged from this practice. Your provider will either request another warning letter be sent to the patient or the patient will receive a letter discharging the patient from your provider's service. No Show count will be within one year timeframe.

_____ _____
SIGNATURE OF PATIENT / PARENT / LEGAL GUARDIAN DATE

Active Duty Tricare only: By receiving psychiatric services at JCMC/JBMH, I understand that any records created will be available to my Military Treatment Facility, **with or without** my consent. With this understanding, I elect to _____ continue or _____ not to continue this appointment.

_____
Signature of Active Duty Member Date

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Patient Medication Advisory Information Form

Name: _____ DOB: _____
Initialing shows my understanding of the following information my doctor and I have gone over.

_____ Do not consume any type of alcohol.
_____ Do not use any type of tobacco.
_____ In case of an emergency, go immediately to the Emergency Room.
_____ Take medication as prescribed.
_____ Do not drive while on medications.
_____ Do not take any other medication without doctor's approval. This includes taking someone else's medication even if you think it's the same as what you are prescribed.
_____ Do not give away or sell your medication.
_____ Do not increase activity without prior discussion with your doctor.
_____ Protect from pregnancy unless prior discussion with your doctor.
_____ School Forms: New forms will be required to be completed as needed. (While on medication trials, this form will not be completed.)
_____ If moving out of state, your medications will only be covered for 30 days. You are advised to set up with a new doctor as soon as possible to avoid disruption of medication/treatment.
_____ It is your responsibility to keep track of your prescriptions. We do not do automatic refills through the pharmacy. We cannot replace prescriptions for stimulants or benzodiazepines if they are lost stolen or for pharmacy/insurance matters. You agree to keep them secure from unauthorized use.
_____ To verify all health information is correct, you must make an appointment for all forms and medication refill requests.

Call the office immediately if you have any side effects. If the side effects are severe go immediately to the emergency department of your local area.

Other:

_____

_____

_____ _____
Patient/Legal Representative Signature Date

You are advised to receive psychotherapy in addition to medication management. Patients to get Lab Work as advised.

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Informed Consent & Controlled Medication Use Agreement

Patient Name: _____ Date of Birth:_____

I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.

2. I will take or allow my dependent child to take the medication only as prescribed by my JCMC provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.

3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).

4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:
   _____

5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.

6. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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Patient Name: _____ Date of Birth:_____

7. I understand that Jacksonville Children's and Multispecialty Clinic participates in North Carolina Controlled Substances Registry. Patient prescription history will be reviewed and any discrepancies may result in dismissal from the practice.

8. Refills will be given only during office hours with three business-days advance notice. If my controlled medication(s) is/are lost, misplaced or stolen or if l finish them earlier than prescribed, they will not be replaced.

9. I will meet regularly with my provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my medication(s) being filled.

10. I understand that my provider or child's provider, may require specialist evaluation of my condition and treatment and I agree to keep appointments when my provider refers me. New patients who are referred to pain management or psychiatry will have three months to establish care with the specialist.

11. Success in treatment is measured by my ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that my provider may change or discontinue this medication if there is no longer evidence that I am receiving a reasonable therapeutic benefit from the medication or that I am no longer a good candidate to continue the medication(s).

12. I agree to taper my dose of the controlled medication(s) to determine their effectiveness on request of my provider.

13. If l am unable to tolerate any controlled medication(s), or if I wish to request changes in dosage or medication(s), I agree to properly dispose of my medications per regulatory guidelines.

14. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

15. I agree to store my medications in a secure location.

16. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

17. I agree to a blood or urine test for drug analysis at any time it is requested by the provider or child's provider. Random drug and alcohol screens are for my protection. I understand that my use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medication(s).

18. I understand that I am responsible for obtaining the hard copy of my prescription unless an exception is authorized by the prescriber. If another Individual is authorized to pick up a prescription on my behalf, that individual must be listed in my HIPAA documentation and provide a copy of their photo ID to JCMC front desk staff.

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Patient Name: _____ Date of Birth:_____

19. I agree that I will not give, sell or in any way distribute prescribed medications to others.

20. I agree I will not in any way attempt to forge or alter a prescription.

21. I agree to bring my medication(s) to the office to be counted if requested.

22. I agree that I will not verbally abuse clinic staff.

23. If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from Jacksonville Children's and Multispecialty Clinic.

24. This controlled medication agreement replaces and invalidates all previous controlled medication agreements made for this chronic condition. I understand that by signing this agreement, I must abide by the rules above which are for my or my child's protection and safety, and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of all services from my provider and his or her practice.

25. I understand that JCMC has an on-call provider and an Urgent Care to address urgent concerns about prescribed medications that may arise during non-clinic hours. After-hours access information can also be obtained at www.thejacksonvilleclinic.com.

Additional Conditions and Information for Patients prescribed Opioid (Narcotic) Pain Medications:

a. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

b. I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals my treatment plan. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

c. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

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d. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, pseudo non-addiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated does of opioid medication.

e. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

f. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I think I may be pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

g. I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an acute or subacute condition or for a specific timeframe such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

h. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

i. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient (or Parent/Guardian) Signature	*Date*
Prescriber Signature	*Date*

Staff Please Note: A copy of this agreement should be provided to the patient upon signing.

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Jacksonville Behavioral and Mental Health

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

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ 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) 353-0680
Fax: (910) 353-3629

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

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: _____

144 Memorial Court
Jacksonville, NC 28546

Phone (910)353-0680
Fax (910)353-3629

Jacksonville Behavioral and Mental Health

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

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.

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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 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.