Cabarrus Rowan Community Health Centers, Inc.

Medical Information (HIPPA) Release and Insurance information

Patient Name: _____ Date of Birth: _____

Authorization of Release of Information

When the Patient is a Child (less than 18 years of age)

The person(s) who has my permission to bring my child _____to his/her ☐
Medical ☐ Dental ☐ BHC Appointments including vaccines, make appointments and confirm or cancel appointments is:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Full Name	Relationship	Phone	Authorization to disclose
			☐**All information**: Appointment, Financial/Billing Pharmacy Pick-Up, Emergency Information, Lab Results, Examination, Diagnosis, and My Treatment ☐**Emergency Information Only** ☐**Other** (Specify): _____
			☐**All information**: Appointment, Financial/Billing Pharmacy Pick-Up, Emergency Information, Lab Results, Examination, Diagnosis, and My Treatment ☐**Emergency Only** ☐**Other** (Specify): _____
			☐**All information**: Appointment, Financial/Billing Pharmacy Pick-Up, Emergency Information, Lab Results, Examination, Diagnosis, and My Treatment ☐**Emergency Only** ☐**Other** (Specify): _____

No Show Acknowledgement

Please, Initial after review

_____Patient Acknowledge of Receipt of No-show Policy: I acknowledge that I have received a copy of CRCHC no-show policy.

Insurance Information

PRIMARY INSURANCE

Plan Name: _____ ID Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security No.: _____ Sex: □Male □ Female
Policy Holder's Date of Birth: _____ Employer: _____

SECONDARY INSURANCE

Plan Name: _____ ID Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security No.: _____ Sex: □Male □ Female
Policy Holder's Date of Birth: _____ Employer: _____

Please, initial each line after review.

_____**Payment Policy**: CRCHC, Inc requires payment on the day service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all your charges and that your responsible for any balance on your account and will be billed until that balance is paid. This program allows patients to get a discount on their charges or your deductibles and co-insurance. Discount will not be applied to your insurance co-payments. You must apply with registration staff with documentation of total income and number of persons in the household. You must reapply for the program every year and payment must be made at time or service. Signing this form indicates you are aware of above policies and procedures and were advised of the sliding free program. I hereby authorize assignment of all insurance benefits payable directly to CRCHC, Inc

_____ **Authorization for Release of Information**: I authorize Cabarrus Rowan Community Health Centers, Inc to release my insurance carrier or its designation agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Cabarrus Rowan Community Health Centers in writing of any information I do not want released.

_____**Referrals/Option to Choose**: CRCHC is a primary care provider and is not equipped to provide all medical services that may be appropriate for your medical care. In some cases, CRCHC Inc. may recommend that you receive additional medical services, such as laboratory services, imaging services or specialty care from another healthcare provider. If this does occur, please be that you may be required to pay on the day of service and/or be billed for any balance on your account with the referral provider

_____**Limits of Confidentiality:** All information that you disclose to your CRCHC provider during the course of treatment is confidential and will not be revealed without your written permission (or your parents' permission if you are under 18-years-old) except for treatment, payment, or healthcare operations as permitted by law. Disclosure may also be permitted or required by law when: (1) there is a reasonable suspicion of child abuse, elder adult abuse and/or abuse of disabled adults; (2) there is a reasonable suspicion that you may present a danger of violence to others; and/or (3) there is a reasonable suspicion that you are likely to harm yourself. Disclosure may be required pursuant to a legal proceeding. If you have any questions about the limits of confidentiality, please discuss these concerns with your provider prior to signing this document.

_____Patient Acknowledge of Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities: I acknowledge that I have received and been given an opportunity to read a copy of the Cabarrus Rowan Community Health Clinic's Notice of privacy Practices and Patient Rights and Responsibilities

Please sign below you have read and understand all policies and consents.

Patient Name (Printed): _____

Signature: _____ Date: _____