MANNING REGIONAL HEALTHCARE CLINIC

DEPENDENT CHILD:

Date:______________ *Patient Name____*
First Middle Initial Last

Date of Birth____________ *Telephone #______________* *Cell Phone #______________* *Sex:* M F

Social Security #___________________ *Marital Status:* S M W D

Street Address____

City____State___________________ *Zip____________*

PARENTS:

Mother's Name_____________________________________ *Birthdate___________________________*

Address:_______________________________________Phone #:_____________Cell #____________

Place of Employment____Phone #__________________

Father's Name_____________________________________ *Birthdate___________________________*

Address:_______________________________________Phone #______________Cell #____________

Place of Employment____Phone #__________________

IF PARENTS ARE DIVORCED–name of parent with legal custody___________________________

**** Regardless of court orders, the parent who brings the child in for treatment is responsible for the charges in full****

EMERGENCY CONTACT:

Name____Phone #____________________________

PAYMENT FOR SERVICES:

Do you have insurance? *Yes______* *No_____*

► ***If no insurance coverage, which form of payment will be used?***

Cash_____Check____Credit Card_____ ***Payment in full is expected at the time of service.***

Person financially responsible for payment of this account_________________________________

INSURANCE INFORMATION:

We will be happy to file your insurance for you today. Please provide accurate insurance information. You are responsible to pay your co-pay and/or deductible at each visit. Because your insurance coverage is an agreement between you and your insurance company, all medical expenses are ultimately your responsibility.

(1)Insurance Company Name: ____

Subscriber______________________________ *Birthdate _________* *Policy Number______________*

(2) Insurance Company Name: ____

Subscriber_______________________________Birthdate__________Policy Number_____________

CONSENTS

FOR TREATMENT AND EVALUATION:

I have brought my dependent child to the Manning Regional Healthcare Clinic for evaluation and treatment. I give my consent to the healthcare providers of the Manning Regional Healthcare Clinic to examine and treat my dependent child..

X____ ________________________
Signature of guardian. *Date*

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS AND ASSIGNMENT OF BENEFITS:

I have been given the opportunity to review the clinic's "Notice of Information Practices" which summarizes the ways my Individually Identifiable Health Information (IIHI) may be used or disclosed by the Clinic for treatment, payment and healthcare operations and states my rights with respect to my IIHI. By signing this form, I am consenting to the Manning Regional Healthcare Clinic's use and disclosures of my IIHI as outlined in the "Notice of Information Practices."

I give my consent to the Manning Regional Healthcare Clinic staff to call my home or other designated location and leave a message on the answering machine, voice mail, or in person, mail to my home or other designated location, or e-mail my home or other designated location, any items that assist the clinic in carrying out treatment, payment and healthcare operations. This can include, but is not limited to, such things as appointment reminders, insurance or billing concerns, lab results, specialty appointments, and procedure appointments.

By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.

I authorize the release of any medical information necessary to process all claims from Manning Regional Healthcare Clinic. I also request payment of insurance benefits (including Medicare if applicable) to be made to Manning Regional Healthcare Clinic.

X____ _____________
Signature of Parent or guardian *Date*

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PRINT PATIENT NAME *Guardian's relationship (if applicable)*