Coastal Healthcare REGISTRATION PEDIATRICS

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION ***PRINT*** ***REFERRED BY:*** _____

Last: _____
First _____ MI _____
Nickname: _____
Address _____
City _____
State _____ Zip _____
Please put an (X) next the your preferred contact number:
Home# _____ (___)
Cell # _____ (___)

PRIMARY CARE DR: _____
Date of Birth _____
Sex: Male Female
Marital Status: Single Married

PATIENT'S INFO:
Social Security # _____
Employer: _____
Employ status: F/T P/T
Student: F/T P/T

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INS CO _____	INS CO. _____
ID # _____ COPAY $ _____	ID # _____ COPAY $ _____
PT's Relationship: ___Self __Spouse __Child __Part	Pt's Relatiion: __Self __Spouse __Child __Partner
If Insured is other than patient (self):	
Insured name: _____	Insured name: _____
SS# _____ DOB _____	SS# _____ DOB _____
Employer: _____	Employer: _____

EMERGENCY CONTACT:

Name: _____ Relationship _____
Address if different that patient: Phone: _____
Street: _____ City _____ Zip _____

Private Insurance Authorization Assignment of Benefits/ Informaton Release:
I, the undersigned, authorize payment of a medical benefit to Coastal Healthcare for any services furnished me by the physician. I understand that I am financially responsible for any amoutn not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for hte purpose of evaluating and administering claim benefits

Patient Signature: _____ **Date:** _____

If the patient is a minor or under 18 years of age, the parent or guardian must complete the information below and sign. Signature of Responsible Party Required.

Parent/Guardian Name: _____
Social Security: _____ **Date of Birth** _____
Address if different than Patient: _____
Phone if different than Patient _____
Signature: _____ **Date** _____

Coastal Healthcare PATIENT INFORMATION

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

Patient Name: _____ Patient/Guardian Email: _____

OK to use email and/or text for appointment confirmation?

EMAIL ____Yes ___No TEXT ____ Yes ____No

OK to leave message at

____ HOME	____Brief	or	____Extended	_____
____ CELL	____Brief	or	____Extended	_____
____ WORK	____Brief	or	____Extended	_____

Race: (Check one below)

_____ American Indian or Native Alaskan
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Other Race
_____ Other Pacific Islander
_____ Unreported or refused to report

Ethnicity: (Check one below)

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report

Language other than English:

_____

PATIENT EMPLOYMENT INFORMATION

Employer address:_____ City_____ Zip_____
Employer Phone number:_____

PHARMACY INFORMATION

Please list your preferred Local and Mail Order Pharmacy. Prescriptions will be done electronically ☐ ☐ directly

LOCAL PHARMACY:

Name:_____
Address:_____
City:_____Zip_____
Phone #_____
Fax: _____

MAIL ORDER PHARMACY:

Name:_____
Address:_____
City:_____Zip_____
Phone #_____
Fax: _____

ERx History Consent:

I hereby give **Coastal Healthcare** and its affiliated providers permission to view my prescription information and history from all external sources. By signing this consent form, I agree that **Coastal Healthcare** can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for all treatment purposes.

Patient Signature _____ Date _____

Coastal Healthcare PATIENT HISTORY FORM Completed by Patient

PT NAME: _____ Date: _____ LIVING WILL ___YES ___NO

ADDRESS: _____ City _____ , NJ Zip _____

Occupation/Employer: _____ ___M ___S ___W ___D

FAMILY: If any Blood Relative has suffered any of the following, circle the number. Print which blood relative

1. Epilepsy	6. Thyroid Disease	11. Osteoporosis	16. Lipid Disorder	_____
2. Migraine	7. Hayfever	12. Arthritis	17. Alcoholism	_____
3. Glaucoma	8. Asthma	13. Heart Disease	18. Hepatitis	_____
4. Diabetes	9. Anemia	14. Stroke	19. Cancer	_____
5. Mental Illness	10.Bleeds Easily	15. Hypertension	20 Other	

PERSONAL HISTORY: Check "√ "and write age when you had any of the following symptoms or disease:

MAIN PROBLEMS: 1	2	3	
__Decreased Hearing	__Persistent nausea - Vomiting	__Chronic fatigue	Alcohol ____oz per wk
__Ringing in ear	__Abdominal pain - chronic	__Diabetes	Caffeine ____# cups/day
__Ear infections - frequent	__Gallbladder trouble	__Thyroid Disease	Smoking _____#per day
__Dizzy spells __Fainting spells	__Abdominal pain - chronic	__Seizures __Stroke	Exercise ___Yes ___No
__Failing vision __Eye pain	__Gallbladder trouble	__Tremor, hands shaking	Street drug __yes __No
__Double or blurred vision	__Jaundice - Hepatitis	__Numbness - tinngling sensation	Hair loss ___Recent ___P
__Nose bleeds - recurrent	__Diarrhea __Constipation	__Headaches - frequent	__Progressive
__Sinus trouble	__Diverticulosis __Colitis	__Arthritis - Rheumatism	**FEMALES:**
__Sore throats - frequent	__Bloody or tarry stools	__Back pain - recurrent	Menstrual Flow:
__Hoarseness - prolonged	__Hemorrhoids __Hernia	__Bone fracture - joint injury	___ Regular ___Irregular
__Hayfever - Allergies	__Urination - overactive bladder	__Osteoporosis	#___days every ___wks
__Pneumonia - Pleurisy	__Overnight more than twice	__Foot pain __Gout	Pain/bleed during or after cycle
__Bronchitis - Chronic cough	__ More than 8 times in 24 hrs	__Rashes __Hives	__yes __No
__Asthma - Wheezing	__Urgency to urinate __leakage	__Psoriasis __Eczema	# of Pregnancies
__Shortness of breath:	__Urination force/flow __ painful	__Sleeping/concentration problem	____Abortions
__on exertion __ lying flat	__Stress incontinence - leakage	__Depression __Nervousness	____Miscarriages
__Chest Pain	___with exercise, movement	__Agitation __Memory loss	____Live births
__High Blood Pressure	__Blood in urine __Kidney stones	__Moodiness __Suicide thoughts	Birth Control Method
__Heart murmur _Swollen ankles	__ Urine infections - frequent	__Phobias __Mental Illness	
__Irregular pulse __Palpitations	__Sexually transmitted disease	__Feelings of worthlessness	___Flushing/Menopause
__Leg pain - when walking	__Recent weight ___gain ___loss	__Rheumatic fever __Scarlet fever	Date of last PAP
__Varicose veins - Phlebitis	__Anemia __Bruise easily	__Chicken Pox __Polio __Mumps	
__Cold numb feet	__Blood transfusions	__Measles __German Measles	Date of last MAMMO
__Loss of appetite	__High risk sexual activity	__Tuberculosis ___Herpes	
__Difficulty swallowing	__Cancer	__Aids/HIV	__Normal __Abnormal
__Heartburn __Peptic ulcer		__Accupuncture - Tattoos	

HOSPITAL ADMISSIONS Do not include pregnancies	YEAR	Illness or Operation ___List continued on reverse side of page		

SPECIALISTS YOU SEE			
Name & Specialty			

Patient Signature: _____ **DATE:** _____

COASTAL HEALTHCARE

PATIENT'S MEDICATION FORM – Completed by Patient/Guardian.. Please Print

Name:	Phone #:	DOB:
Emergency Contact Name & Phone #		

ALLERGIC TO:	**Describe reaction:**

Do you prefer generic if it is recommended and available? _____***YES*** _____***NO***

LIST ALL ***Prescribed Medication and dosage** ***Over the Counter meds** ***Vitamins**	Frequency: (i.e. daily, twice daily, every M-W-F etc)	What time of the day do you take this medication?				Name of doctor that prescribed the medication	Stop Date
		Morning	Noon	Supper	Bedtime		

PATIENT/GUARDIAN SIGNATURE: DATE:

COASTAL HEALTHCARE Medication Info

PATIENTS:

1. **Always keep this form with you.**
2. Take this form to ALL doctor visits and ALL medical testing (lab, x-ray, etc). Take this form to ALL assessment visits for admission for surgery and ALL hospital visits (ER, in-patient and out-patient visits)
3. Update this form as changes are made to your medications. If a medication is stopped, record the date it was stopped. Remember, it's very important to include non–prescription medicines (over the counter drugs) on your Medication Form. Some herbal supplements can have dangerous side affects with prescription medicines.
4. Tell your family, friends and neighbors about the benefits of using this form.
5. When you return to your doctor present this form. **Always keep this form with you.** This will keep everyone up-do-date on your medications.

HOW DOES THIS FORM HELP YOU? By using this form, it:

1. Reduces confusion and saves time. You do not have to remember all the medications you are taking, the form does this for you.
2. Improves communication. Provides doctors and hospitals with a current list of ALL of your medications. Let's the patient and/or family know exactly what medications are to be taken and when.
3. Improves Medication Safety. Medication interactions and duplications can be detected and corrected.

MEDICATION REFILLS:

- *Medication refills are done electronically. You will no longer receive a written script from the office. No need to come to the office and pick up your script! EXCEPTION: Certain class medications will require a written script to be picked up at the office.*
- *Refills requests: You should call your pharmacy , not the office, for medication refills. Your pharmacy or mail order supplier will then contact our office directly with all the information needed to fill your prescription. (correct medication name, dosage, etc)*
- *We request that each patient complete the medication log and bring it with them each visit for review by the doctor.*
- *Allow 2 business days for your pharmacy to process your prescriptions.*

Coastal Healthcare

FINANCIAL POLICY

Welcome to Coastal Healthcare. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. If your insurance company requires referrals, advanced notification is required for non-emergent referrals. Also, when coming to a Coastal Healthcare specialist, you must have your referral before being seen or you will be responsible for payment in full at the time of service. We accept payment from all participating insurance plans, but require that you pay your co-pay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
All missed appointments with the doctor and those cancelled with less than 24-hour notice may be subject to a $25.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge. There may be additional charges, not covered by insurance, including form processing fees (i.e., physicals, disability), after-hours appointments, weekend appointments, appointments on holidays, and a processing fee on over 30 day unpaid balances ($10 per statement).

Collection Agency:
All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.

Financial Hardship:
Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY.

_____ _____

Patient Name-Please Print Date

_____ _____

Patient or Parent Signature Relationship

Coastal Healthcare

1659 Route 88 - Suite 2B
Brick, New Jersey 08724
(732)458-1211 Fax (732)836-3144

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Coastal Healthcare (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a) **Treatment** – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care.

(b) **Payment** – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Health Care Operations** – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECTED HEALTH INFORMATION

(a) **Advice of Appointment and Services** – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(b) **Family/Friends** – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a) **De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

(b) **Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

(c) **Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Public Health Activities** – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

(f) **Abuse, Neglect or Domestic Violence** – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

(g) **Health Oversight Activities** – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.

(h) **Judicial and Administrative Proceeding** – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

(j) **Coroner or Medical Examiner** – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) **Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

(l) **Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

(m) **Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

(o) **Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

(p) **National Security and Intelligence Activities** – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

(q) **Military and Veterans** – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Request special authorization to allow the Practice to use and disclose your protected health information (PHI) for purposes other than those enumerated in this Notice of Privacy Practices (NPP). This request must be made in writing to the Practice's Privacy Officer.

(h) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer, or from this Practice's web site www.shorehealthgroup.com.

(i) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

Coastal Healthcare
Attn: Privacy Officer
1659 Route 88, Suite 2B
Brick, New Jersey 08724
(732)458-1211 Fax (732) 836-3144

PRACTICE'S REQUIREMENTS

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/14/03.

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice:**
   I have been offered a copy of ***Coastal Healthcare's*** Notice of Privacy Practices.

   Patient Name: _____ Date of Birth_____

2. **I wish to be contacted in the following manner (check all that applies):**

   Home Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

   Cell Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

   Work Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

   Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. ***Coastal Healthcare*** operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **Designation of Certain Relatives, Close Friends and Other Caregivers:**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (other than patient) **1)** _____ **2)** _____

Relationship to Patient: **1)** _____ **2)** _____

Date of Birth: **1)** _____ **2)** _____

Telephone #: **1)** _____ **2)** _____

_____ _____
Signature of Patient/Parent/Guardian Date

Coastal Healthcare

OFFICE POLICY

Coastal Healthcare's goal is to provide and maintain a good physician-patient relationship. We start with skilled professional physicians and staff who recognize the importance of good communication on all levels.

1. CHECK IN:

- *Upon arrival, please check in at the front desk. For your initial visit, present a photo ID such as a driver's license and your Insurance Card. You will be asked to complete registration forms. Any payment due by patient is requested during check in.*
- *At all visits thereafter, check in at the front desk, present your current insurance card and any payment due at EVERY visit. Please inform us of any changes to your personal information such as address, phone or insurance.*

2. MEDICATION REFILLS:

- *All refills are done based on patient's adherence to scheduled appointments and medical necessity. Please be prepared to review your medication refill needs at the time of your visit. Contact your pharmacy to request refills outside of scheduled appointments as prescription refills are done electronically to and from your pharmacy. Please call your pharmacy first for your refills. They will contact the office. If you prefer a 3 month mail order, please allow ample time for the order to be processed and received through the mail. Refills for certain class drugs will need to be picked up at the office.*

3. INSURANCE: Under the guidelines of your insurance plan, it is your responsibility to understand your benefit plan.

- *REFERRALS/AUTHORIZATIONS: It is your responsibility to know if a referral or authorization is required to see a specialist. Three (3) business days is requested for non-emergent referrals and authorizations.*

*PATIENT SIGNATURE:*_____ *DATE:*_____

COASTAL
HEALTHCARE

PATIENT:_____ **DOB**_____

CONSENT FOR TREATMENT OF MINOR CHILDREN

Accompanied by an adult other than parent or legal guardian

I, _____

(Parent or legal guardian)

Authorize Coastal Healthcare to treat (child) _____
for routine and emergency medical treatment when deemed necessary by
qualified medical personnel when accompanied by:

_____ Relationship to child:_____
_____ Relationship to child:_____
_____ Relationship to child:_____

This authorization is valid for:

____ Today's visit only Date:_____
From (date) _____ to (date) _____
____ Until revoked in writing by me

THIS CONSENT WILL BE VALID FOR ONE (1) YEAR FROM THE DATE SIGNED

Printed name of parent/legal guardian_____

Signature of parent/legal guardian_____

Date:_____