PEDIATRIC CARE OF KENTUCKY

18 YEAR-OLD TRANSITION TO ADULT 5-22-18

Dear Patient:

Once you reach the age of 18 the guidelines below will apply:

1-At 18 years of age you are legally considered an adult and can make your own medical decisions. Without your written consent, our doctors cannot discuss your health with anyone else unless you sign the authorization attached.

2-You will need to know your medical history. Do you have any allergies, chronic problems, etc?

3-You will be responsible for notifying the office of any address or phone changes.

4-Your insurance card, co-payment, co-insurance and deductible is due at the time of service.

5-Are you covered under your parent(s) insurance? YES NO

6-Is your parent(s) responsible for your medical bills? YES NO

(If your parent(s) refuses, you will be held financially responsible)

7-If you are covered under your parent(s) insurance your parent(s) will have knowledge of your visit when they receive the explanation of benefits from the insurance company.

8-If you are away at school our physicians will be happy to see you for your medical needs when you are home. We encourage you to use your student health service resources as we will not be able to triage or prescribe medications over the phone.

9-If you are away at school and plan to continue medications we have prescribed for the treatment of chronic problems such as asthma, allergies, ADHD, etc., periodically an office visit is required.

10-Pediatric Care of Kentucky will provide care until your 22nd birthday or you begin to develop adult problems. When it gets close to your 22nd birthday please sign a record release and your records will be transferred to your new physician.

Patient's Printed Name Signature Date

PEDIATRIC CARE OF KENTUCKY
18 YEAR-OLD AUTHORIZATION TO RELEASE INFORMATION 5-22-18

Date: ____ /____ /____

Patient Name:

_____

Last First Date of birth

I give permission to the adults listed below access to my health record including but not limited to X-rays, immunizations, lab results, and prescriptions or to act on my behalf in my absence.

_____

Name, phone, and last 4 numbers of **their SS#** Relationship to patient

_____

Name, phone, and last 4 numbers of **their SS#** Relationship to patient

_____

Name, phone, and last 4 numbers of **their SS#** Relationship to patient

THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS THIS SECITON IS CHECKED AND SIGNED

Yes No Patient Signature: _____ Date: _____

Sexual records ☐ ☐

Drug & Alcohol Records ☐ ☐

Psychiatric Records ☐ ☐

Genetic information ☐ ☐

- I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

- I understand there may be medical records from another doctor or another medical facility in my chart.

- I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

- These authorizations are valid unless and until they are revoked, in writing, and presented to Pediatric Care of Kentucky, PSC.

_____

Patient Signature Date