PATIENT REGISTRATION

Patient's Name: _____ **Date of Birth**: _____ **Gender: M F**
(First) (Last)

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(First) (Last)

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(First) (Last)

Patient's Name: _____ **Date of Birth**: _____ **Gender: M F**
(First) (Last)

Child's Home Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Birth State/Country: **Email Address:** _____

Primary Phone: ( ) **Referred By:**_____

Pharmacy Name & address: **Pharmacy Number: ( )**

Mother's Name: _____ Date of Birth _____ Occupation: _____

Cell Phone: ( ) (Circle) IPhone/Android/other Work Phone: ( )

Father's Name: _____ Date of Birth _____ Occupation: _____

Cell Phone: ( ) (Circle) IPhone/Android/other Work Phone: ( )

Legal Guardian: _____ **DOB**: _____ Primary Phone: ( )

Emergency contact (other than parents, not living in the same household**)**

Name**:** _____ Phone**: ( )**

I give permission to the staff of Van Dorn Pediatrics to see and treat my child when the following people bring them into the office: (other than parents)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

INSURANCE & BILLING INFORMATION

Payments are required at time of service (unless prior arrangements have been made)

Billing Address (if different from above):

Subscriber's Name: _____ **DOB:** _____ **Effective Date:** _____

Primary Insurance: _____ **ID#** _____ **Group#**_____

Secondary Insurance: _____ **ID #** _____ **Group#** _____

Tertiary Insurance: _____ **ID #** _____ **Group#** _____

I hereby authorize direct payment of surgical / medical benefits to **Van Dorn Pediatrics, P.C.** for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. Failure to disclose or update all insurance plans may lead to financial \ responsibility. I certify that the information given by me in applying for payment is correct.

PARENT / GUARDIAN (please print**):** _____

SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY

1. Insurance: We participate in most insurance plans, including Medicaid. If you are not insured by a plan with which we do business, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Proof of insurance: All patients are required to provide proof of insurance on the day of their visit. Some insurances also request that we have a SSN (Social Security Number) in order for claims to get submitted. Please always keep this in mind and be willing to provide it, if ever asked.

- Present your primary, secondary or tertiary insurance card at the time of service
- Present a photo ID for verification of identity

3. Coverage changes: Inform us immediately if your insurance carrier changes and provide us with a copy of your new card (front and back) to ensure that claims are submitted to the correct insurance. Failure to notify us may lead to delay in claim submission, and you may be responsible for payment.

4. **Guarantee of payment: Van Dorn Pediatrics requires all families to keep a credit card on file for collection of any co-payments, deductibles, and to resolve any remaining balances.** If your insurance has a contract with Van Dorn Pediatrics, you are not responsible for amounts that are agreed to be written off. If your insurance does not have a contract with Van Dorn Pediatrics, you are responsible for any amounts not paid by your insurance plan. Your credit card on file will be used for these payments. In the event that you default on payment of your account, you are responsible for any and all costs incurred on the collection of your account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, you are responsible for collection fees and interest due to amounts in default.

6. **Missed appointments:** You may be charged for any missed appointment if not cancelled within 24 hours of the appointment, including appointments made within the same day. Missed well visits are subject to a fifty dollar ($50) fee, and other missed visits are subject to a twenty dollar ($20) fee for no show or same day cancellation. More than **3 no shows** can lead to termination from the practice.

7. Forms: There will be a $10 processing fee for all forms (sports, school, physicals and medical).

8. **Collections:** Three statements will be sent before amount is sent to collections. An additional fee will be added once in collections.

9. Virtual visits (Telemedicine) consultations: These visits will be billed to your insurance according to the established guidelines. Benefits related to this service vary by insurance and you may be responsible for co-pay, coinsurance and deductible amounts.

I have read and understand the financial policy and agree to abide by its guidelines for all my children or dependents being treated by Van Dorn Pediatrics:

Parent/Guardian's Signature: _____ Date: _____

CUSTODY

We believe that such matters should not enter into a child's medical treatment. The individual who is requesting the medical treatment is responsible for the payment of the medical bills. We will collect copays and deductibles from the attending parent. "Joint Custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results. We will discuss with the accompanying parent information pertinent to the child's history and/or present exam. We will not call the other parent to give updates on the child, we are not a party to your divorce agreement, you are.

Parent/Guardian's Signature: _____ Date: _____

NOTICE OF PRIVACY

This notice describes how medical information about you/your child (As a patient of this practice) May be used and disclosed and how you can get access to that information.

1. OUR COMMITMENT TO YOUR PRIVACY

The physicians and the staff of Van Dorn Pediatrics, P.C., in accordance with applicable federal and state law, are committed to maintaining the privacy of you/your child's protected health information (PHI). In conducting our business, we will create records regarding you/your child that includes information about their health condition and the care and treatment performed by the Practice. We may change our notice at any time. The new notice will be effective for all PHI maintained at that time.

2. HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTHI INFORMATION (PHI)

The Practice, in accordance with this notice and without asking for express consent/authorization may use and disclose you/your child's PHI for the purpose of:

Treatment: To provide the required health care, the practice may use and disclose you/your child's PHI to those health care professionals, whether on the practice's staff or not, so that it may provide, coordinate, plan and manage you/your child's health care. This also includes laboratories and pharmacies that we deal with on order to diagnose or write your prescription.

Payment: To get paid for services provided to you/your child, the practice may provide PHI, directly or through a billing service, to a third party who may be responsible for you/your child's PHI in other collection efforts with respect to all persons who may be liable for the practice's bills related to your care. 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.

Heath Care Operations: To operate in accordance with applicable law and insurance requirements, and to provide quality health 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/your child, or in training medical students who rotate in the practice.

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

Appointment Reminder: The practice may 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/your child by mail, phone or email.

Directory/Sign in log: The practice may have a sign in log at its reception desk for individuals seeking care in the office. This will include you/your child's name. The sign in log is located in a position where staff as well as others who are seeking care in the office can see it. We may also call you/your child by name when your physician is ready to see you.

Family/Friends: The Practice may disclose your family member, other relative, a close personal friend, or any other person identified by you, you/your child's PHI directly relevant to such person's involvement with your care or payment for your care. The Practice may also use or disclose you/your child's PHI to notify or assist in the notification (including identifying or locating) a family member, or other person responsible for you/your child's location or general condition.

4. YOUR RIGHTS:

You have the right to:

1. Revoke any authorization/consent you have given to the practice by submitting a written request to the practice's privacy officer. You may request restrictions on certain uses and disclosure of you/your child's PHI including treatment, payment or healthcare operations as proved by law. Except in certain instances, the practice may not be obligated to agree to any requested restrictions. In your written request, you must inform the practice of: A) What information you want to limit. B) Whether you want to limit the practice's use or disclosure, or both. C) To whom

you want the limits to apply. If the practice agrees to you request, the practice will comply with your request unless the information is needed in order to provide you/your child with emergency treatment.

2. Receive confidential communication or PHI by alternative means or at alternative locations, for example, you may ask to be contacted at home only and not at work, you must make your request in writing to the practice's privacy officer. The practice will accommodate all reasonable request.

3. Inspect and copy you/your child's PHI as provided by law. To inspect and copy you/your child's 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. Our practice may deny your request to inspect and or copy in certain circumstances, but you will have the right to review the denial as set forth more fully in the written denial notice.

4. Amend your PHI as provided by law. You may ask to amend you/your child's PHI if you believe it is incorrect or incomplete. 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 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 you PHI maintained by the practice, if the information is not a part of the information you would be permitted to inspect and copy, and/or if the information is accurate and compete in our opinion. If you disagree with the practice's denial, you will have the right to submit a written statement of disagreement.

5. Receive an accounting of disclosure of your PHI as provided by law. An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operation purposes. 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 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 before any costs are incurred.

6. Receive a paper copy of this privacy notice from the practice upon request to the practices privacy officer.

7. Complain to the practice or to the Secretary of Dept. of Health and Human Services, if you believe you/your child's privacy rights have been violated. To file a complaint with the practice, you must contact the practices privacy officer, Mobeh Andrawis, M.D. in writing.

5. THE PRACTICE REQUIREMENTS:

The Practice:

1. Is required by federal law to maintain the privacy of you/your child's PHI and to provide you with this privacy notice detailing the practice's legal duties and privacy practices with respect to you/your child's PHI.

2. May be required by state law to maintain greater restrictions on the use of release of you/your child's PHI than that which is provided for under federal law. In particular, the practice is required to comply with the following state statues: Health General Article, Title 4, Subtitle 3, Confidentiality of Medical Records and subtitle 4, Personal Medical Records.

3. Will distribute any revised Privacy Notice to you prior to implementation and will not retaliate against you for filing a complaint EFFECTIVE DATE: This notice is in effect as of October 28, 2004.

PATIENT/GUARDIAN ACKNOWLEDGEMENT: By signing my name below, I acknowledge receipt of a copy of this notice and my understanding and agreement to its terms for all my children or dependents being treated by Van Dorn Pediatrics.

Parent/Guardian's Signature: _____ Date: _____

EMAIL REQUEST RELEASE FORM:

I _____ request my school forms, lab results or vaccine records to be sent via the email listed in my child's/children's registration.

Email: _____

Please check the options below:

- ☐ Lab results
- ☐ School Forms
- ☐ Vaccine Record

Parent/Guardian's Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT

My child is 16 years of age (or older) and has a current driver's license. I give Van Dorn Pediatrics authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits. This form remains in full effect until rescinded in writing by parent/legal guardian.

Parent/Guardian's Signature: _____ Date: _____

TELEHEALTH CONSENT

Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and/ or data communications.

Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, vitals, or other screening tests that assist my provider in diagnosis and treatment; (ii)my provider's inability to perform a physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties, distortion of images or information resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures.

I understand that if my provider believes I would be better served by face-to-face services or another form of care, an in-person appointment will be arranged.

I understand that it is my responsibility to determine whether telehealth services are covered by my insurer. I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible

By signing my name below, I acknowledge I have read and understood the telehealth consent:

Parent/Guardian's Signature: _____ Date: _____

IMMUNIZATION / INJECTIONS

It is our duty to protect each of our patients to the best of our ability, this means having fully immunized patients. I give the staff permission to administer routine immunizations and to provide medication for my child/children. I understand that printed handouts regarding vaccines will be given to me at the time of my immunizations. I also understand that the staff will answer any questions I have at the time of administration. Legal guardians who are not able to abide by out guidelines will be asked to find another medical practice that is able to comply with their beliefs.

Parent/Guardian's Signature: _____ Date: _____

Single Consent to Share Medical Information with Children's IQ Network Providers Treating Me or My Child

INTRODUCTION

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, Van Dorn Pediatrics has elected to participate in the Children's National Health System's IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child's health care provider and one of the country's leading children's hospitals.

This SINGLE CONSENT will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child's healthcare information is encrypted (encoded) **and can be accessed only by health care providers who are caring for you or your child and have a need to know**.

As Van Dorn Pediatrics is a part of the Children's IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child's treatment. I further understand that I will be permitted to change my decision to not allow sharing with other health care providers at any time in the future.

PATIENT RIGHTS: I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN.

PROTECTED DISCLOSURE OF INFORMATION: I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child's treatment as defined in the Notice of Privacy Practices. I agree to Children's National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

By signing below, you are agreeing to all polices outlined as well as choosing to opt in to be part of the CIQN network outlined above for all my children or dependents being treated by Van Dorn Pediatrics.

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____