KidsChoice Pediatrics

Demographics

Today's Date: _____

Patient Information

Last Name:_____ First Name:_____ Middle Initial:____ (nickname)_____

Date of Birth:_____ Social Security #_____ Sex: Female / Male

Address:_____ City:_____ State:_____ Zip:_____

Cell #_____ Home #_____ Work # _____

Race: ___ American Indian ___ Asian ___ Black ___ White ___ Hispanic ___ Refused to report/other _____

Nationality:_____ Primary Language Spoken:_____

Patient lives with:_____ Email:_____

Mother/Stepmother/Guardian

Last Name:_____ First Name: _____

Date of Birth:_____ Social Security Number: _____

Address:_____ City:_____ State:_____ Zip:_____

Cell #_____ Home #_____ Work # _____

Employer:_____ Occupation:_____ Marital Status: M/S/D Other _____

Father/Stepfather/Guardian

Last Name:_____ First Name: _____

Date of Birth:_____ Social Security Number: _____

Address:_____ City:_____ State:_____ Zip:_____

Cell #_____ Home #_____ Work # _____

Employer:_____ Occupation:_____ Marital Status: M/S/D Other _____

Insurance Information

Primary

Policy Holder Last Name:_____ First Name:_____ Relation to patient _____

Insurance Company Name: _____

Claim Address (on back of card): _____

City:_____ State:_____ Zip: _____

ID Number:_____ Group Number: _____

Secondary

Policy Holder Last Name:_____ First Name:_____ Relation to patient _____

Insurance Company Name: _____

Claim Address (on back of card): _____

City:_____ State:_____ Zip:_ ID Number:_

_____ Group Number: _____

Patient Name: _____ **DOB:** _____

Emergency Contacts:

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Pharmacy Information

Name: _____ Phone # _____

City: _____ State: _____ Zip: _____

How did you hear about out practice?

- ○ Friend _____
- ○ Staff member _____
- ○ Magazine _____
- ○ Physician _____
- ○ Other _____

By signing I am stating that the information completed above is current and true to the best of my knowledge.

Printed name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Kidschoice Pediatrics

Consent to Release of Confidential Healthcare Information

Patient's name:_____DOB: _____

As the person signing this document, I understand I am giving permission to the physician and or staff members of Kidschoice Pediatrics to release medical information. **PLEASE LIST BELOW ALL PARTIES THAT YOU ARE AUTHORIZING THE RELEASE OF MEDICAL INFORMATION TO:**

Myself (Mother/Father) ☐ YES ☐ NO Name: _____

Spouse (Mother/Father) ☐ YES ☐ NO Name: _____

Other adult parties authorized:

Name:_____Relationship_____Phone # _____

Name:_____Relationship_____Phone # _____

Name:_____Relationship_____Phone # _____

May we contact you at your place of employment? YES NO Phone #: _____

May we leave information on your home voicemail? YES NO Phone #: _____

May we leave information on your cell voicemail? YES NO Phone #: _____

I also understand that I have the right to revoke this release, but that my revocation is not effective until delivered in writing to Kidschoice Pediatrics.

Date :_____

Name of Parent/Guardian (Print): _____

Name of Parent/Guardian (Signature): _____

KIDSCHOICE PEDIATRICS

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Patient Name:_____DOB: _____

Address: _____

Phone #:_____ Cell#: _____

Reason for Request:_____Continuing Care _____Personal Use_____Other

Reason for transferring: _____
If transferring to another physician please note: All patient information in file is NOT included in the copying process. Records sent to us from other medical facilities will not be part of the copying process. Those records must be requested from the other medical facilities. We will only copy and forward records originated from Kidschoice Pediatrics.

INFORMATION TO BE RELEASED

_____ Complete Chart _____Immunization/Vaccine Record _____Labs/Xray _____Hospital Record

I,_____(parent/guardian) certify the above request is accurate and hereby authorize the release of these records to/from Kidschoice Pediatrics

TO/FROM: (circle one)

KIDSCHOICE PEDIATRICS
10411 COURTHOUSE RD STE A
SPOTSYLVANIA, VA 22553
O: 540-710-6006
F: 540-710-6001

TO/FROM: (circle one)

Facility Name: _____
Address:_____
Phone #: _____
Fax #: _____

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Kidschoice Pediatrics from, and covenant not to sue Kidschoice Pediatrics for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment of eligibility for benefits. I may request to inspect or copy any information use/disclosed under this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire in 6 months after the date specified below, or on the date, event or condition described as: _____
*Note: Complete chart may include any information from previous provider, information about HIV/AIDS status, drug/alcohol abuse, or psychiatric records, you are hereby authorizing disclosure of this information.

Parent/Guardian Signature _____ **Date:** _____

*VA Law allows for copy charges consisting of the following:

Administrative Fee:	$10.00	Administrative Fee	$10.00
Copy per page	$0.50 (first 50 pages)	_____ # of pages @ $.50	$_____
Copy per page	$0.25 (page thereafter)	_____ # of pages @ $.25	$_____
Microfilm/fiche	$1.00 per page	_____ # of pages @ $1.00	$_____
Archive charts	$25.00 (retrieval fee)	Archive Retrieval Fee	$_____
		Total Fee:	$_____

Paid: YES NO Records Mailed YES NO
Vaccine Faxed YES NO

KidsChoice Pediatrics
10411 Courthouse Road, Suite A
Spotsylvania, VA 22553
Office: 540.710.6006 Fax: 540.710.6001

Office Policies and Payment Agreement

All copays are due at the time of service.

Our billing department will apply on your behalf for the coverage of medical services provided by this medical facility, by submitting your claims to your insurance company. Our billing department may be required to release necessary medical information to your insurance company, to determine the insurance benefits of which you may be entitled, in order to process your claims. This is a courtesy that may be withdrawn, if your insurance company becomes uncooperative in making payments.

Although we will make every attempt to receive verification of coverage before services are provided, our office **DOES NOT** guarantee that your insurance company will pay for provided medical services. It must be **FULLY** understood that your insurance contract is between you and your insurance company and it is your sole responsibility to know and understand what is/is not covered by your medical insurance policy.

You understand and agree that if it is determined that your insurance is not in effect on the date services are provided, or if your insurance claim is denied for any reason, **you will be financially responsible for all total amounts due on your bill.** If there is a pending insurance claim, you will continue to receive monthly statements from this medical facility listing all charges, payments, adjustments, and the current amount due.

There is a $50 non-sufficient fund charge for all returned checks and a $50 no-show charge for appointments missed without a 24 hour cancellation notice. This applies to all patients regardless of your insurance. No-shows or continuous missed appointments are grounds for dismissal from this medical facility.

By signing below…..
You authorize our billing department to apply on your behalf for the coverage of medical services provided by this medical facility, and you authorize our billing department to release required medical information to your insurance company in order to determine insurance benefits of which you may be entitled.
You authorize your insurance company to disburse payments to this medical facility for covered medical services and you acknowledge that either you or your insurance company may revoke this authorization at any time in writing.

IN THE EVENT THAT MY ACCOUNT BECOMES OVERDUE, I UNDERSTAND THAT I AM RESPONSIBLE FOR THE OUTSTANDING BALANCE AS WELL AS COLLECTION COSTS, ATTORNEY'S FEES AND COURT COSTS, AND ACCRUED INTEREST ON THE OUTSTANDING BALANCE. A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

You attest that the medical insurance information that you have provided to this medical facility is accurate, you attest that you have thoroughly read, understand and agree to all statements as described herein and you pledge to abide by and be bound to all statements of this Financial Policy and Payment Agreement.

If you do not have active insurance you are considered a self-pay patient and will be responsible for all the charges related to the services rendered at today's appointment with KidsChoice Pediatrics.

Patient Name (please print) _____ DOB_____
Guarantor Name (please print)_____ Relationship_____
Signature of Guarantor_____ Date_____

Kids Choice Pediatrics
10411 Courthouse Road, Suite A
Spotsylvania, VA 22553
Office: 540.710.6006 Fax: 540.710.6001

HIPAA Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

Conducting, planning of direct treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I have been given a copy of the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or payment of healthcare operations. I also understand that you are not required to agree to any requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

IN ORDER TO PROTECT PATIENCE PRIVACY AND COMPLY WITH HIPPA, PLEASE REFRAIN FROM CELL PHONE USAGE WHILE IN OUR OFFICE. THIS INCLUDES TAKING PHOTOGRAPHS AND RECORDINGS

Office Policies

I have been given a copy of Kidchoice Pediatrics' Office Policies. I have read, understand and accept these policies. I also understand that I may contact Kidschoice Pediatrics at anytime to request a copy of these office policies.

Please sign below, stating you have received and understand the Office Policies of Kidschoice Pediatrics and your rights under the Health Insurance Portability & Accountability Act (HIPAA).

Patient Name:_____ DOB: _____

Parent/Guardian printed name: _____

Relationship to Patient:_____ Signature:_____

SUZANNE RICHMAN, M.D.
CAROLINE CONNEEN, NP, LBCLC
JODY CARLTON, MSN,CPNP-PC
OFFICE POLICIES

DEAR NEW PATIENTS AND PARENTS:

WELCOME TO OUR PRACTICE! At Kidschoice Pediatrics it is our mission to provide excellence in pediatric care in a warm and nurturing environment. We want your family to feel comfortable with both our staff and our office environment. Our office is bright and child friendly with whimsical and fun themed rooms. We are a small practice and we take pleasure in developing a close working relationship with our patients and their families. At Kidschoice Pediatrics we care for children from birth to age 18. We provide well child preventative care, acute sick visits, as well as management of chronic problems and diseases.

APPOINTMENTS: At Kidschoice Pediatrics we see patients by appointment. We strive to accommodate all our sick patients with same day appointments. We request that you provide at least 24 hours notice when canceling or rescheduling an appointment so that we may take that time available for a sick child. You may accrue a $50 fee for all no call/no show appointments. After 3 no call/no show appointments you may be discharged from the practice. Our office will confirm your child/children's appointment at least 48 hours prior to your scheduled appointment as a courtesy to you.

We try our very best to stay on schedule, however emergencies sometimes arise. If we are seriously delayed, we will try to notify you beforehand. Please assist us by being on time for your appointment. Occasionally, we may call patients in the waiting room out of turn if they are here for urgent exams or here to see the nurse only. We ask for your patience if you have to wait. We know your time is valuable and we hate to keep you waiting.

Unless prior arrangements are made, only parent or legal guardian may bring child/children for sick or check-up appointments.

TELEPHONE CALLS: 1) **ADVICE:** Our nurse(s) is available to answer your health care questions during office hours. All calls are returned as quickly as possible and always before we leave each day. When our office is closed there is an after hours advice nurse if you have urgent medical needs which cannot wait until the next day. Please call our office number and let the answering service know that you would like to speak with the triage nurse on duty. All non-medical questions such as referrals, prescription refills, scheduling/rescheduling appointments, insurance questions and/or billing questions, please call us during our regular office hours: Monday and Tuesday8:30am to7pm, Wednesday 8:30am to 6 pm, Thursday and Friday8:30am to 5:30pm. Our lunch hours are 12:45pm to 2:00pm. Medical records and provider messaging are available via portal access to all patients.

2) **PRESCRIPTIONS REFILLS**: We feel that each child deserves the best in medical care. We do not feel that it is in your child's best interest to receive antibiotic prescriptions over the telephone without proper evaluation. Thus, we rarely call in prescriptions without first examining the patient. We request at least 24 hours for prescription refill requests. Yearly checkups are an important part of your child's care. No refills on prescriptions will be filled if your child has not been seen for their yearly checkup. We recommend keeping up with this by using your child's birthdate as a guide. Good health habits start yearly.

3) **INSURANCE REFERRALS**: Each insurance company has its own referral process. Some quite simple but others require many steps. To insure that your referral is complete and ready for your appointment we request at least 3 working days notice for referral requests.

AFTER HOURS: We share night and weekend call with a group of local pediatricians. There is always a doctor on call for this practice. The on call doctor has limited early evening and Saturday morning appointments available and urgent sick visits. Please call our office number if you feel your child has an urgent problem that needs evaluation when we are closed. You will be connected to the answering service that will direct you to the on call doctor.

PRIVACY: Your child/children's medical record is strictly private. We do not reveal information regarding your child's health to you employer, friends, or relatives without your written permission. We only release records with your consent or where required by law. We are compliant with the HIPAA (Health Insurance Portability & Accountability Act) privacy rules and have a published privacy available in our office.

INFORMATION CHANGES/INSURANCE CHANGES: If any of your personal information changes such as your address, phone number or insurance plans please inform our office staff. If your insurance changes please check with our office to ensure we are currently accepting your insurance. All co-pays are due at the time of service. Please remember your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account and knowledge of what your insurance policy covers.

BILLING AND CLAIMS: Kidschoice Pediatrics files all of our patients' insurance claims. If you have any questions regarding your account, insurance's explanation of benefits, or bill you have received, please call our office number at 540-710-6006.

PLEASE READ OVER THE NEXT PAGE >>>>>>>>>>>>>>>>

Kidschoice Pediatrics Office Policies
Page 2

MISSED APPOINTMENTS: Our office will bill you for any missed appointments not cancelled within 24 hours. **Three (3) missed appointments with no notification are grounds for dismissal from Kidschoice Pediatrics.**

PAYMENT POLICY: Payment is expected at the time services are rendered. We are required to collect co-payments and deductibles by your insurance company. For your convenience we gladly accept cash, personal checks, VISA and MasterCard. If you are having difficulty making payments, please contact our office for other arrangements.

APPLICABLE FEES: A) All patients are subject to a $50.00 **NO CALL/NO SHOW fee** and for appointments cancelled in less than 24 hours of the appointment. B) Personal check payment that is returned for non-sufficient funds or closed accounts will be subject to a $50.00 returned check fee. C) School forms and other forms that need to be filled out and completed by the physician will be subject to a $10.00 fee/form. D) There is a processing fee of $25.00 administrative fee for copying and/or mailing of medical records.

COURTESY POLICY: It is important for you and your child/children to establish a good working relationship with your pediatrician(s) and her office staff. We enjoy working here and we want you to enjoy visiting us. We make special efforts to explain everything to you regarding your child's medical condition, medicines and treatments. We want you to be actively involved in your child's healthcare. If you are dissatisfied with any aspect of your child's care, please bring it to our attention immediately. We will attend to the problem promptly. However, we would like you to treat our staff with the same respect and courtesy that we extend to you. We have chosen staff, office procedures, medical equipment and office décor with thought and care in order to provide quality medical services in a pleasant, efficient and friendly atmosphere. Disrespect to our office staff can lead to a discharge from our practice.

We look forward to assisting you with your child's health care needs.

Come grow with us,

Suzanne Richman, M.D.
Caroline, Conneen, NP,IBCLC
Jody Carlton, MSN,CPNP-PC

INFORMED CONSENT FOR TELEMEDICINE

Patient Name:_____DOB:_____

Is Patient in their home in VA? YES or NO (CIRCLE)

Provider Name:_____DOS:_____

Provider is located in VA? YES or NO (CIRCLE)

Introduction

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and or subspecialists. The information may be used for diagnosis, therapy, follow-up and /or education, and may include any of the following:

-Patient Medical records

-Medical images

-live two-way audio and video

-Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

-Improved access to medical care by enabling a patient to remain in his or her home or elsewhere in the state of VA, while the physician obtains history, some physical exam observations, and can provide some diagnosis and treatment.

-More efficient medical evaluation and management.

- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risk include, but may not be limited to:

-In rare cases, information transmitted may not be sufficient

(e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).

-Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;

-In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

-In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

-In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.