Olentangy Pediatrics, Inc.

Anne D. Littleton, M.D.
Irene P. Koesters, M.D.
Mitchell R. Camp, M.D.
Eileen M. Maher, M.D.
Autumn M. O'Brien, M.D.
Claire S. Ackerman, Ph.D.
S. Randall Brown, M.D.
Emily T. Ferguson, M.D.
Heather K. Guthrie, Ph.D.

Registration Form

Please write neatly and legibly

Last Name: ______________________________

First Name: ______________________________

Date of birth: ____________________

Mailing Address: ____

City, State, Zip Code: ____

Mobile Phone #: ________________________

Home Phone #: ________________________

Email Address: ____

Emergency Contact Name: __________________________________

Emergency Contact Phone #: ____________________

Relationship to patient: ________________________

How would you like to receive reminders? (Circle all that apply): *Phone* *Text* *Email*

4775 Knightsbridge Blvd., Columbus, Ohio 43214 • 614-442-5557 • Fax 614-442-1070

OLENTANGY PEDIATRICS, INC.

4775 Knightsbridge Blvd Columbus, OH 43214

Notice of Privacy Practices

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice, its physicians and staff for the purpose of treatment, payment, and healthcare operations (TPO). To that end, our practice, its physicians and staff will:

- Adhere to the standards set forth in this Notice of Privacy Practices
- Collect, use, and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of the practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient, parent, or legal guardian.
- Use and disclose PHI to remind patients of their appointments, unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about its patients.
- Recognize that patients have a right to privacy. Our practice will respect the patient's individual dignity at all times. Our practice will respect each patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the practice.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice, its physicians and staff will:
    - i) Treat all PHI data as confidential in accordance with professional ethic, accreditation standards, and legal requirements. Not disclose PHI data unless the patient (or their authorized representative) has properly authorized the release or the release is otherwise allowed by law.
    - ii) Recognize that although our practice owns the medical records, the patient (or their authorized representative) has a right to inspect and obtain a copy of their PHI. Fees for supplies and copying of PHI will apply. In addition, the patient(s) (or their authorized representative) have a right to request an amendment to their medical record if they believe their information is inaccurate or incomplete. Our practice, its physicians and staff will permit patients access to their medical records when their requests are approved by our practice. If we deny the request (in accordance with ORC-3701.741) then we must inform the patient that they may request a review of our denial. In such cases we will have an on-site healthcare professional review the patient's appeal.
    - iii) Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon written request.
- All physicians and staff of our practice will adhere to any restrictions concerning the use and disclosure of PHI that patients (or their authorized representative) have requested and which have been approved by our practice.
- All physicians and staff must adhere to this policy. Our practice will not tolerate any violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment, and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice has the right to change this policy in the future. Any changes will be effective upon the release of the revised privacy policy and will be posted and available to patients upon request.

OLENTANGY PEDIATRICS, INC.

4775 Knightsbridge Blvd Columbus, OH 43214

Receipt of Notice of Privacy Practices Written Acknowledgement

I, ______________________________, have received a copy of Olentangy Pediatrics, Inc.'s Notice of Privacy Practices.

______________________________ ______________

Signature of Parent or Guardian or Patient if over 18 Date

Office Regulations and Guidelines

As a patient or responsible family member of a patient of Olentangy Pediatrics, Inc., I have read and understand the following Office Regulations and Guidelines:

1) I am responsible for paying my bill and balance due in a timely manner. Copays will be paid at time of service. I understand if I do not pay my bill and balance, my file will be sent to a collection agency and my relationship with Olentangy Pediatrics, Inc. could be terminated after 60 days.
2) I am responsible for arranging and scheduling appointments and Olentangy Pediatrics, Inc. will, when able, provide a follow-up reminder.
3) I understand if I do not call or do not cancel a medical appointment which I have scheduled, I will pay a $25 fee.
4) I understand if I do not pay my balance when it is due, I may no longer be given an appointment or receive care from the physicians and staff of Olentangy Pediatrics, Inc.
5) I understand Olentangy Pediatrics, Inc. will not provide vaccinations to patients or families who owe an account balance. In such an instance, I will have my child vaccinated by the Ohio Department of Health.

______________________________ ______________

Signature of Parent or Guardian or Patient if over 18 Date

Release Authorizations

I authorize release of any and all medical information necessary for claim submission or payment of services. I also hereby request that payment of authorized insurance benefits be made to Olentangy Pediatrics, Inc for any services proved to me or my child(ren) by the associated physicians. I assume responsibility for any balance not covered by insurance, including after hours service fees or Saturday visits.

______________________________ ______________

Signature of Parent or Guardian or Patient if over 18 Date

I understand Olentangy Pediatrics, Inc may share my child(ren)'s private healthcare information with other health professionals in the course of healthcare treatment of my child. I acknowledge Olentangy Pediatrics, Inc has made a commitment to protect the private healthcare information of my family. However, I understand the patient's name will be called in the waiting room at the time of our appointment(s).

______________________________ ______________

Signature of Parent or Guardian or Patient if over 18 Date

OLENTANGY PEDIATRICS, INC.

4775 Knightsbridge Blvd Columbus, OH 43214

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I hereby give my consent for Olentangy Pediatrics, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Olentangy Pediatrics Inc.'s Notice of Privacy Practices provide a more complete description of such uses and disclosures.

I have been provided a copy and have the right to review the Notice of Privacy Practices prior to signing this consent.

Olentangy Pediatrics, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Olentangy Pediatrics, Inc. 4775 Knightsbridge Blvd Ste 103 Columbus, OH 43214.

With this consent, Olentangy Pediatrics, Inc. may mail to my home or other alternate location any item(s) that may assist the practice in carrying out TPO, such as appointment reminders, patient statements, etc.

With this consent, Olentangy Pediatrics, Inc. may e-mail to my home or other alternate location any item(s) that may assist the practice in carrying out TPO, such as appointment reminders, patient statements, etc.

I have the right to request Olentangy Pediatrics, Inc. restrict how it uses or discloses PHI to carry out TPO, however the practice is not required to agree to my restrictions request. If the practice does agree to my restrictions, they are bound by this agreement.

By signing this form, I am consenting to Olentangy Pediatrics Inc.'s use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent the practice has already made the disclosures in reliance upon my previous consent. If I do not sign this consent or later revoke it, Olentangy Pediatrics Inc. may decline to provide treatment to me.

____

Patient Name(s)

____

Printed name of Parent/Guardian or Patient if over 18

____ ____________________

Signature of Parent/Guardian or Patient if over 18 Date

OLENTANGY PEDIATRICS, INC.

Consent for Medical Treatment

General Consent for Treatment

By signing below, I am acknowledging I am the patient or the parent/legal guarding of a minor child who is a patient. I voluntarily authorize and consent to medical care, treatments, diagnostic tests, and/or psychological services the providers of Olentangy Pediatrics, Inc. and their designated associates or assistants believe are medically necessary.

I understand by signing this form I am giving permission to the doctors, physician's assistants, nurses, medical assistants, and other healthcare providers of this medical office to provide treatment as long as a patient/physician relationship exists. I understand I have the right to revoke this authorization in writing at any time.

By signing I confirm I have legal ability to consent for treatment of services provided by Olentangy Pediatrics, Inc.

Patient Name: ______________________________ **Date of birth** ______________

______________________________ ______________

Signature of Parent/Guardian or Patient if over 18 Date

Olentangy Pediatrics, Inc.
18-year agreement for Release of Protected Health Information

Patient Name **Date of birth**

_______________________________ _______________

*I, the above-named patient, give the following **adults** (over 18) access to my health records including, but not limited to, immunizations, x-rays, lab results, prescriptions and/or permission to act on my behalf in my absence.*

____

Name of person authorized to access records Phone # Relationship to patient

____

Name of person authorized to access records Phone # Relationship to patient

____

Name of person authorized to access records Phone # Relationship to patient

For confidential records of a psychiatric, sexual, drug or alcohol nature, the above-named person(s) may also have access to the records, test results and prescriptions relating to the specific record(s) categories I have checked yes AND signed my name beside indicating permission for those record(s) to be released.

	Yes	Patient Signature	Date
Psychiatric records	☐		
Sexual records	☐		
Drug & alcohol records	☐		

- I understand if the person or entity receiving this 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 by these regulations.
- I understand there may be medical records from another doctor or another medical facility in my chart.
- I understand I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or my eligibility for treatment.
- I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent action has been taken in reliance on this authorization.

These authorizations are valid unless and until they are revoked in writing and the written revocation is presented to Olentangy Pediatrics, Inc.

____

Patient Signature Printed Name Date

Olentangy Pediatrics, Inc.

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Olentangy Pediatrics Financial Policy
Effective 03/20/2024

Thank you for choosing Olentangy Pediatrics for your family's pediatric care. We would like to inform you of our current office financial policies. Once you have carefully read the following, please sign this document and return to our office staff. If you have any questions, do not hesitate to ask one of our staff members.

- On arrival, please check in at our front desk and present your most current insurance card. If the insurance company that you present is incorrect, you may be responsible for payment of the full cost of the visit. Most insurance companies have a 90 day time limit for claims to be submitted
- It is your responsibility to understand your benefits and network requirements. If you are insured by a non-participating carrier or uninsured, we require payment from you within 14 days of receiving your first billing statement. Any balance over 90 days will be forwarded to a collection agency and your relationship with Olentangy Pediatrics may be terminated.
- It is your responsibility to understand your benefits and to know if you require referrals for specialist visits. Referrals and prior authorizations for services and medications require at least 3 business days to complete.
- It is your responsibility to know what laboratory and radiology facilities are in network for your specific plan. All labs drawn in our office are sent to Nationwide Children's Hospital. Please let our medical staff know prior to collection if your plan requires a specific lab to be used, or if you prefer another facility, so that we can give you an order to take to a facility of your choice to have service performed.
- If you are unable to keep your scheduled appointment, we require you to contact our office at least 24 hours before your appointment to reschedule or cancel any routine physical exam appointments, or 2 hours for any other appointments with our pediatricians. **Any appointments cancelled or not kept following these guidelines will be subject to a $25.00 fee for each child that was scheduled to be seen**. For our psychology department, this fee increases to $150 for each appointment due to the length of time reserved for each patient. Families with three missed appointments will be asked to transfer care to another physician's office. This fee is not covered by any insurance company and will be the responsibility of the parent/guardian.
- If during a well visit your child is sick or has an issue that is not related to the normal growth and development of your child, and he/she needs treatment and/or medical attention for those concerns, your provider may bill the insurance company for both services. Regardless of whether there is no charge for the well visit, you will be responsible for any charges passed on to you for the sick visit portion.

Please call our office if you have a question about your bill. Most problems can be resolved quickly and your call will prevent misunderstandings. Often times, the insurance company is requesting the patient contact them and provide information prior to paying claims. Contacting them will quickly resolve many billing issues. If you have trouble paying a bill, please discuss the situation with our billing staff and arrangements can be made. Financial considerations should never prevent children from receiving the care they need at the time that it is needed.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment due.

____________________________ ____________________
Patient Name Date

____
Parent/Guardian Signature

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