ABC PEDIATRICS PRACTICE, PC
REGISTRATION FORM

Patient's Legal Last Name	First Name	Middle Name	Preferred Name	Date of Birth	Gender	Ethnicity/Race

Patient's Street Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian 1

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Phone Number (cell/work/home): _____

Secondary Phone Number (cell/work/home): _____

Do you consent to staff leaving a detailed message about your child's private health information? (yes/no) _____

Address if different from patient: _____

_____

Email Address: _____

Preferred Method of Contact (phone, email, text): _____

Parent/Guardian 2

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Phone Number (cell/work/home): _____

Secondary Phone Number (cell/work/home): _____

Do you consent to the staff leaving a detailed message about your child's private health information? (yes/no) _____

Address if different from the patient: _____

_____

Email Address: _____

Preferred Method of Contact (phone, email, text): _____

Preferred Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

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MEDICAL HISTORY FORM

Does your child have any known allergies? Please list:

_____

_____

Does your child have any medical problems? (Please circle all that apply)

- Asthma
- Seizures
- Thyroid Problem, if so please list condition: _____
- Scoliosis
- Diabetes
- Autoimmune Problem, if so please list condition: _____
- Heart Problem, if so please list condition: _____
- Gastrointestinal Problem, if so please list condition: _____
- GER/GERD
- ADHD/ADD
- Anxiety
- Depression
- Autism Spectrum Disorder
- Developmental/Intellectual Disability
- Other Problem, please list:
  _____

Does your child take any medications, including prescription or over the counter, daily or as needed?

Please list:

_____

_____

Has your child had any surgeries or procedures to include dental? Please list:

_____

_____

Does your child see any other doctors/specialists to include dental? Please list:

_____

_____

ABC PEDIATRICS PRACTICE, PC

FINANCIAL POLICIES

Who is your child's ACCOUNT GUARANTOR? This is the person who accepts the financial responsibility and receives the patient's bills.

Name _____ Address _____ Phone Number _____

INSURANCE INFORMATION This information is on your insurance card.

Primary Insurance Name _____ Subscriber Name _____

Policy ID Number _____ Group Number _____ Relationship to Child _____ Subscriber's Date of Birth _____

Insurance Address _____ Phone Number _____ Effective Date _____

Secondary Insurance (if applicable) _____ Subscriber Name _____

Policy ID Number _____ Group Number _____ Relationship to Child _____ Subscriber's Date of Birth _____

Insurance Address _____ Phone Number _____ Effective Date _____

I hereby certify that the above information is correct. I authorize my insurance benefits to be paid to the provider and acknowledge that I am financially responsible for any unpaid balances. I also authorize the release of any medical information required by my insurance company. I understand that all copayments are due at the time of service. All costs not paid by my insurance company are my responsibility and are due upon receipt of statement.

I understand that a no show fee of $40.00 will be charged for a missed appointment.

Parent/Legal Guardian Print Name _____ Parent/Legal Guardian Signature _____

Relationship to Patient _____ Date _____

ABC PEDIATRICS PRACTICE, PC

HIPAA PRIVACY CONSENT

I understand that ABC Pediatrics Practice, PC may use and disclose my child's protected health information for purposes of treatment, payment, and healthcare operations. I also acknowledge that I have been offered or have received a notice of privacy practices which provides information about how the practice and individuals involved in my child's care may use and disclose protected health information.

The confidentiality of your child's private health information is very important to us. Please list below to whom we may speak to regarding your child's private health information which includes but is not limited to diagnoses, lab results, imaging results, and medications.

_____

NAME RELATIONSHIP TO PATIENT PHONE NUMBER

MAY WE LEAVE A DETAILED VOICEMAIL YES OR NO? _____

_____

NAME RELATIONSHIP TO PATIENT PHONE NUMBER

MAY WE LEAVE A DETAILED VOICEMAIL YES OR NO? _____

_____

NAME RELATIONSHIP TO PATIENT PHONE NUMBER

MAY WE LEAVE A DETAILED VOICEMAIL YES OR NO? _____

_____

PARENT/LEGAL GUARDIAN NAME PRINT

_____

PARENT/LEGAL GUARDIAN NAME SIGNATURE DATE

ABC Pediatrics Practice, PC
HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your medical services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ, tissue, and breastmilk donation requests
- Work with a medical examiner or funeral director
- Complete workers' compensation, law enforcement, and government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting Dr. Bradshaw by phone, 540-373-2228, or by email, info@abcpediatricsva.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Share information on mental health, psychology notes, and substance abuse treatment

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications and vaccines
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ, tissue, or breastmilk donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.