South Charleston Pediatrics

Patient Registration Information

(*Please print and complete all sections before leaving)*

Patient's Information **Sex:** **Male** **Female**

Name: _____ _____ _____
Last First Middle

Birth Date : _____/ _____/ _____

Physical Street Address: _____ **Apt.**_____

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

Mailing Address : **Same as above**

_____ **Home Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Cell Phone:** _____

Parent or Guardian Name: **1.** _____ **2.** _____
& Relationship

Patient Responsible Party Information

Responsible Party Information

_____ _____ _____
Last First Middle

Birth Date: _____/ _____/ _____ **Social Security #** _____-_____-_____

Street Address: _____ **Apt.**_____

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email address: _____
Do you wish to receive E-Mails concerning Health Information? **YES** **NO**

Patient's Insurance Information

Responsible Party (Please list the person who has the coverage with the insurance company)

_____ _____ _____
Last First Middle

Relationship to patient: _____

Birth Date: _____/ _____/ _____ **Social Security #** _____-_____-_____

Occupation: _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Primary Insurance: _____

Secondary Insurance: _____

3rd Party Designee

Patients Name: _____ D.O.B._____

Parent/guardian: _____ Parent/guardian: _____

Phone #: _____ Phone #: _____

We realize that it is sometimes hard for parents to get off work to bring children to doctors appointments. Please take a few minutes to list 3 people, in parent/guardian absence, which may:

1. Bring your child/children to their appointments
2. May have access to your child/childrens protected health information
3. May be notified of appointments if we are unable to reach the parent or guardian
4. May be able to pick up any medications or samples designated for the child

1. _____

Relationship to patient: _____

Phone #: _____ Cell #: _____

2. _____

Relationship to patient: _____

Phone #: _____ Cell #: _____

3. _____

Relationship to patient: _____

Phone #: _____ Cell #: _____

South Charleston Pediatrics <u>WILL</u> <u>leave</u> <u>messages</u> to remind parents/guardians of upcoming appointments, referrals, x-ray and lab results, billing issues, and any other correspondence the office feels is necessary. We will leave messages on any of the above listed phone numbers if we need to reach a parent/guardian. If you would not like a message left, you must give descriptive information on what you would like:

_____

By signing below I am aware that a cellular phone is not a secure & private line

Signature: _____ Date: _____

Notice of Privacy Practices

South Charleston Pediatrics, PLLC

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and Disclosure of Protected Information

- Federal law provides that we may use your PHI **for your treatment**, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to that specialist.
- Federal law provides that we may use your medical information **to obtain payment** for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered.
- Federal law provides that we may use your medical information **for health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:
    1. required for public health purposes
    2. required by law to report child abuse
    3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
    4. required by law in judicial or administrative proceedings
    5. required for law enforcement purposes by a law enforcement official
    6. required by a coroner or medical examiner
    7. permitted by law to a funeral director
    8. permitted by law for organ donation purposes
    9. permitted by law to avert a serious threat to health or safety
    10. permitted by law and required by military authorities if you are a member of the armed forced of the U.S.
    11. required for national security, as authorized by law
    12. required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official

13. otherwise required or permitted by law.

- Certain types of uses and disclosures of protected health information require authorization, these include:
    - uses and disclosures of psychotherapy notes
    - uses and disclosures of PHI for marketing purposes; and
    - disclosures that constitute the sale of PHI.
- Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

Minors

- For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or guardian to take their child to the pediatrician's office may have access to this child's medical information. We will require to have written authorization from the parent or guardian, in the form of a release, for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.
- You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. A separate form is available for this purpose.
- Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights That You Have

- The Privacy Rule allows patients the right to request restriction(s) on uses or disclosures of their PHI for treatment, payment or healthcare operations. Patients must be informed of their rights to request such restriction(s) to their records; however, the provider is not required to agree to the restriction. If the provider agrees to a restriction(s), it must document the restriction(s) and must abide by the restriction(s) unless there is an emergency and the restricted PHI is necessary to provide emergency treatment. In an emergency, the healthcare provider providing treatment cannot disclose the restricted information beyond the emergency treatment situation.
- A patient-requested restriction on PHI may be terminated by the practice if: 1) the patient agrees to or requests the termination in writing; 2) the patient orally agrees to such termination and the oral agreement is documented: 3) the practice informs the patient that it is terminating the restriction (such a termination is only effective against PHI created or received after the date of termination).
- You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location e.g. at home and not at work. Such requests must be made in writing to your physician. Our practice will accommodate reasonable requests.

- You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to have information in the medical record explained to him or her.
- You have the right to have a copy of your bills and the right to have the bill explained to you.
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosures we make of your medical information. This is a list of certain non-routine disclosures our practice has made of your health information for non-treatment, payment or health care operations purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.
- You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item or service (only healthcare providers are required to include such a statement; other covered entities may retain the existing language indicating that a Covered Entity is NOT required to agree to a requested restriction.)
    - You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction
    - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time period, which may not be longer than six years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have a right to receive electronic copies of health information.

Obligations That We Have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization Contact Information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

South Charleston Pediatrics, PLLC

4607 MacCorkle Avenue, SW

Suite 400

South Charleston, WV 25309

(304)766-4400

Contact Person: Sharmila Jones, MD

By signing this authorization, I allow South Charleston Pediatrics to disclose certain protected health information (PHI) to my insurance company in order to file a claim on my family's behalf. This authorization allows South Charleston Pediatrics to disclose protected health information which relates to my appointment with the office in order to bill my insurance on my behalf. The Date of Service, Level of Service, Reason for visit, Diagnosis, Amount, and any other related information the insurance my request may all be released to my insurance company in the sole capacity for billing purposes.

This authorization shall remain in effect the duration of the relationship between South Charleston Pediatrics and the patient.

The guardian may refuse to sign this authorization or end this agreement at anytime. Upon termination of this agreement, guardian must pay in full for the visit at the time of service. South Charleston Pediatrics will furnish any necessary billing information to the parent or guardian for them to seek financial repayment by the insurance company on their own.

I hereby give permission to South Charleston Pediatrics to bill my insurance on my behalf.

_____ Date _____

Parent/ Guardian Signature

_____ _____

Printed Name Relationship

_____ D.O.B. _____

Child's Name

Charleston Location
830 Pennsylvania Ave, Suite 110
Charleston, WV 25302

South Charleston Pediatrics

(304) 982-7031 (phone)
(304) 766-9450

Hurricane Location
3751 Teays Valley Road
Hurricane, WV 25526

Medical Record Release
(Patient Authorization for Use and Disclosure of Protected Health Information)

Patient(s) Name: _____ **DOB:** _____

_____ _____

_____ _____

Information FROM:_____ **Address:**_____ **Phone #:**_____**Fax#:**_____	**Being Sent TO** **South Charleston Pediatrics** 830 Pennsylvania Ave, Suite 110 Charleston, WV 25302

**********OR**********

Being Sent FROM **South Charleston Pediatrics**	**Information TO:**_____ **Address:**_____ **Phone #:**_____**Fax#:**_____

Reason for transfer of information from South Charleston Pediatrics:

- ☐ Transferring to another physician
- ☐ Other (Please explain):_____

Requested information to be sent:

- ☐ Last Well Child Exam
- ☐ Immunization/Vaccine Record
- ☐ Entire Medical Record* (including all psychological reports & HIV/STD testing)
- ☐ Other: _____

For outgoing medical records, I request that this information be:

- ☐ Mailed to the address above (can only mail medical records to physician practices or to the patient)
- ☐ Charleston office pick up by the patient, guardian or third party designee.
- ☐ Hurricane office pick up by the patient, guardian or third party designee (only last well visits, camp/sports forms and immunization records)

***Entire medical record may only be picked up in the Charleston location**

This authorization will expire on _____. (This must be filled out)

I do not have to sign this authorization in order to receive treatment from South Charleston Pediatrics, PLLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the South Charleston Pediatrics, PLLC Privacy Officer.

_____ _____
Signature & Printed Name of Patient and/or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION