Date_____ How did you hear about Med 4 Kids? _____

Patient's Name_____ Male Female

Date of Birth_____

Names & DOB Siblings _____

_____

Home Address_____

City_____ State_____ Zip _____

Home Phone _____ Cell Phone_____ Emergency _____

Allergies_____ Current Medication_____

Mother's Name_____ SS# _____

Address (if different from above)_____

Date of Birth _____

Employer _____ Work Phone_____

Father's Name_____ SS# _____

Address (if different from above)_____

Date of Birth _____

Employer_____ Work Phone _____

Primary Insurance _____

Policy or Identification Number_____

Subscriber's Name_____ Relationship _____

Other Insurance _____

Email Address_____

I authorize Med 4 Kids to release any medical or incidental information that may be necessary for either medical care or in the processing of insurance; and I direct payment of medical benefits to Med 4 Kids for services rendered. I understand that I am financially responsible for any balance not covered by insurance.

Signature of Parent or Legal Guardian_____

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

: _____ : _____

: _____ : _____

: _____ : _____

: _____ : _____

: _____ : _____

Please answer all questions and provide an explanation, if necessary.

1) Do you have any impairment, for example: visual, hearing, speech, learning, physical, and/or a language or cultural barrier that will affect your ability to understand your child's medical condition and/or treatment?

2) Do you have any religious or culture customs that the doctor should know about?

3) What language do you speak, read, or write?

Primary: _____ **Other:** _____

4) Please circle one or more of the following to indicate the race of your child (for Federal Government reporting purposes).

American Indian or Alaska Native.
Asian.
Black or African American.
Native Hawaiian or Other Pacific Islander.
White.
Declined to Answer

5) Please circle one of the following to indicate your child's ethnicity (for Federal Government reporting purposes).

Hispanic or Latino.
Not Hispanic or Latino.
Declined to Answer.

6) Please indicate how you prefer to be contacted regarding your child's medical issues and reminders.

Home phone: _____ **Cell phone:** _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature_____Date_____

- -

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Appointment & Cancellation Policy

It is very important that you read this policy carefully before signing.

We make every effort to schedule your child's well appointment at the most convenient time for you. It is very important that you keep your appointment as scheduled. **Remember** we have reserved this time for you.

Our policy concerning cancelled or no show appointments is as follows:

A patient with a well appointment must call at least 48 hours in advance prior to canceling or rescheduling their appointment time so we will be able to offer this time to another patient.

No show appointments will be billed a $25 charge, which will be billed directly to you.

The above charges are applied for each occurrence. After the third cancellation or no show appointment, we will treat you for 30 days on an emergency basis only. During this time you will have an opportunity to find another physician.

I_____-(print name of responsible party), understand this policy.

Signature_____Date_____