TOWN PEDIATRICS, PC **2012**
823-F SOUTH KING STREET PHONE 703-777-5222
LEESBURG, VA 20175 FAX 703-777-5144

__ New __ Existing PATIENT REGISTRATION Checked ___ Entered ___

Date	Contact Parent/Guardian	Account Number

Children (please list all your children) *Please Print*

	First Name	Last Name	Nick Name	Sex	Date of Birth	
1						
2						
3						
4						

Mother __ Mother __ Stepmother __ Married __ Unmarried __ Divorced If divorced, child resides with? _____
Father __ Father __ Stepfather __ Married __ Unmarried __ Divorced If divorced, child resides with? _____

Mother's Full Name	Social Security Number	Home Phone Number ( ) -	
Home Address	City	State	Zip
Mother's Employer	DOB	Work Phone Number ( ) -	
Cell Phone Number ( ) -	Preferred Number: _ __ Home ____Work ___ Cell Ok to leave voicemail on preferred? Y/N		

Mother __ Mother __ Stepmother __ Married __ Unmarried __ Divorced If divorced, child resides with? _____
Father __ Father __ Stepfather __ Married __ Unmarried __ Divorced If divorced, child resides with? _____

Father's Full Name	Social Security Number	Home Phone Number ( ) -	
Home Address	City	State	Zip
Father's Employer	DOB	Work Phone Number ( ) -	
Cell Phone Number ( ) -	Preferred Number: _ __ Home ____Work ___ Cell Ok to leave voicemail on preferred? Y/N		

Emergency Contact other than parents (Relative or Friend)

Name	Relationship	Primary Phone Number ( ) -

Primary Insurance Information **__ Check here if SELF-PAY (*or we do not accept your insurance*.)**
Please be advised that our office doesn't bill absentee parents. The guardian bringing the child is considered financially responsible.

Primary Insurance Company			Identification/Policy Number		
Insurance Network, if applicable			Group Number		
Insurance Address			Insurance phone number for eligibility/verification ( ) -		
City	State	Zip	Insurance Co-Payment/Co-Insurance		
Policyholder/Subscriber (not employer)	Social Security Number of Subscriber	Sex	DOB of Subscriber	Employer Plan? Y *or* N	

PLEASE BE AWARE THAT WE DO NOT FILE TO SECONDARY INSURANCE UNLESS IT IS MEDICAID

ASSIGNMENT AND RELEASE

I, the undersigned, certify that the information I have provided is correct and do hearby authorize Town Pediatrics, PC and/or it's physicians (hereafter referred to as Town Pediatrics, PC) to apply for benefits from my insurance company to Town Pediatrics, PC. I permit a copy of this authorization to be used in place of the original on all insurance claim submissions, whether manual, electronic, or telephonic.

I further authorize Town Pediatrics, PC to release any and all of my children's medical records and/or other records and information: (1) needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Town Pediatrics, PC, and (2) to any hospital, lab, doctor, or other healthcare provider to release their medical records of my child/children/self to Town Pediatrics, PC.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient

Parent Acknowledgement of receipt of Children's IQ Network (CIQN) Information Sheet

I have received a copy of Children's IQ Network (CIQN) Information Sheet. In understand that patient information will be stored electronically for my provider's records, and that an electronic health summery will be available to other providers through the CIQN. I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment, unless other arrangements are made. I further agree that I (parent/guardian/self) am responsible for all fees and services rendered for treatment of my child/children/self. As a courtesy, Town Pediatrics, PC will file claims for most major insurance carriers. Town Pediatrics, PC will not file claims to a secondary insurance company. I (parent/guardian/self) agree to verify with the insurance company that Town Pediatrics, PC is a participating provider. I agree to adhere to the 30 day insurance policy of Town Pediatrics, PC. I understand that it is my responsibility to provide current insurance information within 30 days of the date of service. If I fail to do so, I will be responsible for the charges in full and Town Pediatrics, PC will not file the claim to the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and their insurance carrier. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-selection of a primary care physician or not adding a dependent to insurance plan, non-payment at the time of service and / or any other reason I agree to promptly pay all charges. I agree that if for any reason my check is returned that I will be responsible for a $30.00 fee in addition to the amount of the claim. If the balance is not paid and / or timely payments of this account are not made, I authorize Town Pediatrics, PC to retain the services of an attorney and / or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility. This agreement is made this day in the County of Loudoun and shall be governed by the laws of the Commonwealth of Virginia.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient

The **Children's IQ Network®** serves the children of the metropolitan Washington area through the electronic exchange of critical healthcare information. The **Children's IQ Network®** interconnects the Children's National Medical Center hospital, emergency department, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories. Health data pertaining to you or your child are shared between important health care providers within the **Children's IQ Network®** to ensure that accurate and complete information is available for quality health care decisions.

Pediatric care providers will be able to easily find important health information including your visit histories, allergies, medications, health problem summaries, physician notes, vaccine information and x-ray results from the **Children's IQ Network®** Having this information readily available will make your care safer, more efficient and less costly.

Pediatric providers in the **Children's IQ Network®** will be providing care for you through the use of a computerized electronic medical record (EMR). Whenever and wherever you visit your doctor, the EMR will be used to enter information about your health conditions, allergies, test results, treatments, etc. Once the information is entered into the EMR, it will flow into a secure, confidential and private regional health record known as the Continuity of Care record. From that point on, every time you see another care provider within the **Children's IQ Network®**, your health care information will be available to ensure ideal care delivery.

Through participation in the **Children's IQ Network®**, you can be assured that important information will be available to your pediatric care provider when it is most needed. Here are some examples where this could prove to be very important:

You are visiting a new physician but cannot remember details regarding a recent hospitalization or home medications. The physician can easily access your record to determine this information and avoid unnecessary test ordering or duplicate medication prescriptions while at the same time benefitting from previous diagnoses and test result information.

You are taken to an Emergency Room. Your injuries or condition may be such that you cannot communicate with the doctors and nurses taking care of you. The **Children's IQ Network®**, contains important medical information that can be quickly retrieved to find out what medications you are on, what you are allergic to, important contact information and other essential information.

Your physician is going to see you today for follow-up after your recent hospitalization. The doctor has no information on your hospital visit and wants to find out more. The doctor can go to the **Children's IQ Network®** and obtain good information to help him quickly understand what needs to be done when you are seen.

Your health care information in the **Children's IQ Network®** is protected in a highly secure data center with state-of-the-art monitoring and 24 hour each day security. The data is encrypted (encoded) and can be accessed only by health care providers who are caring for you and have a need to know.

Your health information will automatically be included in the **Children's IQ Network®** however you do have the option to opt out (not share) your information. If you choose to opt out, only your primary care provider will be able to see your health information. Your health care information will not be shared with other care providers in the **Children's IQ Network®**

For additional information regarding the **Children's IQ Network®**, please contact your health care provider**.See back of this sheet to opt out of sharing your health record with Children's Network.**

CIQN Opt In/Out Form

Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____

Please make a selection in one of the check boxes below:

☐CIQN Opt In

- I understand that all of my health care information collected by my health care provider will be submitted to the **Children's IQ Network®**, it will be able to be seen by or shared with other health care providers within the **Children's IQ Network®**.
- I understand that my health care information will continue to be available to my primary health care provider as this information makes up my personal medical record.
- I further understand that I will be permitted to change my decision and allow sharing with other health care providers at any time in the future.

☐CIQN Opt Out:

I hereby request to **not** have my health care information shared with other health care providers within the **Children's IQ Network®**.

- I understand that all of my health care information collected by my health care provider will continue to be submitted to the **Children's IQ Network®** however, it will no longer be able to be seen by or shared with other health care providers within the **Children's IQ Network®**.
- I understand that my health care information will continue to be available to my primary health care provider as this information makes up my personal medical record.
- I further understand that I will be permitted to change my decision and allow sharing with other health care providers at any time in the future.

Patient or Guardian Signature: _____

Relationship of Guardian to Patient: _____

Date: _____

Individual Receiving this Form: _____

Town Pediatrics, PC

Patricia F. Rappaport, MD, FAAP
Sandra J. Groeber, MD, FAAP
Nancy Tang, MD, FAAP
Azza H. Idris, MD, PhD, FAAP
Janine A. Rethy, MD, MPH, FAAP, IBCLC

PATIENT RESPONSIBILITIES

1. Notify us of any changes in your address or insurance information at the time of the change.
2. All appointments must be scheduled in advance. **NO WALK-IN'S ARE AVAILABLE!** If you need to cancel or reschedule an appointment, please call 24 hours before your scheduled appointment. There will be a $50.00 fee for all missed or cancelled physicals, and $25.00 for all missed or cancelled office visits without 24-hour notice.
3. Co-payments and all overdue bills must be paid at the time services are rendered. We do not send bills for less than $20, therefore, you will be asked for those balances at future visits.
4. Notify us forty-eight hours or more before referrals are needed. If your insurance requires a prior authorization for services or medications, notify us three or more business days in advance. We will not back date any referrals and we will not fax or mail any referrals. You must **pick the referral up from the business office. If your insurance company requires you to have a referral and you do not, you are responsible for that bill.**
5. Your doctor may order tests that are medically necessary. It is **your** responsibility to contact your insurance company to determine the facility/lab you can use and to notify our staff.
6. Pay your bill promptly, if there is financial hardship, please call the billing office at (703) 777-5222 option 5, to arrange a payment plan. There is a $30 fee on all returned checks. Please resolve billing issues before your next appointment.
7. There is a fee for copying medical records. We charge a processing fee of $10.00 and .50 per page, not to exceed $25.00 per patient. Medical records can take up to 10 business days to be processed so please allow enough notice to ensure you receive them before the time they are needed. Medical records are to be picked up at our office unless you are already out of state by the time they are ready. We will not fax any medical records.
8. Unless otherwise stipulated by your physician, please wait 5 days after a test is performed to call us for your results. This ensures that final results are available in the office. Your doctor may ask you to schedule a follow-up appointment to discuss test results. You will **not** be notified of any negative strep tests or **normal** routine urinalysis, lead levels or cholesterol results from checkups.
9. When requesting a prescription refill, please call your pharmacy so they can fax a refill request to us. We require 3 business days, not including Saturday or Sunday, from the time of your request to process your refill. Please make sure you return for follow-up appointments in the time frame stipulated by your physician. For proper medication monitoring, prescriptions for narcotic and stimulant medications are not mailed and must be picked up at the front desk during regular business hours but not during our lunch hour which is 12:30-1:30. You can speak with the physician writing your prescription if alternative arrangements need to be made and the physician will be responsible to carry out the alternative plan. Any alternative arrangements will be made on a case by case basis by the physician writing your prescription.
10. We will only provide written prescriptions for you to mail to the mail-order pharmacies. We do not call in, fax, or mail these prescriptions.

I have read and understand the responsibilities:

Patient Signature _____ Date _____

Thank you for your cooperation and understanding.

823-F South King Street • Leesburg, Virginia 20175 • Phone: (703) 777-5222 • Fax: (703) 777-5144

The patient has the right to:

- Considerate and respectful care.
- Obtain from physician complete and current information regarding his or her diagnosis, treatment and prognosis in terms that can be reasonably understood.
- Receive from physician information necessary to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of his or her actions.
- Every consideration of privacy regarding his or her own medical care.
- Expect all communications and records pertaining to care be treated as confidential.
- Expect that within her capability a physician must make reasonable response to the request of a patient to be treated; and the right to be treated.
- Obtain information regarding the relationship of the physician to the other health care and educational institutions insofar as his or her care is concerned.
- Examine and receive an explanation of his or her bill, regardless of the source of payment.
- Know what practice rules and regulations apply.

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 at the address above 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, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name_____

Relation to Patient_____

Signature _____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____Initials_____Reason_____

Patient Name

Town Pediatrics Intake Form

BIRTH DATE | AGE

REFERRED BY

Previous MD_____
Previous MD Phone #_____
Reason for change_____
Moved here from_____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health Problems

Child lives with both parents? ☐ Yes ☐ No

If no, what is the child's custody status?

_____

How often does he/she see the parent(s) not in the home?

_____

Are there siblings living outside the home not listed? If so, please list their names and where they live. _____

_____

_____

_____

Birth History

Birth Weight _____

Was the baby born at term? _____ Early? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain _____

_____

During pregnancy, did mother:

Smoke ☐ Yes ☐ No Drink Alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No

What_____ When _____

Was the delivery Vaginal? _____ Cesarean? _____

If cesarean, why? _____

Did your baby have any problems right after birth?

☐Yes ☐No Explain _____

_____

Was initial feeding: Breast? ___ Bottle? ____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

_____

Mother's OB/GYN _____

***** Parents of Newborns please stop here and skip to Family History section.******

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had any serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medications or drugs? ☐ Yes ☐ No

Medication Allergies: Please list ALL medication allergies and describe the reaction to each._____

_____

Medications: Please list **ALL** medications including over the counter, herbal, vitamins or prescription. _____

Does your child have any food allergies? ☐ Yes ☐ No

Food Allergies: Please list ALL food allergies and describe the reaction to each _____

_____

Past History

Does your child have, or has he/she ever had:

Chickenpox ☐ Yes ☐ No Explain _____

Frequent ear infections ☐ Yes ☐ No Explain _____

Problems with ears or hearing ☐ Yes ☐ No Explain _____

Nasal allergies ☐ Yes ☐ No Explain _____

Any chronic or recurrent skin problem (acne, eczema, etc) ☐ Yes ☐ No Explain _____

Asthma, bronchitis, bronchiolitis, or pneumonia ☐ Yes ☐ No Explain _____

Problems with eyes or vision ☐ Yes ☐ No Explain _____

Any heart problem or heart murmur ☐ Yes ☐ No Explain _____

Anemia or bleeding problem ☐ Yes ☐ No Explain _____

Blood transfusion ☐ Yes ☐ No Explain _____

Frequent abdominal pain ☐ Yes ☐ No Explain _____

Constipation requiring doctor visits ☐ Yes ☐ No Explain _____
Bladder or kidney infection ☐ Yes ☐ No Explain _____
Bed-wetting (after 5 years old) ☐ Yes ☐ No Explain _____
(For girls) Has she started her menstrual periods? ☐ Yes ☐ No Explain _____
(For girls) Are there any problems with her periods? ☐ Yes ☐ No Explain _____
Frequent headaches ☐ Yes ☐ No Explain _____
Convulsions or other neurologic problem ☐ Yes ☐ No Explain _____
Concussion ☐ Yes ☐ No Explain _____
Diabetes ☐ Yes ☐ No Explain _____
Thyroid or other endocrine problem ☐ Yes ☐ No Explain _____
Use of alcohol or drugs ☐ Yes ☐ No Explain _____
Any other significant problem ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No
Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No
Are you concerned about your child's attention span? ☐ Yes ☐ No
Explain: _____

If your child is in school:
How is his/her behavior in school? _____
Has he/she failed or repeated a grade in school? _____
How is he/she doing in academic subjects? _____
Is he/she in special resource classes? _____

Family History

Have any family members had the following:

Deafness ☐ Yes ☐ No Who _____ Comments _____
Nasal allergies ☐ Yes ☐ No Who _____ Comments _____
Asthma ☐ Yes ☐ No Who _____ Comments _____
Eczema ☐ Yes ☐ No Who _____ Comments _____
Heart disease (before 50 years old) ☐ Yes ☐ No Who _____ Comments _____
High blood pressure (before 50 years old) ☐ Yes ☐ No Who _____ Comments _____
High cholesterol ☐ Yes ☐ No Who _____ Comments _____
Anemia ☐ Yes ☐ No Who _____ Comments _____
Diabetes (before 50 years old) ☐ Yes ☐ No Who _____ Comments _____
Thyroid or other endocrine problem ☐ Yes ☐ No Who _____ Comments _____
Autoimmune disease (Lupus, etc.) ☐ Yes ☐ No Who _____ Comments _____
Infammatory Bowel (Crohn's, ulcerative colitis) ☐ Yes ☐ No Who _____ Comments _____
Bed-wetting (after 10 years old) ☐ Yes ☐ No Who _____ Comments _____
Epilepsy or convulsions ☐ Yes ☐ No Who _____ Comments _____
Alcohol abuse ☐ Yes ☐ No Who _____ Comments _____
Drug abuse ☐ Yes ☐ No Who _____ Comments _____
Mental illness ☐ Yes ☐ No Who _____ Comments _____
Mental retardation ☐ Yes ☐ No Who _____ Comments _____
Immune problems, HIV, or AIDS ☐ Yes ☐ No Who _____ Comments _____
Additional family history _____