Pediatric Associates of Williamsburg

A practice of CHKD Health System

119 Bulifants Boulevard, Williamsburg, VA 23188
Phone: 757-564-7337 Fax: 757-564-3205

New Patient Information (Nueva información del paciente):

Patient Name (Nombre del Paciente): _____

Sex (Sexo): F_____ M_____ Birth Date (Fecha de Nacimiento): _____

Mailing Address (Direccion Postal): _____

City, State (Ciudad, Estado):_____ Zip (CodigoPostal)_____

Primary Phone (Numrero de telefono primario): _____

E-mail: _____

Last 4 digits of your SSN for patient portal: _____

Pharmacy Preference: _____

Parents Names and Phone Numbers (Nombres de Padres y numero de telefono):

Mom (Madre) -_____

Dad (Padre) - _____

Other (Otro): _____

Ethnicity (Etnicidad):

___ African American (Africano Americano)	___ Asian/Pacific Islander (Asiatico/Isleno Pacifico)	___ Hispanic /Latin (Hispano/Latino)	___ Multi-Racial (Multiples razas)
___ American Indian/Eskimo (Indio Americano/Eskimo)	___ Caucasian (Caucasico)	___ Indian/ M.E (Indio/del Medio Oriente	___ Unknown (Desconocido)

Responsible Party Information (Informacion de la Persona Encargada/Responsable):

Responsible Party Name (Nombre de la persona encargada)_____

DOB (Fecha de Nacimiento)_____ Social Security #(Seguro Social):_____

Cell Phone (Numero de telefono Cellular) _____

Address (Direccion)_____

Primary Insurance:

Subscribers Name & Address (Nombre del suscriptor y Direccion): _____

_____

Subscriber DOB (Fecha de Nacimiento del suscriptor)_____

Insurance Company (Compania de la Aseguranza) _____

Subscriber # (Numero del Suscriptor)_____

Group# (Numero de Grupo)_____ Plan #: _____

Relationship to Subscriber (relacion al suscriptor): _____ Self (mismo) _____ Spouse (esposo/a) _____ Child (hijo/a) _____ Other (otro)

Do you have a secondary insurance? _____

Pediatric Associates of Williamsburg-Family Information

Child's name (Nombre del paciente)_____ DOB: _____

Is this child taking medication now? (Este nino esta tomando algun medicamento actualmente)
Yes (Si)___ No___
Has this child been on long term medication in the past? (En el pasado, este nino ha tomado medicamentos por un period de teimpo largo?) Yes (Si)___ No___
Please list all long term meds (Por favor escriba todos los medicamentos que su nino ha tomado por mucho tiempo):_____
Does this child have any medication allergies (Este nino es alergico a algun medicamento?) Yes (Si) ___ No___
Please list all medication allergies (por favor escriba los medicamentos que le ocasionan alergia a su nino)

_____

Family Medical History (Historial Medico familiar):
Do any relatives (Parents, brothers, sisters or grandparents have? (Tiene algun pariente (padres, hermanos, hermanas o abuelos) alguna de las condiciones o enfermedades en la siguiente lista?) ***Please specify which Grandparent/Por favor especifique qué abuelo

	Parents (Padres)		Brothers (Hermano)	Sisters (Hermana)	Grandparents (Abuelos-Madre)		Grandparents (Abuelos-Padre)	
	Mom	Dad			Gma	Gpa	Gma	Gpa
Birth Defects (Defectos de nacimiento)								
Seizures (Convulsiones)								
Autism (Autismo)								
Mental Retardation (Retraso Mental)								
Allergies (Allergias)								
Asthma (Asma)								
Attention deficit (Deficit de atencion)								
Vision problems (Problemas con la vista)								
Cancer (Cancer)								
Diabetes (Diabetes)								
Hearing Problems (Problemas escuchando)								
Stroke (infarto)								
High blood pressure (Presion alta)								
High cholesterol (Colesterol alto)								
Heart disease before age 55 (Enfermedad del Corazon antes de la edad de los 55 anos)								

Has this child had any chronic medical problems (Este paciente ha tenido algun problema medico cronico)
Yes (Si)__ No ___ If Yes please explain (Si la respuesta a la pregunta anterior es si, por favor explique)

_____

Has this child been hospitalized? (Este paciente ha sido hospitalizado anteriomente) Yes (Si)___No___
If Yes, please explain (Si la respuesta a la pregunta anterior es si, por favor explique)

_____

Has this child had any surgery? (Este paciente ha tenido alguna cirugia?) Yes (Si)___ No___
If Yes please explain (Si la respuesta a la pregunta anterior es si, por favor explique)

_____

0 2 2 7 7

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS HEALTH SYSTEM, INC.

AUTHORIZATION TO GIVE CONSENT FOR OUTPATIENT MEDICAL TREATMENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Child/Patient Name(s):	Date of Birth:	Hospital Medical Record #:

Until revoked by me in writing, the following persons are authorized to act on my behalf:

(1) to give consent to medical and/or diagnostic treatment in Children's Hospital of The King's Daughters Health System (CHKDHS) physician offices, outpatient clinics/departments (including Lab and Radiology), and outpatient therapy departments as deemed necessary, by Children's Hospital of The King's Daughters, Inc., ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG") of my child named above;

(2) to give consent for testing my child's blood for HIV antibodies in accordance with the laws of Virginia which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient;

(3) to assign benefits of third party payors for direct payment to CHKDHS and/or CSG; and

(4) to receive financial information regarding my child's health care and/or medical information about my child's condition, treatment or health care received at CHKDHS and/or CSG.

I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf thus acknowledging the following statement and binding me to its terms in my absence: The undersigned parent and/or legal guardian agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment to CHKDHS and/or CSG. I furthermore irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. I understand my insurance policy is a contract between my insurance company and me, and I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand I will receive a separate statement and bill from the laboratory or radiology department performing the test. If all charges are not paid when due to CHKDHS and/or CSG, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY THREE AND ONE-THIRD PERCENT (33-1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of $25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to the CHKDHS and/or CSG Billing Representative where you received your care.

AUTHORIZED PERSONS:

First Name	Last Name	Phone	Relationship to Child	Date
First Name	Last Name	Phone	Relationship to Child	Date
First Name	Last Name	Phone	Relationship to Child	Date

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

Witness _____ Date _____

DO NOT USE AS CONSENT FOR INPATIENT, ER, OR DAY SURGERY VISITS

Children's Hospital of The King's Daughters Medical Group

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION:

AT THE REQUEST OF THE PRACTICE

I AUTHORIZE

Name/Institution: _____

Address: _____

City/State, Zip: _____

Phone Number: _____ **Fax Number** _____

TO DISCLOSE THE FOLLOWNG INFORMATION: **(description of individual health information to be disclosed)**

Patient Name and DOB: _____

☐ Any and all of the medical records pertaining to the treatment of the individual seen on or about _____, 20_____

☐ Other (specify): _____

TO MAKE THE DISCLOSURE TO:

Pediatric Associates of Williamsburg
119 Bulifants Boulevard, Williamsburg, VA 23188
757-564-7337 (phone)/757-564-3205 (fax)

Purpose of Disclosure: _____

_____

I understand that any disclosure of health information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. (Note: the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements)

I understand that I have the right to revoke this Authorization at any time in writing, except to the extent action has been taken in response to this authorization by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with right to contest a claim under my policy. (The written revocation must be legible and include the name and date of birth of the individual, the date of the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to receive the information, the signature of the person with legal authority for authorization/revocation and if not the individual description of their legal authority for authorization/revocation and their phone number.)

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below.

I understand that I may refuse to sign this authorization and that in this instance,

☐ **My refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits**

☐ **The law allows conditioning of treatment, payment, or my eligibility for benefits on this authorization ,and the consequence of my refusal to authorize this disclosure is**

Required if request is for the <u>purpose of Marketing:</u>

I understand that the practice ☐ **will** ☐ **will not receive payment as a result of using/disclosing this information**

I have the right to inspect or copy any information used/disclosed under this authorization

☐ **A copy of this authorization was provided to me**

I certify that I am the patient/legal guardian with the authority to authorize disclosure of the individuals protected health information.

_____ _____ _____

Signature of Patient/Legal Guardian **Relationship to Patient/Legal Authority** **Date**

Mark Downey, M.D. Kristina Powell M.D. Brian Tyler M.D. Kathleen Swayne, M.D.
Ertle Jones Jr, M.D. Beverly Coleman, C.P.N.P. Jane Henley, C.P.N.P. Harley Bonniville MSN CPNP-PC

Pediatric Associates of Williamsburg

This is a notification of our No-Show policy. A "No Show" is an appointment that was not completed either by the patient not having arrived at the office for the appointment within 15 minutes of the appointment, or by the parent calling to cancel or reschedule the appointment within 24 hours.

Canceling or rescheduling an appointment within 24 hours does not offer the office enough notification to fill that slot with another patient and is still considered a No Show.

Sibling appointments who have more than 2 no shows may lose the privilege of having both appointments on the same day and may be split to prevent further multiple no show appointments.

1st No-Show will result in a notification.

2nd No-Show will result in a warning letter and a $25.00 charge thereafter

3rd No-Show will result in a verbal warning that any No show after will cause a termination from the practice

Please note, when a family account is terminated for No Shows this includes all siblings as well. You will then have to transfer care to another practice.

We understand that life happens and there are many issues that may arise that will cause you to miss an appointment. **Please ensure we have your updated phone number and email to allow for text and email reminders of your appointments**. If you have an ongoing issue that may cause you to miss an appointment such as transportation issues, please know you can contact your child's insurance provider to see if they can help you with transportation.

Always contact the office promptly if you believe you may not be able to keep an appointment and allow us to work with you.

_____ _____

Signature Date

_____ _____

Witness Date

WRITTEN ACKNOWLEDGEMENT
Receipt of Notice of Privacy Practices

Pediatric Associates of Williamsburg
119 Bulifants Blvd Suite A
Williamsburg VA, 23188
757 564 7337

I certify that I was provided the Notice of Privacy Practices. The notice describes the uses and disclosures of my protected health information by the health care provider listed above. The notice also describes my rights and duties with respect to my protected health information. The "Notice of Privacy Practices" is also posted on the www.chkd.org. website.

Please sign and mail or bring this Acknowledgment of the "Notice of Privacy Practices" to the office address listed above.

Patient Name (please print): _____ DOB: _____

_____	_____	_____
Signature of Patient/Legal Guardian	Relationship to Patient/Legal Authority	Date

FOR OFFICE USE ONLY: To be completed only if no signature is obtained.

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained, for example:

[ ] Individual refused to sign

[ ] Other: (Specify):

_____

_____

_____

_____	_____
Staff signature	Date

Children's Hospital
of The King's Daughters
Medical Group

Pediatric Associates of Williamsburg

Main Office 757-564-7337 Fax 757-564-3205
Phone hours of Operation Monday thru Friday 7:30 am to 4:30 pm Saturday 8:00am to 11:30 am

We strive to provide excellent service to all of our families. To assist in this process we have put the following policies in place to help meet your needs.

Medication Refills: Medication Refill Line: 757-564-7337 Option 3

- Patients receiving routine/maintenance medications to manage chronic conditions must have a re-check appointment every six months.
- We need 48 hrs. to process a medication refill request. Please plan ahead and request your refill when you have a one week supply of medication left.
- A request for medication refills during a sick visit cannot be a substitute for a medication re-checks appointment. As explained above, chronic conditions must have a re-check appointment every six months. (Asthma, Allergy, ADHD & Birth Control)
- When requesting a medication refill please utilize our medication refill line (757-564-7337 option 3) and please leave the following information:
  - State your child's name and spelling of the first and last name with their date of birth
  - State the parent's name and phone number to be reached if we have any questions
  - State the pharmacy name and number you want your prescription to go to
  - State the medication name, dosage, schedule and how many refills you would like.
  - Please note your request will be complete in 48hrs and to check with your pharmacy. We will not call you unless we have questions.
- **ADHD Medications and Narcotics/Controlled Medications** cannot be called into the pharmacy due to Federal/State prescribing laws/regulations. These prescriptions must be picked up by a parent/guardian with a picture ID (or other authorized individual as documented in the patients' medical record). Picture ID is required at the time of each pickup. Prior Authorizations may take up to 1 week to process.

Appointment Cancellations, No-Shows and Late Arrivals: To make/change or cancel an appointment 757-564-7337 option 2

- Please note that all appointment cancellations should be done during regular office hours and at least 24 hrs. In advance.
- If you miss your appointment and have not called with in the 24 hr. time frame you will be charged a $25.00 fee. Chronic No-Shows can be cause for dismissal from our practice.
- If you arrive to your appointment 15 mins or more after the scheduled appointment time you will be rescheduled to the next available appointment.

Form Completion and Medical Records: 757-564-7337 option 4 then 1

- Any forms that need to be completed on our behalf for your children (i.e. sports, camp, summer activities, and college or school entrance) you will need to allow 72 hrs. for these forms to be completed. We cannot complete these forms if your child has not obtained a physical in the last 12 months.
- All medical record request will be processed in the order received and will be ready within 72 hrs. You can request medical records on line at www.chkd.org/paw

Have you signed up for the CHKD Patient Portal? All of your request can be handled online and you have access to your child's Medical Record. Please ask the front desk to assist you in signing up today!!!!

Pediatric Associates of Williamsburg

Please note that our office policy for form(s) completion is 72 hrs. from the time your drop it off.

Form(s) dropped off on:	Form(s) to be picked UP between 1:30 and 4:30pm:
Monday	Thursday
Tuesday	Friday
Wednesday	Monday
Thursday	Tuesday
Friday	Wednesday
Saturday	Thursday

Medication refills will be completed within 48 hrs. of your request.
Medication Refill Line (757) 564-7337 option 3

Medication Refill Request placed on:	Check with your Pharmacy or pick-up in office after 3:00 pm:
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday
Thursday	Monday
Friday	Tuesday
Saturday	Wednesday

Thank you
Pediatric Associates of Williamsburg