Valcourt Pediatric Associates

Vision: To improve the lives of youth & families.

Patient Registration Form – Pediatrics

PATIENT INFORMATION

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Patient's Last Name	First	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female
Patient's Last Name	First	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female
Patient's Last Name	First	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female
Patient's Last Name	First	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female

Patient's Street Address	Apt. No.	City	State	Zip	Authorized phone #'s for Voice Mails:

PARENT/LEGAL GUARDIAN INFORMATION

☐ Married ☐ Separated ☐ Divorced ☐ Not Married ☐ Deceased

PARENT 1 and Guarantor (person responsible for bill)	Date of Birth	**PARENT 2**	Date of Birth
Last Name First Middle Initial		Last Name First Middle Initial	
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian: _____ ☐ Other *(relationship)*		Relationship: ☐ Mother ☐ Father ☐ Legal Guardian: _____ ☐ Other *(relationship)*	
Street Address Apt. No.		Street Address Apt. No.	
City State Zip		City State Zip	
Cell Phone ☐ *check if primary*	Home Phone ☐ *check if primary*	Cell Phone ☐ *check if primary*	Home Phone: ☐ *check if primary*
E-mail:	Mother's Maiden Name:	E-mail:	Mother's Maiden Name:

Emergency Contact if parents cannot be reached: *(Signed authorization required)*: Name_____

Relationship _____ Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance Company:	Subscriber's Full Name:	Subscriber's Date of Birth:
Relation to patient: ☐ Parent ☐ Other:_____	Subscriber's Social Security Number:	
Secondary Insurance Company:	Subscriber's Full Name:	Subscriber's Date of Birth:
Relation to patient: ☐ Parent ☐ Other:_____	Subscriber's Social Security Number:	

PHARMACY INFORMATION

Local Pharmacy	Pharmacy Phone number
Pharmacy Address, City, State, Zip	Mail Order Pharmacy Name

Acknowledgement: By signing below I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Valcourt Pediatric Associates to provide any and all medical treatment to myself or my dependent.

Signature: _____ Date: _____

Acknowledgements: By signing below you signify acknowledgement of the following:

- You have received the *Disclosure Form for Sharing and Communication* in this packet and it explains our participation in an Accountable Care Organization (ACO) and Health Information Exchange (HIE) and additional ways we may utilize your information to better serve you.

Signature: _____ Date: _____

Valcourt Pediatric Associates

DISCLOSURE FORM FOR SHARING AND COMMUNICATION

We may utilize a **Patient Portal** and/or an **Automated Appointment Reminder** and **Messaging** system to allow us to better serve you. (ex. appointment reminders via phone and text, online appointment requests, communicate with office via email, online access to your medical information) By providing your cell phone number and email address we will automatically enroll you in this system(s) if they are available.

I have been made aware of the above disclosure. _____ Initials

Disease and Immunization and California Immunization (CAIR) Registries are a computer based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals, to assess needs and avoid redundant immunizations, and control disease outbreaks.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of information about how we may use and disclose your protected health information. We encourage you to read it in full.

Health Information Exchange (HIE) - we may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange.

Accountable Care Organizations (ACO) – we will be sharing your health information with our Accountable Care Organization (ACO).

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy on our website **www.valcourtpeds.com.** If you have any questions about our *Notice of Privacy Practices* please contact our Privacy Officer at (706) 955-4639.

I acknowledge receipt of the *Notice of Privacy Practices* of **Valcourt Pediatric Associates**.

I have been made aware of the above disclosures and understand that complete details are available in the Notice of Privacy Practices I was given. _____ Initials

_____ _____

Name of Patient/Legal Representative *(please print)* Date

_____ _____

Signature of Patient/Legal Representative If Legal Representative, please give relationship

Valcourt Pediatric Associates

ASSIGNMENT OF BENEFITS FORM

I hereby assign and convey Valcourt Pediatric Association, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Valcourt Pediatric Associates (VPA) for any equipment or services (i.e., provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand and agree:

- That I am financially responsible to the organization for all charges regardless of any applicable insurance or benefit.
- It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to VPA any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from VPA or its attorneys in order to claim such medical benefits.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments on the services I receive.

Patient/Beneficiary Name *(Please print)*	Relationship	D.O.B.
Patient/Beneficiary Name *(Please print)*	Relationship	D.O.B.
Patient/Beneficiary Name *(Please print)*	Relationship	D.O.B.
Patient/Beneficiary Name *(Please print)*	Relationship	D.O.B.
Parent/Guardian *(Please print)*	**Signature**	Today's date

Valcourt Pediatric Associates

PRIVACY QUESTIONNAIRE - PEDIATRICS

Patient's Last Name	First	Middle Initial	Date of Birth ___/___/_____ *mm dd yyyy*
Patient's Last Name	First	Middle Initial	Date of Birth ___/___/_____ mm dd yyyy
Patient's Last Name	First	Middle Initial	Date of Birth ___/___/_____ *mm dd yyyy*
Patient's Last Name	First	Middle Initial	Date of Birth ___/___/_____ *mm dd yyyy*

1. Please ***list any persons other than*** your child's biological parents, members or other persons, if any, who may accompany your child and consent for treatment, and whom we may inform about your child(ren's) general medical condition or diagnosis (including treatment and healthcare operations):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. Please list the family members or other persons whom we may inform about your child(ren's) medical condition ONLY IN AN EMERGENCY:

   Name: _____ Phone number: _____

   Name: _____ Phone number: _____

3. Please list the name(s) of persons who are specifically **NOT** allowed to consent for treatment or be informed about your child(ren's) general medical condition or diagnosis. If a child's parent is listed, please **provide us with a copy of legal documents regarding custody or specific restrictions.**

   Name: _____ Name: _____

4. If we are able to send e-mail in a secure format, would you like to receive e-mail reminders/notifications? If yes, please provide your e-mail address: _____

   _____ _____

   Signature of Patient ≥ 18 years of age/Legal Guardian Today's Date

   _____ _____

   Name of Legal Guardian *(Please print)* Relationship to Patient *(Please print)*

Valcourt Pediatric Associates

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F
Previous Physician		Request for Records Transfer Complete ◯ Y ◉ N	Date of Last Well Child Exam	
Mother's Full Name		Father's Full Name		
Step-Mother's Full Name (If Applicable)		Step-Father's Full Name (If Applicable)		
Custodial Provider's Full Name (If different from above)		Relationship to Patient		

Birth History

Birth Weight _____ Preg#_____ Mom's age_____ Was the birth ◯ Vaginal ? ◯ Cesarean? □ Early? □ Late?
If birth was early, how many weeks early? _____ If Cesarean, why? _____
Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain _____
Did baby have any problems right after birth? □ Yes □ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:
□ Smoke Cigarettes (amount)_____ □ Drink Alcohol (amount) _____
□ Use "street" drugs (type)_____ □ Use Prescription Drugs (type)_____

Was initial feeding □ Breast Milk? □ Formula?

Current and Past History

Is your child currently on any medication?	■ Y	□ N	Explain_____
Does your child have any serious or chronic illnesses?	■ Y	□ N	Explain_____
Has your child had serious injuries or accidents?	■ Y	□ N	Explain_____
Has your child had any surgeries?	■ Y	□ N	Explain_____
Has your child ever been hospitalized?	■ Y	□ N	Explain_____
Is your child allergic to any medications?	■ Y	□ N	Explain_____
Has your child ever reacted to immunizations?	■ Y	□ N	Explain_____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	■ Y	□ N	Explain_____
Nasal allergies or eczema	■ Y	□ N	Explain_____
Frequent ear infections or sore throat	■ Y	□ N	Explain_____
Problems with ears or hearing	■ Y	□ N	Explain_____
Problems with eyes, vision or teeth	■ Y	□ N	Explain_____
Frequent headaches or other neurologic problems	■ Y	□ N	Explain_____
Frequent abdominal pain	■ Y	□ N	Explain_____
Constipation requiring doctor visits	■ Y	□ N	Explain_____
Bladder/kidney problems or bedwetting	■ Y	□ N	Explain_____
Any heart problems/murmur	■ Y	□ N	Explain_____
Anemia or bleeding problem	■ Y	□ N	Explain_____
Thyroid or other gland problem	■ Y	□ N	Explain_____
Diabetes	■ Y	□ N	Explain_____
ADD/ADHD	■ Y	□ N	Explain_____
Mental Health Issues	■ Y	□ N	Explain_____
Use of drugs or alcohol	■ Y	□ N	Explain_____

Valcourt Pediatric Associates

Household Information

Please List All Those Living in the Child's Home		
Name	**Relationship to Child**	**DOB**

Are there siblings not listed above? If so, please list their full names and ages and where they live. _____
_____
_____

Child Care:_____

Smokers in household? □ Y □ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Who_____	Comments_____
Allergies	□ Y	□ N	Who_____	Comments_____
Asthma	□ Y	□ N	Who_____	Comments_____
Birth Defects	□ Y	□ N	Who_____	Comments_____
Blood Disorders	□ Y	□ N	Who_____	Comments_____
Bone Disorders	□ Y	□ N	Who_____	Comments_____
Cancer	□ Y	□ N	Who_____	Comments_____
Diabetes	□ Y	□ N	Who_____	Comments_____
Endocrine Disease	□ Y	□ N	Who_____	Comments_____
Ear/Nose/Throat Disorders	□ Y	□ N	Who_____	Comments_____
Eye Disorders	□ Y	□ N	Who_____	Comments_____
Gastrointestinal Disorders	□ Y	□ N	Who_____	Comments_____
Heart Disease	□ Y	□ N	Who_____	Comments_____
High Blood Pressure	□ Y	□ N	Who_____	Comments_____
High Cholesterol	□ Y	□ N	Who_____	Comments_____
Immune Disorders	□ Y	□ N	Who_____	Comments_____
Joint Problems	□ Y	□ N	Who_____	Comments_____
Kidney Disease	□ Y	□ N	Who_____	Comments_____
Liver Disease	□ Y	□ N	Who_____	Comments_____
Lung Disease	□ Y	□ N	Who_____	Comments_____
Migraine Headaches	□ Y	□ N	Who_____	Comments_____
Metabolic Disorders	□ Y	□ N	Who_____	Comments_____
Obesity	□ Y	□ N	Who_____	Comments_____
Seizure Disorders	□ Y	□ N	Who_____	Comments_____
Skin Disorders	□ Y	□ N	Who_____	Comments_____
Stroke History	□ Y	□ N	Who_____	Comments_____
Thyroid Disorders	□ Y	□ N	Who_____	Comments_____
Mental Health History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____

Valcourt Pediatric Associates

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION EFFECTIVE APRIL, 2003

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.

If you have any questions about this notice, please contact the:

VALCOURT PEDIATRIC ASSOCIATES
1511 Anthony Rd

Augusta, Ga 30904

WHO WILL FOLLOW THIS NOTICE:

This notice describes our office's practices and that of:

- Any health care professional authorized to enter information into your chart;
- All departments and affiliates of the **Valcourt Pediatric Associates**
- All employees, staff, and other personnel and students.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or office operation purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at **Valcourt Pediatric Associates**. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office, whether made by our personnel or your personal doctor. Your other personal doctor's may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which **Valcourt Pediatric Associates** may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and,
- Follow the terms of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Disclosure at Your Request:

We may disclose information when requested by you. You must submit your request in writing utilizing the "Authorization for the Use or Disclosure of PHI" to **Valcourt Pediatric Associates.**

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, medical assistants, technicians, students, or other office personnel who are involved in taking care of you. **For example**, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. We also may disclose medical information about you to people outside the office who may be involved in your medical care after you leave the office, such as family members, clergy or others (skilled nursing facilities, home health agencies, transport companies, community agencies, physicians or other practitioners/agencies) we use to provide services that are part of your care. This information is stored in the office computer system and is accessible via a secured network and/or interface transmission to authorized healthcare providers in order to make sure they have your information as quickly as possible to treat you.

For Payment:

We may use and disclose medical information about you so that the treatment and services you receive at the office may be billed to and payment may be collected from you, an insurance company or a third party. **For example**, we may need to give your health plan information about a procedure you received at the office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the office who are involved in your care, to assist them in obtaining payment for service they provide you.

Business Associates:

We may use and disclose medical information about you to contracted services provided by business associates so they can perform a job we have asked them to do. To protect your medical information we require business associates to appropriately safeguard your information. **For example,** we may disclose your medical information to a transcription service to transcribe dictated reports from health professionals caring for you in the office, copy services for making copies of your health record or to a billing service to submit your claim to the insurance company for payment.

As Required By Law:

We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety:

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

Organ and Tissue Donation:

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Community Education:

If you participate in a community education program, seminar or workshop, we may call you to discuss your appointment or payment options for the program, discuss your Protected Health Information during the training program, and mail you information about the programs we offer. If you do not want any of these to occur, please fill out either the **"Request for Restriction on the Manner of Confidential Communication"** or the " **"Request for Special Restriction on the Use or Disclosure of PHI"** and give it to the staff of the Community Education Service.

Outpatient Rehabilitation:

If you are part of a rehabilitation program, we may call you to discuss your appointment or treatment, we may mail you a notice of upcoming events, and we may have open discussions in the treatment area which could include some of your Protected Health Information (PHI). If you do not want any of these to occur, please fill out the **"Request for Special Restriction on the Use or Disclosure of PHI"** and give it to the staff of the rehabilitation service.

Valcourt Pediatric Associates

TELEMEDICINE MEMBER CONSENT FORM

Patient Name: _____ Date of Birth _____ ID#: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time

_____ _____ _____

Witness signature Date Time

5/2015, 11/2018

Valcourt Pediatric Associates

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Parent's Name: _____ Phone #: _____

The information you may release to this signed release form is as follows: health information to the following:

☐ Complete Records ☐ Radiology Reports ☐ Care Plan

☐ Pathology Reports ☐ Hospital Reports ☐ Other _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____**Valcourt Pediatric Associates**_____

Address:_____**1511 Anthony Rd**_____

City: State: Zip Code: __**Augusta, Ga 30904**_____

The purpose/reason for this release of information is as follows:

_____

Signature/Stamp: _____

Printed Name of Patient/Personal Representative: _____

Signature of personal representative: _____ Date:_____

Description of Personal Representative's Authority: _____