HOMETOWN PEDIATRICS

Dear Caregiver / Patient,

Welcome to Hometown Pediatrics! It is our pleasure to welcome you and your family to our practice and thank you for allowing us to take care of your children.

Please complete and bring the following forms with you to your child's first appointment:

- ☐ **Patient Information** (updated from must be completed for each child every year)
- ☐ **Family History** (updated form must be completed for each child every year)

Thank you,
Your Care Team at Hometown Pediatrics

HOMETOWN PEDIATRICS PATIENT REGISTRATION FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

DATE: _____

OFFICE: _____

Mother / Father / Guardian Information ***(for child(ren) listed below)***

Name _____ Date of Birth _____

Address _____ Home Phone ( ) _____

City _____ Cell Phone ( ) _____

State _____ Zip Code _____ Work Phone ( ) _____

Employer Name _____ E-mail Address _____

Mother / Father / Guardian Information ***(for child(ren) listed below)***

Name _____ Date of Birth _____

Address _____ Home Phone ( ) _____

City _____ Cell Phone ( ) _____

State _____ Zip Code _____ Work Phone ( ) _____

Employer Name _____ E-mail Address _____

Marital Status (circle) Married Single Separated Divorced Widowed

IF DIVORCED: ☐ JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL DOCUMENTS PROVIDED

Patient Information ***(Please List ALL Children Under 18)***

Legal Name	Preferred Name	PCP in our Office	Sex M/F	DOB mm/dd/yy	Child lives with? (Mother/Father/Both)

Address child lives at ***(If Other Than Above)***

Address _____ Phone ( ) _____

City _____ State _____ Zip _____

Emergency Contact ***(Other Than Parent)***

Name _____ Relationship _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Authorized Care Givers ***(Other Than Parent)***

The following people are authorized to discuss personal health information or bring my child to Hometown Pediatrics for evaluation and treatment, including immunizations:

Name _____ Relationship _____ Phone ( ) _____

Name _____ Relationship _____ Phone ( ) _____

Name _____ Relationship _____ Phone ( ) _____

Name _____ Relationship _____ Phone ( ) _____

HOMETOWN PEDIATRICS PATIENT REGISTRATION FORM

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial Hometown Pediatrics (**circle one**) **can** **cannot** treat and administer injections/vaccines to my unaccompanied child/children (if over 16 years of age).

_____ Initial I _____ authorize Hometown Pediatrics to contact me by telephone with medical information to my child(ren)'s care. If I am unavailable, this authorization gives Hometown Pediatrics permission to leave this information either on my answering machine or with a member of my household.

Phone number to call with information: _____

_____ Initial I authorize Hometown Pediatrics or whomever they designate to evaluate and treat my above named child and to release to our insurance company any information acquired in the course of my child's examination or treatment, and to receive all payments for such examination or treatment. Hometown Pediatrics has my permission to release any diagnostic studies, report, etc., to a specialist involved in caring for my child.

_____ Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____ Initial A parent / guardian / or authorized care giver is to be present at every visit. If someone else is bringing your child, **we will need prior written authorization** that includes authorization for treatment, your contact information, and insurance and co-pay payment authorization for this visit.

PAYMENT POLICIES

_____ Initial **Insurance Information*:*** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances:** When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** Hometown Pediatrics reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Payments**: Hometown Pediatrics accepts cash, checks or credit cards. Payment plans can also be setup by contacting our billing department at (203) 452-8329.

_____ Initial **Co-Payments**: are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. All returned checks will be subject to a service charge of $35.

_____ Initial **Self-Pay**: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccine for Children program.

_____ Initial **Divorce Situations**: The parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____ Initial **Referrals**: If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

_____ Initial **Evening, Weekend & Holiday Code**: Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows**: A $25 no show fee will be assessed for all well and specialty consult visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

HOMETOWN PEDIATRICS PATIENT REGISTRATION FORM

In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE:

- ☐ Caucasian
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Asian Pacific American
- ☐ Pacific Islander
- ☐ Subcontinent Asian American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Black Non-Hispanic
- ☐ Other Race or Ethnicity
- ☐ White Non-Hispanic
- ☐ Race Not Reported – Refusal
- ☐ Race Not Reported – Don't Know
- ☐ Race Not Reported – Not Ascertained

ETHNICITY: ☐ Latino/Hispanic ☐ Not Latino or Hispanic ☐ Other ☐ Refused

Language predominantly spoken _____

How did you hear about our practice _____

COMPLETION OF THIS SECTION IS <u>OPTIONAL</u>

GENDER IDENTITY **Child's Name:** _____

- ☐ (M)ale – person specifies gender identity as male.
- ☐ (F)emale – person specifies gender as female.
- ☐ (FTM) Transgender Male / Female-to-Male – person specifies gender identity as transgender male.
- ☐ (MTF) Transgender Female / Male-to-Female – person specifies gender identity as transgender female.
- ☐ (G) Genderqueer – neither exclusively Male nor Female.
- ☐ (O)ther – person specifies a gender identity that is other than the options of Male, Female, Transgender Male, Transgender Female, or Genderqueer.
- ☐ (D)eclined

My signature below indicates I am the legal guardian for the patient(s) listed on the front page, that I have provided accurate information to the best of my knowledge, and I understand and agree to the provisions as stated.

Signature of Parent / Legal Guardian _____ Date _____

Print Name of Parent / Legal Guardian _____

Please always notify us any changes to the above information

FAMILY HISTORY FORM **DATE** _____

HOMETOWN PEDIATRICS

Patient's Name _____ Nickname _____ Date of Birth _____

Other children with same parents: _____

	Date of Birth	Height	Illness/Medical Problems
Father of child			
Mother of child			

	Illness/Medical Problem	Age Died	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Does anyone in your family have any of the following diseases? If so, state the relationship to the child.

	Yes	No	Relationship		Yes	No	Relationship
ADHD				Hearing Loss			
Alcoholism/Drug Use				Heart Disease			
Allergies				Hemochromatosis			
Asthma				High Cholesterol			
Autism				Hypertension (high blood pressure)			
Birth Defects/Genetic Problems				Immune Disorders			
Bleeding Problems				Infertility/PCOS			
Blood Clots				Lazy Eye			
Cancer & type				Mental Illness (depression, bipolar, anxiety)			
Congenital Cataract				Migraines			
Celiac Disease				Overweight/Obesity			
Developmental Delays/Learning Disabilities				Renal Disorder (kidney)			
Diabetes, type 1 or 2				Retinoblastoma			
Eating Disorders				Rheumatologic Disorder			
Eczema				School Problems			
Epilepsy (seizures)				Scoliosis			
Food Allergy				Sickle Cell/Thalassemia			
Gastrointestinal Disease (colitis, Crohn's)				Smoking			
Glaucoma				Thyroid Disease			

Are there any other medical problems that run in your family? _____

Hometown Pediatrics HIPAA Notice of Privacy Practices

Effective date of this notice –July 5, 2022

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION AS A PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your child's 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 is information that identifies you and relates to health care services, the payment of health care services or your physical or mental health or condition, in the past, present or future. This notice describes your rights to access and control your child's PHI.

Our Responsibilities

Federal law requires that we maintain the privacy of your child's PHI and provide to you this Notice of our legal duties and privacy practices. We are required to notify affected individuals following a breach of unsecured PHI. We are required to abide by the terms of this Notice, which may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our duties, or other practices stated in this Notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new notice in which the material change is reflected.

Uses and Disclosures of PHI for Treatment, Payment, and Health Care Operations

- Federal law provides that we may use your child's 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 a specialist involved with your child's care.
- Federal law provides that we may use your child's 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 child's visit and a description of the services rendered.
- Federal law provides that we may use your child's 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 your child received from us, or to conduct cost-management and business planning activities for our practice.

Uses and Disclosures of PHI for Appointment Reminders, Treatment Alternatives, or Fundraising Activities

- We may use and disclose your child's PHI to contact you as a reminder that your child has an appointment for a office visit. We may use and disclose your child's PHI to advise you or recommend possible service options or alternatives that may be of interest to you. We may contact you for fundraising activities. However, you will be provided the opportunity to opt out of receiving such fundraising communications.

Disclosures You May Authorize Us to Make

- We will not disclose your child's PHI without authorization, except as described in this Notice. Most uses and disclosures of psychotherapy notes, as applicable, require your authorization. Subject to certain limited exceptions, we may not use or disclose PHI for marketing without your authorization. We may not sell PHI without your authorization. You may give us written authorization to use and/or disclose health information to anyone for any purpose. If you authorize us to use or disclose such information, you may revoke that authorization in writing at any time.

Health Information Exchanges.

- We may participate in one or more health information exchanges (HIEs) and may electronically share your child's health information for treatment, payment, and healthcare operations purposes with other participants in the HIEs. HIEs allow your health care providers to efficiently access and use your child's pertinent medical information necessary for treatment and other lawful purposes. Depending on State law requirements, you may be asked to "opt-in" in order to share your child's information with HIEs, or you may be provided with the opportunity to "opt-out" of HIE participation. If you opt-in to the HIE (or do not opt-out depending upon state law requirements), we may provide your child's health information to the HIEs in which we participate in accordance with applicable law. Patients who opt-in will be required to provide written authorization and may revoke their authorization at any time.

Other Specific Uses or Disclosures When Legally Required.
We will disclose your child's PHI when required by any Federal, State or local law.

In the Event of a Serious Threat to Life, Health, or Safety. We may, consistent with applicable law and ethical standards of conduct, disclose your child's PHI if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your life, health, or safety, or to the health and safety of the public. When There Are Risks to Public Health. We may disclose your child's PHI for public activities and purposes allowed by law to prevent or control disease, injury, or disability; report disease, injury, and vital events such as birth or death; conduct public health surveillance, investigations, and interventions; or notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

To Report Abuse, Neglect or Domestic Violence. We may notify government authorities if we believe a child is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when required or authorized by law, or when the child's personal representative agrees to the disclosure.

To Conduct Health Oversight Activities. We may disclose your child's PHI to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. However, we may not disclose your child's PHI if you are the subject of an investigation and your child's PHI is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. We may disclose your child's PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order, or, in response to a subpoena, discovery request or other lawful process, if we determine that reasonable efforts have been made by the party seeking the information to either notify you about the request or to secure a qualified protective order the release of any confidential medical information.

For Law Enforcement regarding your health information. Under Ohio law, some requests may require a court order. As permitted or required by law, we may disclose specific and limited PHI about

you for certain law enforcement purposes.

For Research Purposes. We may, under very select circumstances, use your PHI for research. Before we disclose any of your child's PHI for such research purposes in a way that you could be identified, the project will be subject to an extensive review and approval process, unless otherwise prohibited as with Medicaid.

For Specified Government Functions. Federal regulations may require or authorize us to use or disclose your child's PHI to facilitate specified government functions relating to military and veterans; national security and intelligence activities; protective services for the President and others; medical suitability determinations; and inmates and law enforcement custody.

For Workers' Compensation. We may use or disclose your child's PHI for workers' compensation or similar programs.

Transfer of Information at Death. In certain circumstances, we may disclose your child's PHI to funeral directors, medical examiners, and coroners to carry out their duties consistent with applicable law.

Organ Procurement Organizations. Consistent with applicable law, we may disclose your child's PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purposes of tissue donation and transplant.

Minors

- For divorced or separated parents: each parent has equal access to health information about their un-emancipated 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.

Your Rights with Respect to PHI

You have the following rights regarding PHI that we maintain:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your child's health information. You have the right to request a limit on our disclosure of your child's PHI to someone who is involved in your child's care or the payment of your child's care. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it unless the request concerns a disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full. To request such restrictions, please contact Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833

Right to Receive Confidential Communications. You have the right to request that we communicate with you in a confidential manner. For example, you may ask us to conduct communications pertaining to your child's health information only with you privately, with no other family members present. If you wish to receive confidential communications, please contact Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833. We may not require that you provide an explanation for your request and will attempt to honor any reasonable requests.

Right to Inspect and Copy Your PHI. Unless your access to your child's records is restricted for clear and documented treatment reasons, you have a right to see your child's PHI upon request. You have the right to inspect and copy such health information, including billing records, at a reasonable time and

place. A request to inspect and copy records containing your child's PHI may be made to Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833. If you request a copy of such health information, we may charge reasonable copying, processing, and personnel fees. If the PHI that is the subject of a request is maintained in one or more designated record sets electronically and if you request an electronic copy of such information, we will provide you with access to the PHI in the electronic form and format requested if readily producible in such form and format; or, if not, in a readable electronic form and format as agreed upon by us and you.

Right to Amend Your PHI. You have the right to request that we amend your child's records, if you believe that your PHI is incorrect or incomplete. That request may be made as long as we maintain the information. A request for an amendment of records must be made in writing to Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833. We may deny the request if it is not in writing, or does not include a reason for the amendment. The request also may be denied if your child's health information records were not created by us, if the records you are requesting are not part of our records, if the health information you wish to amend is not part of the health information you are permitted to inspect and copy, or if, in our opinion, the records containing your child's health information are accurate and complete. We take the position that amendments may take the form of including a written statement from you and may not include changing, defacing or destroying any necessary information related to your child's health care.

Right to Know What Disclosures Have Been Made. You have the right to request an accounting of disclosures of your child's PHI made by us for certain reasons, including reasons related to public purposes authorized by law, and certain research. The request for an accounting must be made in writing to Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833. The request must specify the time period for the accounting, and may not be made for periods of time in excess of six (6) years prior to the date on which the accounting is requested. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable, cost-based fee.

Right to a Paper Copy of This Notice. You have a right to receive paper copy of this Notice at any time, even if you have received this Notice previously. To obtain a paper copy, please contact Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833

Where to File a Complaint

You have the right to complain to us if you believe that your child's privacy rights have been violated, including the denial of any rights set forth in this Notice. Any complaints to us shall be made in writing to Hometown Pediatrics, 152 W. 2nd St. Delphos, OH 45833.

We encourage you to express any concerns you may have regarding the privacy of your child's information. You will not be retaliated against in any way for filing a complaint. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C., 20201 or call toll-free (877) 696-6775, by e-mail to OCRComplaint@hhs.gov, or to Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, Ill, 60601, Voice Phone (312) 886-2359, FAX (312) 886-1807, or TDD (312) 353-5693.