Chillicothe Pediatrics

An Affiliate of Nationwide Children's Hospital

Patient Information Form: Please Print

Please fully complete

Patient Information:

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

DOB _____ Sex: ☐ Male ☐ Female Phone#_____

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____ SSN _____ Relationship to Patient _____

Employer _____

Child lives with ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Legal Guardian ☐ Other

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____

Address _____ City _____ State _____ZIP_____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____ SSN _____ Relationship to Patient _____

Employer _____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____

Policy Holder _____ DOB _____ Employer _____

ID# _____ Group# _____ SS# (If needed for billing) _____

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____

Policy Holder _____ DOB _____ Employer _____

ID# _____ Group# _____ SS# (If needed for billing) _____

Please list all children in your family who come to this practice:

_____DOB _____ _____DOB _____ _____DOB _____

_____DOB _____ _____DOB _____ _____DOB _____

Preferred E-Mail for the patient portal: _____

Preferred Pharmacy: _____ Address _____ Phone _____

Emergency Contact:

Name _____ Relationship _____ Phone _____

How were you referred to this practice?

Existing patient _____ Physician _____ Name of patient or physician _____

Newspaper _____ Telephone _____ Internet _____ Website _____ Insurance company _____

Other _____

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

Printed name of patient or parent/guardian Signature Date

Patient Name_____Birth Date_____

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	Yes	No
Asthma/wheezing/pneumonia	□	□ _____
Allergies- food/pets/seasonal	□	□ _____
Anemia/blood disorder	□	□ _____
Diabetes	□	□ _____
Ear infections/strep throat	□	□ _____
Genetic disorder	□	□ _____
Heart disease/defects	□	□ _____
Intestinal problems	□	□ _____
Neurological (headaches/seizures)	□	□ _____
Psychological (ADHD, autism, anxiety)	□	□ _____
Urinary tract infections/disorders	□	□ _____
Other chronic conditions	□	□ _____

Has your child ever been hospitalized overnight? □ Yes □ No Please explain and give dates _____

_____

Please list any specialist(s) your child is seeing _____

_____

Medications

Allergies to medications and reactions _____

Current medications and dose _____

_____

Vitamins, herbal supplements, over the counter medications _____

Surgical History

Type of surgery and date of surgery _____

Social History

Who lives in the household with your child? □ Parent (Mom) □ Parent (Dad) □ Siblings #_____ □ Other _____

Parent(s) □ Married □ Single □ Divorced □ Remarried Name of Step-parent_____

□ Custody (Please bring in custody papers if other than shared)

Smokers □ Yes □ No Pets □ Yes □ No What Kind? _____ Age of home_____

Does your child stay home with you? □ Yes □ No Does your child attend daycare/preschool/babysitter? □ Yes □ No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school _____

Patients Race: □ American Indian or Alaska Native □ Asian □ White □ Hispanic □ Black or African American □ Native Hawaiian/Other Pacific Islander □ Other □ Decline to report

Patients Language: □ English □ Spanish □ Indian □ Russian □ Other _____

Patients Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin □ Decline to report

General Consent Agreement

Patient: _____ Date of birth: _____

Consent for Medical Treatment:

I consent to let the clinical providers and employees of **Chillicothe Pediatrics** (the practice) do all things that may be needed to diagnose, treat and care for the needs of the patient referenced below to include any necessary examination, immunizations, medical diagnosis, surgery, treatment and/or hospital care to be rendered to the minor child named below under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio.

I authorize the practice to take photos, video or audio recording of me/my child for diagnostic and identification purposes.

I understand that the practice is not responsible for personal belongings lost during my visit.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the result of my examination or treatment.

Patient Rights and Responsibilities:

I understand I have the right to take part in decisions about the health care and plan for treatment. I have received a copy of the Patient Rights and Responsibilities and my questions have been answered.

Consent to Release Medical Information:

I consent to let the practice share/release/exchange information such as clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, health care provider, and/or to any insurance company or organization that helps pay my bill. The practice may also give information to any welfare organization to which I have applied or may apply for aid.

Assignment of Insurance Benefits:

I assign to the practice, my physician and other healthcare professionals involved in the patient's care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs I identify for which benefits may be available to pay the practice for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Practice Price Disclosure:

I have a right to see a list of prices for services provided.

Patient: _____Date of birth: _____

Financial Responsibility:

I (or my guarantor, if appropriate) will pay all bills for care including bills that insurance benefits do not pay. This includes bills from the practice, physicians or any other entities that provided services during my care.

Removal from the practice:

If I decide to stop medical care against the advice of doctors, I understand that the practice and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices which sets forth the ways in which protected health information may be used or disclosed by the practice and outlines my rights with respect to such information.

Consent for Automated Calls and Texts:

I authorize the practice, its affiliated entities, and third party service providers to call or text me at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from the practice.

_____**initial** I do not wish to receive text messages or automated appointment reminders.

Acknowledgement of Receipt of Children's Community Practice Patient Policies:

I hereby acknowledge that I was offered or received a copy of the Children's Community Practice Patient Policies, Which set forth the responsibilities a patient must abide by as part of this physician practice.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Patient Name(s) _____

Signed _____ Signed _____

PATIENT, IF 18 YEARS OR OLDER DATE TIME PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE/TIME

_____(_____)_____

STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

Signed _____ _____

WITNESS DATE TIME PRINT NAME OF PARENT/GUARDIAN

Children's Community Practice Patient Policies

Missed Patient Appointments

Our office will do it's best to make reminder calls and text messages 7 days and twenty-four (24) hours prior to your scheduled appointment. If you are unable to make your scheduled appointment, you must call and cancel that appointment at least twenty-four (24) hours in advance of your appointment. If your appointment is on Monday, you may leave a message. If appropriate notification is not given, or you do not show up for your appointment, you may be charged a fee.

Forms

Forms for physicals, daycare, simple school forms, work permits, medication, etc. when presented at the time of your child's appointment the provider will complete and sign without a charge. If presented later outside of an appointment, there may be a $25 charge. For FMLA forms, a $25 will always be charged. Please allow up to five (5) working days for these forms.

Prescription refill

Please allow forty-eight (48) business hours (i.e. not Saturday, Sunday or holidays) when calling for a prescription refill.

Insurance Information

At each appointment, you will be asked to verify your insurance information and effective date. Please make sure you bring your child's up to date insurance card to each appointment. If your insurance is no longer in effect, you will be responsible for the visit charge.

Non-emergent after hour calls

Our office provides after hour coverage for emergent sick calls that cannot wait until the next business day. Please leave a reliable phone number where you can be reached, so your child may receive immediate care.

Patient Portal Access:

The practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Someone who knows the right password or pass- phrase to log in to the portal site can only read secure messages and information. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

1. Please make sure we have your correct email address and inform us if it ever changes.

2. Also, keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Disclaimer on Example HIE Authorization and Withdraw Authorization Forms

These forms are being provided to NCH community practices as an example only. They were created for NCH and we are not requiring any practice to use the exact same document nor representing that it is what they should use. They are being offered only as a suggestion as we require all practices to have their patients sign a valid HIPAA authorization as a prerequisite to participation in the NCH HIE. We encourage any practice using these forms as an example to have their legal representative review if they so desire.

Please provide NCH with a copy of whatever documents your practice decides to use as their final HIE release form, and forward any material changes that are made, for our record.

1264 Hospital Rd.
Chillicothe, Ohio 45601

Chillicothe Pediatrics

An Affiliate of Nationwide Children's Hospital

HEALTH INFORMATION EXCHANGE
PATIENT AUTHORIZATION FORM

Patient Information			
	Last Name	First Name	Middle
	Date of Birth		Other possible names
	Phone #	Address	
	City	State	Zip Code

A Health Information Exchange ("HIE") is a safe way for health care providers to get the most up-to-date health information about your child. The HIE will allow **Chillicothe Pediatrics** and **Nationwide Children's Hospital** to access or share your child's health information with other healthcare providers. This may improve your child's overall care through the use of an electronic medical record. By signing this form, you are agreeing that your child's health information, including test results, lab reports, X-rays, medication lists or any other relevant electronic health information may be shared across participating health care providers.

You acknowledge that you read this form, were given the opportunity to ask questions and got answers you understood.

1. I understand that this authorization will expire one year from the date of my signature below.

2. I understand that I may revoke this authorization at any time by submitting a *Patient Withdraw Authorization Form* and submitting it to my healthcare provider, or by notifying, in writing, the Privacy Officer, at Nationwide Children's Hospital, 700 Children's Drive, Columbus, OH 43205. I understand that if I withdraw authorization, no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it has already been used in reliance on my previous authorization. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.

3. I understand that if I previously exercised my right to opt-out of the HIE, and am now signing this form to be reinstated so that my health information can be electronically accessible through the HIE by authorized health care providers, that by signing this form all of my health information from both before and after today's date, including the period of time when I opted out, will be shared through the HIE.

4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

5. I understand that my refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my health information is required for the provision of healthcare or to obtain payment for healthcare.

6. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.

Print Name of Patient	Print Date of Birth
Signature of Patient or Legal Representative	Date Time
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Chillicothe Pediatrics

An Affiliate of Nationwide Children's Hospital

HEALTH INFORMATION EXCHANGE
PATIENT WITHDRAW AUTHORIZATION FORM

Patient Information			
	Last Name	First Name	Middle
	Date of Birth		Other possible names
	Phone #	Address	
	City	State	Zip Code

I wish to WITHDRAW authorization for my child's participation in the Health Information Exchange. I understand that no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it has already been used in reliance on my previous authorization.

Print Name of Patient	Print Date of Birth
Signature of Patient or Legal Representative	Date Time
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)