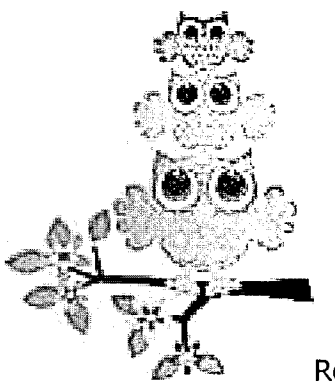
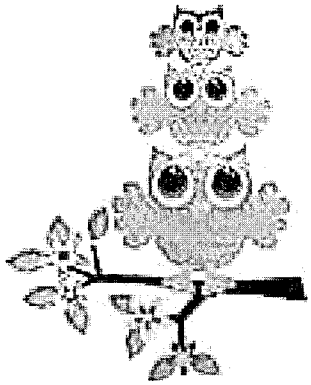


Royal Oak Pediatric Associates



We would love to hear how you heard about/found us:

1. Friend
2. Family
3. Have other children that go here
4. Facebook
5. Hospital/OB
6. Phonebook
7. Internet
8. Employee:_____

We also have a PATIENT PORTAL for you to use!

Royal Oak Pediatric Associates, Inc.
929 N Main Street
Marion, VA 24354
Telephone 276-783-8183 and Fax Number 276-782-9267

Authorization to Use or Disclose Protected Health Information

Patient Name:_____Date of Birth:_____
Account Number:_____ Daytime Telephone Number: _____

I,_____ , understand Royal Oak Pediatric Associates is authorized by me to use or disclose my Protected Health Information (PHI) for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below. I specifically authorize any current employee or owner of _____to disclose the information as outlined. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date.

Description of the information to be used or disclosed *(check all that apply):*

[ ] The patient's entire medical record
Note explanation as to why the entire record may be disclosed
[ ] Certain Medical Data Information as related to:
- [ ] Date of Service(s): _____
- [ ] Specific condition(s): _____
- [ ] Specific service(s) or procedure(s):_____
- [ ] Specific medication(s):_____
- [ ] Other:_____

[ ] Other:_____

The patient has a right to revoke this authorization in writing.

Royal Oak Pediatric Associates will accept written revocations of this authorization via: Certified U.S. mail or facsimile at this number: 276-782-9267 I fully understand and accept the terms of this authorization.

_____ _____
Patient or Legal Guardian Signature Date

Royal Oak Pediatric Associates

929 N. Main St
Marion, VA 24354
(276)783-8183

Patient Information

First Name_____ MI____ Last Name_____ Date of Birth_____
Mailing Address_____
Physical Address_____
Home Phone_____ Cell Phone_____ SSN_____

Legal Guardian/Guarantor Information *Required *

First Name_____ MI____ Last Name_____ Date of Birth_____
Email Address:_____
Mailing Address_____
Home Phone_____ Cell Phone _____SSN_____
Relationship: Spouse Mother Father Guarantor (specify)_____
Occupation_____ Employer_____
Employer Address_____ Work Phone_____

First Name_____ MI____ Last Name _____Date of Birth_____
Email Address:_____
Mailing Address_____
Home Phone_____ Cell Phone _____SSN_____
Relationship: Spouse Mother Father Guarantor(specify)_____
Occupation_____ Employer_____
Employer Address_____ Work Phone_____

**It is customary at the time of visit for the patient to pay the deductible, co-pay, co-insurance and balances not covered by their insurance. ~ *
**Parent bringing child to office is responsible for payment. We do not bill parent at another address. * *

Who is responsible for this account?_____ Relationship to Patient_____

Insurance Information * ALL required in order for us to bill vour insurance*

Primary Insurance_____
Policy Holders Full Name_____ SSN_____DOB_____
Policy ID_____ Policy Group#_____
Secondary Insurance_____
Policy Holder Full Name_____ SSN_____ DOB_____
Policy ID_____ Policy Group#_____

Emergency Contact

First Name:_____ Last Name:_____ Relationship: _____
Address:_____
Home Phone_____ Work Phone_____ Cell Phone_____
Patient/Guarantor Signature_____ Date _____

Medication History Authorization

My preferred local pharmacy is: Name_____
Address _____
My preferred mail order pharmacy is: Name _____

I hereby give authorization to the physicians of Royal Oak Pediatric Associates to retrieve my Medication History as prescribed by other physicians from my prescription plan.

_____ _____
Printed name Signature

INSURANCE ASSIGNMENT AND RELEASE AGREEMENT

I the undersigned have insurance coverage with _____ and
Name of Insurance Carrier
assign directly to ***Royal Oak*** **Pediatric** ***Associates*** all medical benefits if any otherwise payable to me for the services provided. I **understand that I am financially responsible for all charges including the cost of Collection Agency fees, whether my insurance company pays or not.**
I hereby authorize ***Royal Oak Pediatric Associates*** to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ Date:_____
Signature of Patient /Guardian

Deemed Consent Form

I understand that the laws of Virginia provide if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis ~ or C viruses. I further understand that by law I will have deemed to consent to the release of these test results t<~ the person who is exposed to my body fluids.

Date. _____ Responsible Party _____

Witness:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Name: _____ Date: _____ DOB: _____

To comply with Federal HIPAA regulations, health care providers must obtain a patient's permission to share that patient's protected health information with any other person. There are limited expectations to this rule. Until a child reaches ate 18, parents may have access most of their child's health information without first obtaining child's permission. However, regardless of the child's age, parents do not have access to diagnosis, or treatment of information, including payment information, for venereal diseases, reproductive health, abortion, drug and alcohol abuse unless the child specifically authorizes the release of such information.

You can use this form to authorize us to share your protected health information. Each person you have identified will have the same access or you can designate what information you allow for each person.
Please include yourself and other parent. Please check all that apply.

1. _____ Relationship:_____ Phone:_____

___ Authorized to bring for care – this person can accompany patient to visits and receive medical information during visit time only.

___ Authorized for medical decision making – this person will be able to authorize medical care provided for patient

___ Authorized to receive protected health information for the patient (i.e. – labs, x-rays, etc.)

___ Emergency Contact Only

2. _____ Relationship:_____ Phone:_____

___ Authorized to bring for care – this person can accompany patient to visits and receive medical information during visit time only

___ Authorized for medical decision making - this person will be able to authorize medical care provided for patient

___ Authorized to receive protected health information for the patient (i.e. – labs, x-rays, etc.)

___ Emergency Contact Only

3. _____ Relationship:_____ Phone:_____

___ Authorized to bring for care – this person can accompany patient to visits receive medical information during visit time only

___ Authorized for medical decision making - this person will be able to authorize medical care provided for patient

___ Authorized to receive protected health information for the patient (i.e. – labs, x-rays, etc.)

___ Emergency Contact Only

4. _____ Relationship:_____ Phone:_____

___ Authorized to bring for care – this person can accompany patient to visits and receive medical information during visit time only

___ Authorized for medical decision making - this person will be able to authorize medical care provided for patient

___ Authorized to receive protected health information for the patient (i.e. – labs, x-rays, etc.)

___ Emergency Contact Only

I have had full opportunity to read and consider the contents of this form, I confirm my authorization for use, request and release of protected health information as described in this form. I understand that I may cancel this authorization at any time by contacting our office.

I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the federal privacy laws.

Signature: _____ Date: _____

(Patient or Legal Custodian/Authorized Representative)

Royal Oak Pediatric Associates, Inc.
929 N Main Street
Marion, VA 24354
Telephone 276-783-8183 and Fax Number 276-782-9267

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

NOTICE OF INFORMATION PRACTICES

1. Royal Oak Pediatric Associates may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Royal Oak Pediatric Associates is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.
3. An authorization from the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided.
5. Royal Oak Pediatric Associates will abide by the terms of the notice currently in effect at the time of the disclosure.
6. Royal Oak Pediatric Associates reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Royal Oak Pediatric Associates will provide each patient with a copy of any revisions or its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.
7. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
8. Any patient, guardian or personal representative has the right to inspect and obtain their medical record.
9. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
10. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.
12. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed and the results will be reported to the Privacy Officer.
13. It is the policy of Royal Oak Pediatric Associates that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective date:_____ Name of Patient: _____
Signature of Patient or Legal Guardian:_____Date:_____