

RICHMOND PEDIATRICS
 PATIENT DEMOGRAPHIC FORM
 Please Print

Date:

PATIENT INFORMATION					
Last Name	First Name	Middle Initial	Preferred Name		
Date of Birth	Social Security Number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Address	Apt#	City	State	Zip Code	
Home Phone	Work Phone	Other Phone <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax			
Email Address		Preferred Phone No.		Language Other than English	
RESPONSIBLE PARTIES					
Patient Lives With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Name-Relationship):					
Father's Name: Last:		First:	Middle Initial:	DOB:	
Address/Phone Same as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No: Address:		City:	State	Zip Code	
Home Phone:		Cell Phone:		SSN:	
Employer:		Occupation:		Emp Phone #:	
Mother's Name: Last:		First:	Middle Initial:	DOB:	
Address/Phone Same as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No: Address:		City:	State	Zip Code	
Home Phone:		Cell Phone:		SSN:	
Employer:		Occupation:		Emp Phone #:	
Person Responsible for Insurance: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Name-Relationship):					
PATIENT'S INSURANCE INFORMATION** Please provide Insurance Card and Pharmacy Card to our Receptionist					
PRIMARY INSURANCE					
Is patient a full time student in secondary education on parent's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Insurance Company		ID/Member #:		Group #:	
Policy Holder's Name:		Policy Holder's DOB:		Member/Customer Service Phone #:	
SECONDARY INSURANCE					
Is secondary insurance available: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Insurance Company		ID/Member #:		Group #:	
Policy Holder's Name:		Policy Holder's DOB:		Member/Customer Service Phone #:	
PHARMACY CHOICE					
Name:		City:	Zip Code:	Phone No.:	
Address:		State:			

OVER

PATIENT INFORMATION				
Last Name	First Name	Middle Initial	Nickname/AKA	
EMERGENCY/NEXT OF KIN CONTACT INFORMATION				
Last Name:	First Name:	Relationship to Patient		
Address:	Apt#	City	State	Zip Code
Home Phone:	Cell Phone:	Work Phone:		
SIBLING INFORMATION				
Name:	Date of Birth:	Name:	Date of Birth:	
Name:	Date of Birth:	Name:	Date of Birth:	
Name:	Date of Birth:	Name:	Date of Birth:	
OTHER CONTACT INFORMATION - NOT LIVING WITH PATIENT				
Last Name:	First Name:	Relationship to Patient		
Address:	Apt#	City	State	Zip Code
Home Phone:	Cell Phone:	Work Phone:		

Charges for new patients are due and payable at the time of the first visit unless a valid insurance card is presented.

I authorize my insurance benefits to be paid directly to Richmond Pediatrics. I hereby authorize the physician or insurance company to release my information necessary to secure payment.

Signature: _____

Date: _____

Richmond Pediatrics Social History

Date: _____

1. Child's name: First name _____ Last name _____

2. Your name: First name _____ Last name _____

3. What is your relationship with child: Mother Father Other : _____

4. Who lives at home with child? (If there are multiple homes, please indicate whose home ie. Mother's house, Father's house etc.)

	Relationship to child/Name	Date of Birth		Relationship to child/Name	Date of Birth

5. Are child's parents? Married Unmarried but living together Separated Divorced Other (specify) _____

6. Which languages are spoken regularly in your home? English Spanish Other (specify) _____

7. Does anyone besides parents provide care for your child? (Ie. Nanny, relative, friend) Yes No

If yes, who? _____

8. Does your child go to daycare? Yes No

9. Does your child go to school? Yes No Grade _____

If yes, Preschool General Education classroom Special Education School Name _____
If Daycare: Hours per week _____

10. Do any household members smoke? Yes No

11. Do you live in an older home with peeling paint or remodel going on now? Yes No

12. Are there any guns in the home? Yes No If Yes, are they locked? Yes No

13. Are there any pets in the home? Yes No If yes, what kinds? _____

14. How much screen time (TV/video/computer game) does your child have each day? _____

15. Is there any history of family violence or abuse? Yes No

16. Is your child adopted? Yes No

17. Is your child in the foster system? Yes No Was he/she in the foster system in the past? Yes No

18. Do the parents and caregivers agree about how to raise this child? Yes No

19. Which other adults besides the parents/guardians are allowed to bring the child in for care? (ie name of nanny, grandparent) Please list names:

Pediatric Family History Form

Child's Name: _____ **Date:** _____

Please indicate with an X any relatives with any of the following conditions

Medical Condition	Mom	Dad	Sister	Brother	Grandparent	Aunt/Uncle
Anemia						
Asthma						
Autism						
Autoimmune Disorder						
Bleeding or clotting disorder						
Cancer: What Type? _____						
Congenital Anomaly/Birth Defect						
Depression or other mental health problems						
Diabetes						
Eczema						
Food Allergy						
Headache or Migraine						
Heart Attack or Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
ADD or Learning Disability						
Stroke						
Alcoholism or other Substance abuse						
Suicide						
Thyroid Disorders						
Tuberculosis						
Death before age 56: What Cause? _____						
Other						

Please give any further details about the disorders above, if you know them:

Notice of Privacy Practices

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.

Richmond Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of **Richmond Pediatrics**. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

Office Manager
206-546-2421

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.

- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our clinic to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

**Office Manager
206-546-2421**

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our office manager at **Richmond Pediatrics**. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and 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 health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.

- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
 - Medical quality review by your health plan,
 - Accounting, legal, risk management, and insurance services; and
 - Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
 - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
 - To public health or legal authorities:
 - To protect public health and safety.
 - To prevent or control disease, injury, or disability.
 - To report vital statistics such as births or deaths.
 - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.

- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. **Uses and disclosures that require your authorization.**

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications:** we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. **Web site**

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: www.richmond-pediatric.com.

7. **Effective date**

This Notice is effective as of **9/19/2013**.

Notice of Privacy Practices Acknowledgment

Richmond Pediatrics has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact our office manager at 206-546-2421 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Richmond Pediatrics.

Printed name of patient

DOB: ____ / ____ / ____

Patient or legally authorized individual's signature

Date

Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

Authorization to Use or Disclose Protected Health Information

Richmond Pediatrics 357 NW Richmond Beach Rd (Phone) 206-546-2421 (Fax) 206-542-9028

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Richmond Pediatrics may use or disclose the following health care information (check all that apply):

- All health care information in medical record
- Transfer of care/changing physicians
- Health care information in medical record relating to the following treatment or condition:

- Health care information in medical record for the date(s): _____
- Other (e.g., X-rays, bills)—specify date(s): _____

Exchange Information between the following entities:

<input type="checkbox"/> Exchange/between	<input type="checkbox"/> To	<input type="checkbox"/> From	<input type="checkbox"/> Exchange/between	<input type="checkbox"/> To	<input type="checkbox"/> From
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Organization

Street Address

City, State, Zip

Phone

Fax

Richmond Pediatrics
Organization

357 NW Richmond Beach Rd Shoreline, WA 98177
Street Address

City, State, Zip

206-546-2421 206-542-9028
Phone Fax

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

- at my request
- other (specify) _____

This authorization ends:

- on (date): _____
- when the following event occurs: _____
- in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply – If no boxes are checked, this information will NOT be released):

- HIV/AIDS
- Mentally Transmitted Diseases
- Mental Health or Illness
- Drug and/or Alcohol Abuse
- Reproductive Care (minors only)

Minors – a minor patient’s signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

OVER

- to receive research-related treatment in connection with research studies **or**
 - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Richmond Pediatrics** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form—a form is available from **Richmond Pediatrics** or
 - Write a letter to **Richmond Pediatrics** .

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Patient or legally authorized individual signature	Date	Time
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Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

Minor patient's signature, if applicable	Date	Time
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