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: ☐ Male ☐ Female

Home Address	Apt#	City	State	Zip Code

Home Phone	Work Phone	Other Phone ☐ ☐ ☐ CellPagerFax

Email Address	Preferred Phone No.	Language Other than English

RESPONSIBLE PARTIES

Patient Lives With: ☐ Father ☐ Mother ☐ Other (Name-Relationship):

Father's Name: Last:	First:	Middle Initial:	DOB:

Address/Phone Same as Patient? ☐ Yes ☐ 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? ☐ Yes ☐ No

If No: Address:	City:	State	Zip Code

Home Phone:	Cell Phone:	SSN:

Employer:	Occupation:	Emp Phone #:

Person Responsible for Insurance: ☐ Father ☐ Mother ☐ 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? ☐ Yes ☐ 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: ☐ Yes ☐ No

Name of Insurance Company	ID/Member #:	Group #:

Policy Holder's Name:	Policy Holder's DOB:	Member/Customer Service Phone #:

PHARMACY CHOICE

Name: Address:	City: State:	Zip Code:	Phone No.:

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: _____

Printed Name: _____ Relationship to Patient: _____

Richmond Pediatrics Social History Form

Date: _____

Child's Name: _____

Completed By: _____

1. What is your child's living situation?	☐ Single home ☐ >1 home ☐ Foster home ☐ Group home ☐ Shelter/homeless
2. With whom does your child live?	☐ Both parents together ☐ Parents separately ☐ Mother ☐ Father ☐ Step-parent(s) ☐ Grandparents

HOUSEHOLD #1

Name	Relationship	Date of birth

HOUSEHOLD #2 (if applicable)

Name	Relationship	Date of birth

3. Are child's parents? ☐ Married ☐ Unmarried but living together ☐ Divorced ☐ Separated ☐ Single ☐ Other_____			
4. Is the child adopted? If YES, from where?_____	No	Yes	
5. Is the child in the foster care system?	No	Yes	
Was he/she in the foster care system in the past?	No	Yes	
6. What languages are spoken regularly in the home?	☐ English	☐ Spanish	☐ Other_____
7. Does any household member smoke?	No	Yes	
8. Are there any guns in the home?	No	Yes	
If YES, are guns locked with ammunition separate?	Yes	No	N/A
9. Are there pets in the home? If YES, what kinds?_____	No	Yes	
10. Do you feel safe in your home?	Yes	No	
11. Do parents and caregivers agree about how to raise this child?	Yes	No	

OTHER SIDE ->->

Richmond Pediatrics Family History Form

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

Medical Condition	Mom	Dad	Sister	Brother	Grandparent	Aunt/Uncle
Anemia						
Bleeding or clotting disorder						
Asthma						
Food Allergy To what?_____						
Nasal allergies						
Eczema						
Congenital Anomaly/Birth Defect						
Depression/Anxiety (specify)						
Other mental illness						
Alcohol abuse						
Drug Abuse						
Suicide						
Migraines						
Headaches						
Epilepsy/Seizures						
Cancer: (before 55 years old) (please indicate type)						
Diabetes (before 55 y/o)						
Obesity						
Heart Disease (before 55 y/o)						
High Blood Pressure						
High Cholesterol/Takes cholesterol medication						
Death before age 56: Cause?_____						
Stroke						
Thyroid Disorders						
Tuberculosis						
Kidney Disease						
Liver disease						
Learning disability/Developmental disability						
Autism/Asperger's/PDD						
ADD/ADHD						
Immune problem						
Other:						
Unknown						

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

RICHMOND PEDIATRICS

VACCINES FOR CHILDREN FORM

Please Print

Richmond Pediatrics receives our vaccines from the State of Washington. The manner in which the State breaks down its distribution information requires us to ask the following:

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Language other than English
Date of Birth		Primary Physician	
Ethnicity (Please check one) ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino			
Race (Please check all that apply) ☐ Black or African American ☐ Native American or Alaska Native ☐ Pacific Islander or Hawaiian Native ☐ Hispanic ☐ White/Caucasian ☐ Asian ☐ Declined			

Patient's Vaccine for Children (VFC) Status is: *(Choose One)*

- ☐ American Indian or Alaska Native
- ☐ Medicaid: Department of Social and Health Services (DSHS) - Healthy Options or Fee for Service
- ☐ No Health Insurance
- ☐ Underinsured (the child has health insurance coverage that has limited or no coverage for administration of vaccines)
- ☐ Private Insurance

  Please note: The private insurance category includes private health plans and children in state sponsored health plans (e.g. Health Care Authority Basic Health Plan (BCP), and DSHS CHIPRA (formerly SCHIP), CHP or other non-Medicaid DSHS health plans.)

Signature: _____ Date: _____

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.
- **Seattle Children's Care Network:** We participate in a clinically integrated network called the Seattle Children's Care Network (SCCN). As part of the SCCN, we may share your patient health information with other members of the SCCN, or with entities acting on behalf the SCCN, for joint quality improvement activities, to better coordinate your care, and for other joint activities of the network.
- **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-pediatrics.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.

_____ DOB: ____/____/____
Printed name of patient

_____
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: _____

_____

Richmond Pediatrics
Infant, Child and Adolescent Medicine

357 NW Richmond Beach Road Shoreline, WA 98177
Phone: (206)546-2421 Fax: (206)542-9028
www.richmond-pediatrics.com

Financial Policy

Responsible Party

You are financially responsible for paying for services that are provided to you by our providers. If the patient is a child, the responsible party will be the biological parent and/or the assigned representative authorized to seek medical care for the child and is the party that brings the child in for services.

Understanding Your Benefits

Please familiarize yourself with your insurance benefits and verify that the provider you are seeing is part of the preferred provider network. Your health plan mandates that you are financially responsible for payment of all copays, deductibles, and non-covered services; Richmond Pediatrics is contractually obligated to collect them. We do not verify insurance benefits, which is why we highly recommend that you contact your insurance company and familiarize yourself with your policy's benefits.

Understanding Our Charges

Patients will be charged for each service that is performed during the course of an office visit. Included in the base charge for an office visit is a discussion about the nature of the illness, an examination of the patient, medical decision making, development of a treatment plan and discussion with the patient about the plan. Other activities (procedures) are billed in addition to the charge for the examination. These charges may include, but are not limited to, sutures, wart removal, vision & hearing tests, removing wax or foreign bodies from ears or nose, lab tests, administration of immunizations and other additional services. Please note that if during a well-child examination any additional concerns are raised or illnesses are treated there may be additional charges associated with this visit.

After Hours Care

If a medical problem arises after routine office hours, and you would like advice from the Seattle Children's Hospital Nurse Triage Team, call our regular office phone number (206-546-2421) and our answering service will connect you. Please note that there is an $18 charge for each call to the nurse triage team, and you will be responsible for the bill, as this service is not covered by insurance. You may instead contact your insurance company's own after hours consulting nurse line, as this service may be offered by them free of charge. This nurse line telephone number is often found on your insurance card.

Co-Payments are due at the time you check in for your appointment.

Billing Statements

You will receive a billing statement from us after the insurance has processed your claim if there is any patient balance remaining. Your charges will be listed along with any payments received from your insurance company. This listing will correspond to the explanation of benefits (EOB) that you will receive from your insurance company. You will receive a statement from our office every 30 days until the balance is paid in full.

Rebilling Fee

All balances are due and payable upon receipt of your statement. If your account becomes 30 days past due, a $10 rebilling fee will be added to your account and will continue to be added once every 30 days until your balance is paid or payment arrangements are made with our billing department. If you are unable to pay the entire amount due, please contact our billing department at 206-546-2421 ext. 303 to set up payment arrangements.

Returned Check Fee of $30 will be charged to your account for all returned checks.

Payment Options

Richmond Pediatrics accepts cash, checks, money orders, VISA, MasterCard, Discover, & American Express. Credit card payments can be made in person, by mail, or over the phone by calling 206-546-2421, ext. 303.

Collections

In the event that your account remains unpaid for more than 90 days and no one has made any attempt to make a payment, your account will be sent to an outside collection agency.

Missed Appointments or Late Cancellations

Richmond Pediatrics will charge and dismiss families for:

1. Not showing up for scheduled appointments
2. Late cancellations: Cancelling appointments with less than 24 hours' notice (one full business day)

What will happen if you miss an appointment or cancel your appointment with less than 24 hours' notice (one full business day):

1st Occurrence - No charge, a reminder letter of our policy will be sent

2nd Occurrence - $25 charge for an illness visit, $50 charge for physicals and consultation visits

3rd Occurrence - Charges as above, and a warning letter notifying you of dismissal if there is another no show or late cancellation

4th Occurrence - Charges as above; dismissal from practice

I have read and agree to the above Richmond Pediatrics Financial Policy:

*Please note any alteration and or notes made on this form will not be valid unless prior approval from our billing department and noted below with signature of authorized billing department personnel.

Responsible Party's Signature	Relationship to Patient
Responsible Party's Printed name	Date Signed
Patient's Name	Patient's DOB
Patient's Name	Patient's DOB
Patient's Name	Patient's DOB
Patient's Name	Patient's DOB
Patient's Name	Patient's DOB

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:

☐ Exchange/between	☐ To	☐ From	☐ Exchange/between	☐ To	☐ From

_____	Richmond Pediatrics
Organization	Organization
_____	357 NW Richmond Beach Rd Shoreline, WA 98177
Street Address City, State, Zip	Street Address City, State, Zip
_____	206-546-2421 206-542-9028
Phone Fax	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

To be completed **by the patient**

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (initial all that apply – *If nothing is initialed, this information will NOT be released):*

_____ HIV/AIDS

_____ Sexually 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

_____

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

_____

Minor patient's signature, if applicable Date Time

OVER