RVA PEDIATRICS, P.C.

CHARLES V. TERRY, M.D., F.A.A.P.
G. THOMAS ROWE, M.D., F.A.A.P.
JOCELYN B. VERGARA, M.D., F.A.A.P.
PETER S. HEYMAN, M.D., F.A.A.P.
LORA G CHRISTIAN, M.D., F.A.A.P.
MELANI B. DE SILVA, M.D., F.A.A.P.

2018

Patient's Primary Physician Name: _____ **Patient Account:**_____

Child's Information

Last Name, First Name, MI | Sex | Date of Birth

_____ _____ _____

Race: (please circle) American Indian/Alaska Native; Asian; Black/African American; Hispanic/Latino; Native Hawaiian/Other Pacific Islander; White; More than one race; Refused/Unreported

Parent's Information

Parent/Guardian (Guarantor) | Date of Birth | Parent/Guardian | Date of Birth

_____ _____ _____ _____

Relationship to patient: _____ Relationship to patient: _____

Home address: _____ Home address: _____

City/State/Zip: _____ City/State/Zip: _____

Home phone #: _(____)_____ Home phone #: _(____)_____

Cell phone #: _(____)_____ Cell phone #: __(____)_____
Please indicate preferred number for contact Please indicate preferred number for contact

Email: _____ Email: _____

Employer: _____ Employer: _____

Work #: __(____)_____ Work #: ___(____)_____

Parent's marital status: Married Divorced Partner (circle one)

Is English your primary language: YES NO (circle one)

If no, please indicate primary language: English, Spanish, French, Hindi, Other _____

Insurance information

Name of Primary Insurance: _____ Effective date: _____
Insurance phone #: _____ Insurance address: _____
Policyholder name: _____ Relationship to patient: _____
Policyholder date of birth: _____ Policyholder's SSN: _____
Policy ID #: _____
Group #: _____

Name of Secondary Insurance: _____ Effective date: _____
Insurance phone #: _____ Insurance address: _____
Policyholder name: _____ Relationship to patient: _____
Policyholder date of birth: _____ Policyholder's SSN: _____
Policy ID #: _____
Group #: _____

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Patient Account: _____

In case of emergency, notify (other than parent):

Name: _____ Phone #: _(____)_____
Relationship to patient: _____

Siblings: full name and DOB _____
_____

Who referred you to our practice: _____
How would you like your reminder to be sent: Text (____-_____) or Voice (____-_____)
(Standard text message fees from your carrier may apply)

Preferred Pharmacy: _____ Address: _____
Pharmacy phone #: _____

I hereby authorize RVA Pediatrics, P.C. to release information to the insurance company named herein. I hereby authorize payment directly to RVA Pediatrics, P.C. or benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney or agency for collection, that I will be responsible for agency or attorney's fees as well as court cost and interest.

_____ _____
Guarantor 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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 16, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

This Notice is effective on or after September 16, 2013.

CONSENT to Use and Disclosure of *Protected Health* Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by RVA Pediatrics, P.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. RVA Pediatrics, P.C. may or may not agree to restrict the use or disclosure of protected health information. If RVA Pediatrics, P.C. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

RVA Pediatrics, P.C. reserves the right to modify the privacy practices outline in the notice.

Signature

I have reviewed this consent form and give my permission to RVA Pediatrics, P.C. to use and disclose my health information in accordance with it.

_____

Name of Patient (Print or Type)

_____

Signature of Parent

_____

Date

_____ _____

Signature of Patient Representative (if other than parent) Relationship of Patient Representative to Patient

Notice of Privacy Practices

Privacy Practices Acknowledgement

RVA Pediatrics, P.C.

Patient Chart # _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Patient Name: _____ Birthdate: _____

Signature: _____

Date: _____

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Lora G. Christian, M.D., F.A.A.P.
Melani B. de Silva, M.D., F.A.A.P.
Matina S. Goodwin, R.N., CPNP
Kirsten C. Slagle, R.N., CPNP
Elizabeth G. Downey, R.N., CPNP
Tiffany C. Lancaster, R.N., CPNP
E. Thornton Beale, R.N., CPNP

EMERITUS
Thomas P. Overton, M.D.
(1927-2014)
Edward J. Wiley, Jr., M.D.
R. Stanley Kirchmier, II, M.D.

10410 Ridgefield Pkwy
Richmond, VA 23233
OFFICE (804) 754-3776
FAX (804) 754-2365

7000 Patterson Ave
Richmond, VA 23226
OFFICE (804) 282-9706
FAX (804) 288-8513

14400 Sommerville Ct
Midlothian, VA 23113
OFFICE (804) 379-5437
FAX (804) 379-5670

www.rvapediatrics.com

AFTER HOURS AND EMERGENCIES:
1 (877) 819-0320

rva pediatrics

RVA PEDIATRICS IMMUNIZATION POLICY

Our practice firmly believes in the effectiveness of vaccines to prevent illness and to save lives. We firmly believe in the safety of vaccines.

Our entire group has reviewed all of the literature, evidence based research, and current studies, and we firmly believe that vaccines DO NOT cause Autism or other developmental delays.

Our practice understands that you want what is best for your child and so do we. We know that, in light of the recent measles virus outbreak, there has been much conflicting information on immunization and vaccine safety. We can help you get the reliable information you need to make an informed decision

Our practice firmly believes that vaccinating children and young adults may be the single most important health promoting intervention we perform as healthcare providers and that you can perform as parents.

To accomplish this goal together, our practice will follow the guidelines and schedules for immunizations established by The American Academy of Pediatrics and The Centers for Disease Control. We do not recognize any “alternative” immunization schedules.

While we understand that parental choice may play a role in the vaccination of children, we request that you abide by our policy. If this is not an acceptable choice for you, we respectfully request that you seek out another pediatric group for your children’s care.

IMMUNIZATION POLICY

RVA Pediatrics, P.C.

Patient Chart # _____

ACKNOWLEDGEMENT FORM

I have received the RVA Pediatrics Immunization Policy, and I have been provided an opportunity to review it. I agree to abide by this policy to have my child properly vaccinated or I may be dismissed from the practice.

Patient Name: _____ Birthdate: _____

Signature: _____

Date: _____

RVA Pediatrics, P.C.

PERMISSION TO DISCUSS PHI
(other than the parent)

Patient Name: _____

Date of Birth: _____ Account #: _____

I, _____, parent or guardian of _____, a minor, hereby give permission for the following people to have access to my child's personal health information, including, but not limited to, medical records, treatment plans, immunizations, test results, and prescriptions, both written, verbal, or electronically transmitted:.

- _____ /_____
  relationship
- _____/ _____
  relationship
- _____/ _____
  relationship
- _____/ _____
  relationship

☐ **I do not give permission to discuss my account with anyone other than myself.**

I understand that I may revoke this authorization at any time by sending written notification to: RVA Pediatrics, P.C., 10410 Ridgefield Parkway, Richmond, VA 23233.

I understand that once any information is disclosed to a third party listed above, RVA Pediatrics, P.C. is not liable for any re-disclosure by that party and the information may no longer be protected by federal or state law.

_____
Signature of Parent or Guardian (or child over 18 years of age)

_____
Date