PATIENT INFORMATION FORM: PLEASE PRINT
Please fill this form out completely – **ALL INFORMATION IS REQUIRED**

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 _____

EMPLOYER _____

PARENT OR LEGAL GUARDIAN INFORMATION:

FIRST NAME _____ LAST NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

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 _____ ADDRESS _____

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 _____ ADDRESS _____

ID# _____ GROUP# _____ SS# IF NEEDED FOR BILLING _____

PLEASE LIST ALL CHILDREN IN YOUR FAMILY WHO COME TO HAND IN HAND PEDIATRICS:

_____ _____ _____

_____ _____ _____

NEAREST NON-PARENT RELATIVE OR FRIEND NOT LIVING WITH YOU:
NAME: _____ RELATIONSHIP: _____ PHONE: _____

HOW WERE YOU REFERRED TO THIS PRACTICE?
EXISTING PATIENT _____ PHYSICIAN _____ NAME OF PATIENT OR PHYSICIAN: _____
NEWSPAPER _____ TELEPHONE _____ INTERNET _____ HAND IN HAND WEBSITE _____ INSURANCE CO _____
OTHER _____

Hand In Hand Pediatrics, Inc.
Receipt of Notice of Privacy Practices and
Request for Limitations and Restrictions of
Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street, Apt. #

_____
City, State Zip

I, _____, have received a copy of *Hand In Hand Pediatrics, Inc.'s* Notice of Privacy Practices.

If you would like PHI restricted: (Please check all that apply)

- ☐ Home Phone #
- ☐ Home Address
- ☐ Occupation
- ☐ Name of Employer
- ☐ Visit Notes
- ☐ Hospital notes
- ☐ Prescription Information

How would you like use and or disclosure of your PHI restricted?

_____

_____

_____ _____
Signature of Patient (or Legal Guardian if under 18 years of age) Date

Patient Please Note: **The Practice is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.**

Hand In Hand Pediatrics, Inc.
Notice of Privacy Practices
Effective date of this Notice – Updated 4/1/16

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and Disclosure of Protected Information

- Federal law provides that we may use your PHI **for your treatment**, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to that specialist.
- Federal law provides that we may use your medical information **to obtain payment** for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered.
- Federal law provides that we may use your medical information **for health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:
    1. required for public health purposes
    2. required by law to report child abuse
    3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
    4. required by law in judicial or administrative proceedings
    5. required for law enforcement purposes by a law enforcement official
    6. required by a coroner or medical examiner
    7. permitted by law to a funeral director
    8. permitted by law for organ donation purposes
    9. permitted by law to avert a serious threat to health or safety
    10. permitted by law and required by military authorities if you are a member of the armed forced of the U.S.
    11. required for national security, as authorized by law
    12. required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
    13. otherwise required or permitted by law.
- Certain types of uses and disclosures of protected health information require authorization, these include:
    - uses and disclosures of psychotherapy notes
    - uses and disclosures of PHI for marketing purposes; and
    - disclosures that constitute the sale of PHI.
- Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

Minors

- For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or guardian to take their child to the pediatrician's office may have access to this child's medical information. We prefer to have written authorization from the parent or guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.
- You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. A separate form is available for this purpose.
- Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights That You Have

- You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
- You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location e.g. at home and not at work. Such requests must be made in writing to your physician. Our practice will accommodate reasonable requests.
- You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosures we make of your medical information. This is a list of certain non-routine disclosures our practice has made of your health information for non-treatment, payment or health care operations purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.
- You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item or service.
    - You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction
    - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time period, which may not be longer than six (6) years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have a right to receive electronic copies of health information.

Obligations That We Have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization Contact Information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Organization Name: Hand In Hand Pediatrics
Address: 6051 Memorial Dr., Dublin, OH 43017
Telephone Number: (614) 799-6044
Contact Person: Office Manager

Patient's name _____ DOB _____

HIPAA Privacy Authorization Form
Patient Authorization for Use and Disclosure of Protected Health Information

(to be used by patients over 18 years of age)

By signing, I authorize Hand In Hand Pediatrics (healthcare provider) to use and/or disclose certain protected health information (PHI) about me to _____ (individual seeking the information) and their relationship to patient _____.

This authorization permits Hand In Hand Pediatrics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

Exclude: ☐ mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment ☐ other (specify) _____

This authorization for release of information covers the period of healthcare from _____ to _____, or ☐ all past, present, and future periods (either enter a date above or check box).

The information will be used or disclosed for the following purpose:

_____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Hand In Hand Pediatrics. **In fact, I have the right to refuse to sign this authorization.** When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: Hand In Hand Pediatrics, 6051 Memorial Dr., Dublin, OH 43017, or fax to (614) 799-6088.

Signed by: _____ _____

Signature of Patient Date signed

Witnessed: _____ _____

Signature / printed name Date signed

Patient must be provided with a signed copy of this authorization form.

Hand in Hand Pediatrics
Financial and Patient Responsibility Policy
Updated January 7, 2016

Patient Authorization: I authorize the physicians of Hand in Hand Pediatrics to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to Hand in Hand Pediatrics. 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 30 days. My signature on this form verifies that I have been given the opportunity to read the Hand In Hand Financial and Patient Responsibility Policy, and that I understand and agreed to the Hand in Hand Financial and Patient Responsibility Policy.

_____ _____
Name of Patient **Date of Birth**

_____ _____
Signature of Patient or Responsible Party **Date**

HIPAA – I have reviewed a copy of the Hand In Hand Pediatrics, Inc.'s Notice of Privacy Practices.

_____ _____
Signature **Date**

Please read and initial each section below

No Show/Cancellation Policy - I understand and agree to pay the $50.00 missed appointment fee for any appointment that is not cancelled at least 2 hours in advance for same day appointments and 24 hours in advance for all other appointments. If my insurance company does not allow a no show fee then I understand that my child(ren)'s continued participation in the practice may be terminated.
Initials _____

Form Policy - I understand and agree to pay the forms fee for all forms not brought to my child's physical (well child check) appointment. I will be told the charge in advance and the form must be paid for before it may be picked up.
Initials_____

Repeat Referral Fee - I understand and agree to pay the $25.00 Repeat Referral Fee if I need to have Hand In Hand Pediatrics reschedule a referral because I did not cancel 48-72 hours in advance and Hand In Hand Pediatrics had to submit new paperwork and reschedule the referral.
Initials_____

Non-Emergent After Hours Call - I understand and agree to pay the Non-Emergent After Hours Call fee if I use the emergency line for non-emergent calls. All non emergent calls should wait until the office opens or may be left on the general message line.
Initials_____

Prescription Refill – I understand that requests for prescription refills must be called in by the parent or patient (if over 18 years of age) and that it will take 48 business hours to have the refill completed.
Initials_____

Returned Check Fee - I understand and agree to pay the $35.00 returned check fee if my check is returned unpaid by the bank.
Initials_____

Hand in Hand Pediatrics
Financial and Patient Responsibility Policy
Updated May 27, 2015

Practice Goal: To provide a friendly, warm environment in which we can help you nurture your child and provide expertise in pediatric medical care.

A Pledge to Our Patients: We are dedicated to meeting your health care needs, and to treating you with the respect, dignity, and the consideration each person deserves. In your care and treatment you have the right to expect:

- To have your personal privacy maintained.
- To have all information and records about your care kept confidential.
- To receive quality care regardless of age, race, sex, religion, disability, sexual orientation, or diagnosis.
- To receive the information necessary to enable you to make decisions regarding your plan of treatment. This includes the right to accept or refuse medical care as permitted by law and to be informed of the medical consequences of such refusal.
- To receive a timely response to your request for service.
- To have your health care managed as individually and effectively as possible.
- To have all persons who have contact with you clearly identified by name and function.
- To participate in the consideration of ethical issues that may arise in your care.
- To have access to the information contained in your medical records.
- To receive, upon request, a copy of your itemized bill in a timely manner, an explanation of the bill, assistance in filing insurance forms and arranging financial payment options.

Patient Rights & Responsibilities: We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. Good health care means that you and/or your family will need to participate in your treatment. You agree to:

- Provide information about past illnesses, hospitalizations, medications, and other health matters.
- Provide a copy of your written Advance Directives, Living Will, or Durable Power of Attorney for Health Care if you have one.
- Inform your physician(s) and other caregivers if you anticipate problems in following prescribed treatment.
- Request additional information or clarification if needed.
- Understand that we do our best to accommodate your needs and the needs of our other patients.
- Contact the office as soon as possible if you are unable to keep your appointment.
- Recognize the impact your lifestyle may have on your personal health.

Patient Financial Responsibilities: As a patient of Hand in Hand Pediatrics, the following information is provided to avoid any misunderstandings or disagreement concerning payment for professional services:

- Our office participates with a variety of insurance plans. Questions about financial arrangements should be directed to our billing manager at (614)799-0503. It is your responsibility to :
    1. Bring your insurance card to every visit, and make us aware of any changes in your coverage.
    2. Provide all necessary information for insurance claims.
    3. Be prepared to pay your copay at each visit. Payment can be made by cash, check, or credit card.
    4. For medical care not covered under your insurance, payment in full is due at the time of the visit. Any charges billed to you must be paid within 30 days.
- Provide us with current addresses, phone numbers, work, and insurance information.
- If the patient is a minor (under age 18), the parent, guardian, or unaccompanied minor is responsible for any payment due at the time of the service, bringing the necessary referrals and insurance card.
- If the minor does not reside with both parents, we will hold both parents financially responsible.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member service department (the number is on your card).
- If you fail to make a payment in full for the services that are rendered, your outstanding balance may be forwarded for collection. You may be responsible for the fees assessed by the collection agency.

Patient Access to the Practice – always call our main telephone numbers - (614) 799-6044 for the Dublin office and (937) 642-0535 for the Marysville office.

During Office Hours:

--Staff will be trained to recognize symptoms of patients and determine the speed with which a patient needs to be seen.
--At no time will schedulers or clinical staff attempt to diagnose or treat over the telephone without the explicit directions of the physician.
--Schedulers will utilize an emergent/urgent scheduling protocol to determine the time frame to work in a potential emergent or urgent patient.

After Hours:

--We will maintain a physician on call seven days per week, 24 hours a day for urgent calls that cannot wait until the office opens.
--After normal business hours, patients may access the on-call physician by calling only the normal business phone number (614)799-6044. The patient will be instructed as to how the physician on call can be reached in case of an emergency.
--Physicians will respond by phone to on-call issues usually within 30 minutes. Treatment may be rendered over the phone or, at the discretion of the physician, the patient may be instructed to go to the nearest urgent care or emergency room.

Hand in Hand Pediatrics

Financial and Patient Responsibility Policy
Updated May 27, 2015

Missed Patient Appointments - Our office will do it's best to make reminder calls 24 – 72 hours prior to your scheduled appointment. If you are unable to make your scheduled appointment, you must call and cancel that appointment at least 24 hours in advance of your appointment time. If your appointment is on Monday, you may leave a message on the voice mail by calling the main phone number (614) 799-6044 and choose option 3. For sick visits made the same day, notification should be at least 2 hours prior to the appointment time. If appropriate notification is not given, or you do not show up for your appointment, you will be charged $35.00.

Forms - Forms for physical exams for daycare, simple school forms, work permits, etc. will be filled out and signed without a charge if they are presented at the time of that patient*s physical exam. If they are presented at a later date, there will be a charge. The charge will depend on the length and complexity of the form. FMLA forms, insurance company forms etc. will be charged whenever they are presented. Please allow up to 7 working days for these forms. You will be notified when they are ready for pick-up. If you need the form within 24 hours, there is an additional $20.00 charge.

Repeat Referrals - Our staff spends many hours each day doing referrals to specialists at no charge to patients. It entails not only calling the office for an appointment time and contacting the insurance company, but also filling out forms, having the Doctors complete them, and contacting you with the appointment information. If you are unable to show for your referral, please notify our office, or the office to which you are being referred to, 48-72 hours in advance of your appointment. This allows your child to be rescheduled using the same paperwork. We will charge you $25.00 if you no show to your appointment and another referral is required.

Prescription refills – For prescription refills allow 48 business hours (i.e. not Saturday, Sunday or holidays). Parents/patients are required to call the refill request in personally, we will not approve a refill that is called in or faxed in from the pharmacy.

Incorrect Insurance Information - Our receptionist will be asking you to verify your insurance information and present your insurance card each time you come to our office. We will verify the information we have for the child that is being seen that day, other children will be updated as they come in. Make sure you know the date your insurance is in effect. If the insurance company denies your child, and it is because of inaccurate information you have given us, we will be charging $35.00 to resubmit it to the insurance company.

Non-emergent after hour calls - Our physicians provide after hour coverage for emergent sick calls - in other words, calls that cannot wait until the office reopens. Please keep your calls to our physicians for that purpose and make sure you leave one (1) phone number where you can be reached - the physicians will not make multiple return phone calls. Also, be sure to turn privacy block off, and accept the physician's restricted call so the physician's call will get through.

If it is determined, that a phone call is non emergent, you will be sent a notification for the first call, continued misuse will result in a $20.00 per call charge.

When in doubt, call. This is not meant to stop urgent calls, it is meant to stop the overuse of unnecessary after hours calls that could appropriately be handled during our regular office hours.

Connor's Questionnaires - These forms are used for assessing ADHD and associated disorders. Each form is costly and frequently they are not returned. We will provide up to 4 forms at no charge; any additional forms will be provided for a $5.00 per form charge. There is no charge for using the Vanderbilt forms or for using the ADHD portal. However, regardless of the form or portal use there is a charge to have the forms assessed and interpreted.

Documentation of all discussions will be made in the chart.