Associates in Pediatric Care-Hampton, LLC
2101 Executive Drive, Suite 160
Hampton, VA 23666
Office: (757) 838-8166 Fax: (757) 838-8233

Preparing For Your First Appointment

We are excited to welcome you to our pediatric practice! In order to serve your family best, please prepare to bring the following:

- Any insurance cards for current coverage
- Your driver's license or another valid photo ID
- Payment for any co-pays due
- A list of any prescription medications and vitamins the patient is currently taking
- Updated Immunization Record

A list of questions you'd like to ask, such as:

- How should I contact you when I have a question?
- What's the best way to get a prescription refilled?
- How far in advance will I need to make an appointment?
- Where should I go if the patient needs urgent or emergency care?

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www.APCHampton.com

PATIENT INFORMATION

Patient's Full Name _____ **DOB** _____ **Sex** _____

Address _____ **City, State, Zip Code** _____

Phone # (Home) _____ **Phone # (Cell)** _____ **E-mail Address** _____

Emergency Contact _____ **Relationship to patient** _____ **Phone #** _____

Prior Physician _____

Medical Insurance and Vaccination Information

Name of Insurance Company _____ **Subscriber's Name and DOB** _____

Subscriber's Policy # _____

Parent or Guardian grants permission for the administration of all Federal/State mandated pediatric vaccinations? Check one: Yes (☐) or No (☐)

Pharmacy and Allergy Information

Pharmacy Name _____ **Pharmacy Phone #** _____

Drug Allergies/Food Allergies/Allergic Reactions _____

I AGREE TO PAY FOR MEDICAL SERVICES/ATTORNEY COLLECTIONS FEES IF DENIED BY INSURANCE COMPANY.

Signature _____ **Print Name** _____

Date _____

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HIPAA PRIVACY NOTICE

Your Information. Your Rights. Our Responsibilities.

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. Effective date: 05/01/2020**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.
Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Please direct questions or concerns to HIPAA privacy officer:
Macy Stapleton, MSN, APRN,PPCNP-BC
apchampton@gmail.com
(757) 838-8166

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HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name:_____

Patient Birth Date: _____

We at Associates in Pediatric Care-Hampton, LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient

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Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Associates in PEDIATRIC CARE Hampton, LLC

Appointment & No-Show Policy Acknowledgement

APPOINTMENTS AND PATIENT RESPONSIBILITIES

In the interest of good healthcare practice, it is desirable to establish an appointment and no-show policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that goal.

• All appointments are confirmed the day before.

• We ask that you arrive 15 minutes prior to your appointment time, as this will allow staff to check your current information, copy your insurance card and obtain photo identification.

• If for any reason you are unable to keep your appointment, please give us 24 hours' notice, so we can provide that time for someone with urgent care needs.

NO SHOW POLICY

An appointment is considered a "no show" 15 minutes past the scheduled time. Text message & call reminders are sent to the primary number 3-5 days before the scheduled appointment. If you do not confirm your appointment, you will receive a phone call reminder.

Patients need to have time to go through the check in process. Therefore, if a patient shows up 15 minutes past the scheduled time, they are 30 minutes late.

• If 3 no shows occur per family, it will result in termination of care for patient and family.

• Missed appts may result in a $25.00 charge if you don't call 24hrs before your scheduled appt to cancel or reschedule.

• New families who no show their initial appointment will not be rescheduled after the second no show, unless there is a valid reason.

• Families who arrive after their scheduled appointment will be seen at the discretion of the provider. If approved, the patient who arrived late will be worked into the provider's schedule.

I HAVE READ AND UNDERSTAND THE APPOINTMENT AND NO-SHOW POLICY.

Signed by _____ Date_____

Printed Name _____ Relationship to patient _____

Patient Name _____ Patient date of birth_____

Associates in Pediatric Care – Hampton, LLC
Macy Stapleton, MSN, APRN, PPCNP-BC
Alexandra Worthington, MSN, CPNP
2101 Executive Dr, Ste 160, Hampton, VA 23666-3089
Phone: (757)838-8166 | Fax: (757)838-8233 | www.APCHampton.com

Code of conduct policy

APC Providers prides itself on offering five-star service. It is our goal to exceed your expectations and provide you with the best possible patient experience. To ensure we can serve you to the best of our ability, we pledge to treat you with respect and courtesy, as your outcome is our top priority. We also request our patients treat our staff, providers with the same level of respect and courtesy. Inappropriate or abusive actions or language will result in immediate dismissal.

I HAVE READ AND UNDERSTAND THE CODE OF CONDUCT POLICY.

Signed by_____ Date_____

Printed Name_____ Relationship to patient_____

Patient Name_____ Patient date of birth_____

Associates in PEDIATRIC CARE Hampton, LLC

Initial History Questionnaire

PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Form Completed By: _____ Date Completed: _____

HOUSEHOLD – Please list all occupants living in the child's home, their relationship to the child, and their age:

_____

_____

_____

BIRTH HISTORY – (Under 5 years)

Birth Weight: _____ lbs. _____ oz. Date of adoption *(if applicable)*: _____

Was the baby born at: ☐ Early ☐ Term ☐ Late *If early*, how many weeks gestation? _____

Type of Delivery: ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Were there any problems pertaining to the pregnancy or birth? ☐ Yes ☐ No (*If yes, please explain*)

_____

During pregnancy, did the mother (*Check all that apply*): ☐ Smoke ☐ Drink Alcohol ☐ Use drugs or medications

GENERAL – (if applicable)

Do you consider your child to be in good health? ☐ Yes ☐ No (*Please explain*): _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No (*Please explain*): _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No (*Please explain*): _____

Has your child had any surgeries? ☐ Yes ☐ No (*Please explain*): _____

Has your child ever been hospitalized? ☐ Yes ☐ No (*Please explain*): _____

Is your child allergic to any medicine or drugs? ☐ Yes ☐ No (*Please explain*): _____

Does your child take any medications on a regular basis? ☐ Yes ☐ No (*Please explain*): _____

DEVELOPMENT – (if applicable)

Name of school (or daycare): _____ Grade: _____

How is his/her behavior in school? _____

Has he or she repeated a grade in school? ☐ Yes ☐ No If yes, what grade(s)? _____

How is he or she doing in academic subjects? _____

Is he or she in special or resource classes? ☐ Yes ☐ No

Are you concerned about your child's physical development? ☐ Yes ☐ No *(please explain)*

_____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No *(please explain)*

_____

Are you concerned about your child's attention span? ☐ Yes ☐ No *(please explain)*

_____

FAMILY HISTORY – Have any family members had the following:

Deafness	☐ Yes	☐ No	Diabetes (before age 50)	☐ Yes	☐ No
Allergies (food or environmental)	☐ Yes	☐ No	Epilepsy or Convulsions	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Alcohol/Drug Abuse	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Mental Illness/Depression	☐ Yes	☐ No
Heart Disease or Sudden Death	☐ Yes	☐ No	Mental Retardation	☐ Yes	☐ No
High Blood Pressure (before age 50)	☐ Yes	☐ No	Immune Problems, HIV/AIDS	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Anemia/Bleeding Disorder	☐ Yes	☐ No	Gastrointestinal Problems	☐ Yes	☐ No
Liver/Kidney Disease	☐ Yes	☐ No	Blood Disorders	☐ Yes	☐ No

PAST MEDICAL HISTORY – Does your child have *or* has your child ever had:

Allergies (food, drug, or environmental)	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Muscle, Joint, or Bone Problems	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No	Seizures/Epilepsy	☐ Yes	☐ No
Bladder or Kidney Problems	☐ Yes	☐ No	Serious Injuries or Illnesses	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Anomalies	☐ Yes	☐ No	Immune Problems, HIV/AIDS	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Vision or Eye Problems	☐ Yes	☐ No
Developmental or Behavior Disorders	☐ Yes	☐ No			

If Yes, please explain: _____

ADDITIONAL HISTORY

Does your child smoke cigarettes or use tobacco?	☐ Yes	☐ No
Are firearms present in the home that the child resides?	☐ Yes	☐ No
Are there working smoke/carbon monoxide detectors in the home?	☐ Yes	☐ No
Are there pets in the home?	☐ Yes	☐ No