1809 S. Church Street
Suite 302
Smithfield, VA 23430
Phone: 757-780-8400
Fax: 757-432-3279

Patient and Family Information

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress: _____

Child 2: Last Name: _____ First Name: _____ MI: ____

DOB: ____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Child 3: Last Name:_____First Name:_____MI: ____

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Child 4: Last Name:_____First Name:_____MI: ____

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Pharmacy Name:_____ Pharmacy Phone #: _____

Parent/Legal Guardian #1:

Child(ren)'s parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er) ☐ Other

Name:_____Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

Infinity Pediatric & Adolescent Medicine may contact me via: ☐Home ☐Cell ☐Work ☐Email

Infinity Pediatric & Adolescent Medicine may leave messages or lab results via: ☐ Home ☐Cell ☐ Work ☐ Email

Lives with patient? Yes / No

_____

(Street) *(City/State/Zip)*

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

Infinity Pediatric & Adolescent Medicine may contact me via: ☐ Home ☐ Cell ☐Work ☐ Email

Infinity Pediatric & Adolescent Medicine may leave messages or lab results via: ☐Home ☐Cell ☐Work ☐Email

Lives with patient? Yes / No If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

_____

(Street) *(City/State/Zip)*

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Emergency Contacts, other than parents. Name & Relationship:

Name:_____Phone: _____

Name:_____Phone: _____

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Consent To Treat Minor

I hereby give consent to Infinity Pediatric & Adolescent Medicine to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, nurse practitioner or physician assistant, as well as any assistant on the staff of Infinity Pediatric & Adolescent Medicine.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Infinity Pediatric & Adolescent Medicine recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize the release of medical
(patient's name)
information **TO:**

Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

FROM:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

☐ **All health information (including growth charts and vaccination records)**

☐ History/Physical Exam ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ Lab Results
☐ Progress Notes ☐ Consultation Reports ☐ Radiology/Images ☐ Pathology Reports
☐ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

☐ Yes, I consent to the release of this information.
☐ No, I do not consent to the release of this information.

Purpose of disclosure:
☐ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Infinity Pediatric & Adolescent Medicine is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Infinity Pediatric & Adolescent Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Infinity Pediatric & Adolescent Medicine to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Infinity Pediatric & Adolescent Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

Child/Children(s) Name(s):_____

_____

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Financial Policy

Infinity Pediatric & Adolescent Medicine participates with most insurance plans. Each insurance policy is different and it is impossible for us to know what your particular benefits may be. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits or what your payment obligations will be at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Credit Card on File[1]

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in fullon the day of service. This discount does not apply after the day of the visit.

No-Show Policy

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Repeated no-shows will result in the family being advised to transfer care out of the practice.

Divorced/Separated Parents and Custodial Arrangements

Infinity Pediatric & Adolescent Medicine does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

I have read and understood the above policy and agree to it.

Signature_____ Date____/___/_____

Name _____

Relationship to patient_____

[1] **This policy does not apply to patients with Medicaid and Medicaid HMO insurance**

Infinity
Pediatric & Adolescent Medicine

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Infinity Pediatric & Adolescent Medicine, its affiliates and its employees. Infinity Pediatric & Adolescent Medicine will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Infinity Pediatric & Adolescent Medicine. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected

health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer; 3
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5)

to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Infinity Pediatric & Adolescent Medicine in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

info@infinitypam.com or

Privacy Officer
Infinity Pediatric and Adolescent Medicine,
PLLC 1809 S. Church St., Ste. 302
Smithfield, VA 23435