New Patient Intake Form

Patient Name: Last:________________________________ First:_________________________ Middle Initial:_____
Preferred Name: __________________________ DOB: ____________________

Sex: M / F / T / NB   Preferred Pronouns: she/her he/him they/them/theirs

Address: ____

City: ______________________ State: _______ Zip: __________
Home #: _________________________ Cell #: _________________________ Work #: ______________________
Email address: ____

Patient Race: African American Caucasian Indian Asian White
Hispanic Pacific Islander Two or more races Other

Patient Ethnicity: Hispanic Non-Hispanic Prefer Not to Report

Preferred Language: _______________

Is this a foster child? Yes / No

If yes, Primary Caregiver/Legal Guardian's Name: ______________________________

Emergency Contact: _____________________________ Phone: ____________________ Relation: _____________

Responsible Party Info: (if patient is a minor):

Name: ____ SS#: ________________________ DOB: _____________

Relation to Patient: ________________________ Home #: ___________________ Cell #:_____________________
Mailing Address: ____
City: ___________________________________ State: _______ Zip: ______________

Does the patient have Medical Insurance coverage? Yes / No
Primary Insurance Company: ______________________________________ Policy number: __________________________
Policy Holder Name: ____ DOB: _______________________
Policy Holder's Address (if different from patient): ____
City: _______________________________ State: _______ Zip: __________

Secondary Insurance Company: ______________________________________
Policy Holder Name: ____ DOB: _______________________ Policy Holder's Address: (if different from the patient): Address: ____
City: ________________________ State: _______ Zip: __________

Preferred Primary Care Physician: ____

Please be aware that while we will do our best to have your child seen with their primary provider at every appointment, sick/urgent visits are given to the first provider with availability.

Preferred Pharmacy: _______________________________ Address: ____

Parent / Legal Guardian Signature: ____ Date:_____________

Consent Forms

Patient Name: ___________________________________ **Date of birth:** ______________ **Today's Date:** ____________

Name of person completing form: ____________________________________ **Relationship to patient:** _________________

Consent for Treatment

I hereby consent for myself (or my child) to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of New Beginnings Pediatrics may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Parent / Legal Guardian Signature: ____ Date:_____________

Notice of Privacy Practices

I acknowledge that I have access to a copy of New Beginnings Pediatrics Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used. I understand no authorization is required from me for New Beginnings Pediatrics to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. **If you would like a copy of New Beginnings Pediatrics Privacy Practices, please ask the receptionist. **

Parent / Legal Guardian Signature: ____ Date:_____________

Payment Agreement

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. I hereby authorize any benefits due me to be paid directly to NBP (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits. In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by NBP and agree to pay for said medical services according to such terms.

Patient (if 18 years or older) / Legal Guardian Signature: ____________________________Date:___________

Self-Pay Agreement

I agree to pay for medical services rendered at New Beginnings Pediatrics. I understand that there are payment plans available at my request. I understand that these plans will be based on my financial income and will be reviewed prior to approval.

Parent / Legal Guardian Signature: ____ Date:_____________

Authorization to Treat in Absence of Parent or Guardian (optional)

If my child is brought in the office by ____________________________________, I consent for my child to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child cannot be seen at New Beginnings Pediatrics without another legal guardian present.

Parent / Legal Guardian Signature: ____ Date:_____________

Authorized Person(s) for Protected Health Information Disclosure

I hereby authorize New Beginnings Pediatrics to disclose any and all medical and Protected Health Information to the person(s) indicated below:

Name	Relationship	Phone Number
_________________________	_______________________	_______________________
_________________________	_______________________	_______________________

Parent / Legal Guardian Signature: ____ Date:_____________

3708 S Main St, Ste B • Blacksburg, Virginia 24060 • Phone: (540) 739-3623 • Fax: (540) 408-0428 • info@nbpedsva.com

Authorization for Release of Confidential Health Care Information

This authorizes New Beginnings Pediatrics to request and receive from the Virginia Department of Health Professions any and all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (New Beginnings Pediatrics). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Parent / Legal Guardian Signature: ____ Date:_____________

Notification of Appointments /Treatments

New Beginnings Pediatrics makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, New Beginnings Pediatrics may call or text my home, cell, work, or other designated phone numbers and leave a message on my voicemail in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations. This includes but is not limited to appointment reminders, insurance items, and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided and communication may consist of leaving messages on voicemail, emails, letters, etc.

By signing below, you are giving permission for New Beginnings Pediatrics to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Parent / Legal Guardian Signature: ____ Date:_____________

Late Cancellation and No-Show Policy

• Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

• A late cancellation is defined as failure to contact the office at least **24 hours in advance** to cancel the appointment. **There will be a $25 charge for late cancellations.** This is not billable to the insurance and is due prior to scheduling another appointment.

• A no-show is defined as missing a scheduled appointment. **There will be a $25 charge for no-show appointments for ALL patients.** This is not billable to the insurance and is due prior to scheduling another appointment.

• NEW PATIENTS who miss **TWO consecutive initial office visits** without giving the office at least 24-hour notice may not be permitted to schedule another appointment.

• ESTABLISHED patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

Late Arrivals Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but is not always an option.

Parent / Legal Guardian Signature: ____ Date:_____________

VCOM Notice

New Beginnings Pediatrics is a teaching facility. This practice is a place where medical students can get hands-on experience with patients. It is important for them to talk to patients about their health and illnesses and gain real-world experience in a clinical setting. We would be grateful if you could help us in their education. Your PCP will see your child after the student has done their evaluation during the visit. All students are bound to the same HIPAA standards as other staff. However, this is all entirely voluntary. If you would rather not see a specific student, change your mind after signing consent, or want the student to leave at any time, please notify the staff immediately. The quality of your care will not be impacted. By signing this section I understand that any aforementioned medical students and physicians may use my medical information (including but not limited to medical notes, x-rays, photos, ultrasounds, etc) that have been de-identified and used for the purpose of presentations, lectures, or papers for further teaching.

Please check: I __do or ___do not consent to medical students and residents to be a part of mine or my child's care.

Parent / Legal Guardian Signature: ____ Date:_____________

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes____ No____

Please note: If you answered yes to the above question, it is the policy of NBP that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.