New Beginnings
PEDIATRICS

Patient Name: Last:_____ First:_____Middle Initial:_____
Preferred Name: _____ SS#: _____ DOB: _____

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

Address: _____

City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Work#: _____
Email address: _____

Preferred methods of communication (for appt reminder only): Home/Voice Cell/Text/Email

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: _____

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Does the patient have Medical Insurance coverage? Yes / No

Primary Insurance Company: _____

Policy Holder Name: _____ DOB: _____

Policy Holder's Address: _____

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: _____

Preferred Pharmacy: _____ Address: _____

Parent / Legal Guardian Signature: _____ Date:_____

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

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Consent for Treatment

I hereby consent 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:_____

Acknowledgement of Deemed Consent for HIV / Hepatitis B or C Virus Blood Testing

Virginia Law authorizes health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to body fluids (ie: needlestick) of a patient in a manner which may transmit HIV or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for these antibodies pursuant to this provision, the testing would be explained, and the testing would be explained, and you would be given the opportunity to ask any questions you might have. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

Parent / Legal Guardian Signature: _____ Date:_____

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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. If medical claims are submitted to an insurance company by New Beginnings Pediatrics on my behalf, I understand that the copayment or deductible is due at the time care is rendered. 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 (referrals) 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:_____

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Patient Name: _____ **DOB:** _____

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:_____

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:_____

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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:_____

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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. Care provided to you by the practice will not be affected in any way. 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 be de-identified and used for the purpose of case presentations, lectures, poster presentations, 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.