Pediatric New Patient Packet

By marking yes to special confidentiality, you are stating that if your partner/spouse or parent/guardian were to receive a bill or phone call from this clinic about your appointment today, you would worry about your safety. Special confidentiality is not pertaining to your medical records. □NO □YES

Patient's First Name: ________________ **Middle**: ______________ **Last**: ________________________
Patient's Date of Birth: ______________ **Age**: _________ **Sex**: ☐ Male ☐Female
Patient's SSN: ______________________ **Patients Marital Status**: ___________________
Mailing Address: _________________________________ **City**: _______________ **Zip**: ____________
Physical Address: ________________________________ **City**: _______________ **Zip**: ____________
Cell: ______________ **Home**: ______________ **Work**: ____________ **Email**: ____________________
Mothers Name: _____________________________**DOB**: ____________ **Phone**: __________________
Fathers Name: ______________________________**DOB**: ____________ **Phone**: __________________
Responsible Party (if different than above): _______________________________**DOB**: ___________
Who does the child primarily live with: ____
Who has legal guardianship of the child:____
Emergency contact: **Relationship to patient**: **Phone**:

Insurance Coverage: ☐ **OHP** ☐ **Medicaid** ☐ **Medicare** ☐ **Commercial Insurance** ☐ **None**
Primary Insurance: _________________ **ID#**: __________________ **Group #**: __________________
Policy Holder: _____________________ **Relationship to Patient**: _______________**DOB**: __________
Policy Holder Employer: ______________________________
Secondary Insurance: ______________ **ID#**: ____________________ **Group #**: __________________
Policy Holder: ____________________**Relationship to Patient**: ____________ **DOB**: ______________
Policy Holder Employer: ______________________________

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care: including mental health issues, HIV/AIDS related records, appointment scheduling, or payment information. This is not a release for medical records. This is only for permission to speak with designated family or personal representatives.

Name: _______________________ **Relationship**: ___________________ **Phone**:___________________

Name: _______________________ **Relationship**: ___________________ **Phone**:___________________

Please write a date that you are giving the above named people permission to discuss your medical information, or initial next to LIFETIME.

Authorization Period: FROM: ___________TO:____________ OR LIFETIME:_________________

Patient Signature: ____ **Date**: ______________

Parent/Legal Guardian Signature: _______________________________**Date**: _______________

The following information is needed to assist the clinic in securing funds. Your cooperation is appreciated. <u>All information disclosed in this section is reported anonymously and will not impact access to care</u>.

Please circle the correct amount or check the box if monthly income is above all amounts.

Number of Persons in Household	1	2	3	4	5	6
Household Income is Less Than	1,063	1,437	1,810	2,183	2,557	2,930
Household Income is Less Than	1,595	2,155	2,715	3,275	3,835	4,395
Household Income is Less Than	2,127	2,873	3,620	4,367	5,113	5,860
Income is Above all amounts	☐	☐	☐	☐	☐	☐

☐ Choose not to provide my financial information.

Has the patient ever been in the military? Yes No **Has the patient ever been seen at the VA?** Yes No	
US Citizenship: By Birth Permanent Resident/Alien Student Visa Other	
Ethnicity: Hispanic Non-Hispanic Choose not to disclose	
Race: Black White Asian American Indian Pacific Islander Hawaiian Other	
Language Spoken: ____________________ **Do you need a translator?** Yes No	
Is the patient: a single parent? Yes No **Homeless?** Yes No **Resident of public housing?** Yes No	
Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose	
Sexual Orientation: Straight Lesbian/Gay Bisexual Other Don't know Choose not to disclose	

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Aviva Health, to render needed treatment to the above named patient.
2. I authorize Aviva Health to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to Aviva Health for services rendered.
4. I understand that I am responsible for all charges incurred through Aviva Health.

I request that payment under the medical Insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If it becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

I have read the above and agree to the terms provided.

Signature of applicant: ____ **Date**: ___________________

Signature of Parent/Guardian: ____**Date:** _________________

Staff initials: _________________________________ **Date:** ________________

Office Policies

MAKING APPOINTMENTS: Please be as specific as possible regarding your area of concern. This will help us to schedule the proper amount of time necessary for your care.

MISSING APPOINTMENTS: Please notify the Clinic as soon as possible if you are unable to keep your appointment. Canceling appointments less than 24 hours in advance could result in a “No Show.” This also includes referral appointments to outside clinics, physicians, and walking out on your appointment. Our answering service is available 7 days a week, 24 hours a day for your convenience. Please notify us if your scheduled appointment time needs to be changed. This allows for someone else who is waiting to be seen to be added to our schedule.

BEING LATE FOR APPOINTMENTS: Please be at least **10 min early for your routine appointments and 30 min early for new patient appointments.** This will ensure staff has time to input your information into your chart. Failure to arrive on time may result in rescheduling your appointment. Your appointment time is an allotted time. ______ **(Patient or responsible party initials)**

LAB AND X-RAY REPORTS: Your lab and x-ray results are part of the total picture of your health and must be analyzed by your health care provider in light of your history and physical exam. When you have a lab or x-ray, there will be additional charges that you are responsible for. Please check with that office before you have the services. You will be notified of your results, or your provider will discuss your results at your follow-up visit. **Please allow up to 2 weeks for this process.**

PRESCRIPTION REFILL POLICY: Please call your pharmacy and request a refill, even if it states “no refill” they will notify us. **Please give us 48 to 72 hours to process your refill.** We will review your chart and notify the pharmacy of the practitioner’s decision. Please notify the pharmacy 1 week before your meds are finished. **It is your responsibility to monitor the amount of medication you have.**

REFERRALS FOR OREGON HEALTH PLAN PATIENTS: The Oregon Health Plan requires us to submit a request for referral when the practitioner orders a specialist consult. The process can take up to 1 week or sometimes longer. We will contact you when this process has been completed and instruct you to call the specialist to make your appointment. Please be patient. It takes to get the approval.

PAYMENTS: Payments are expected at the time of service. You will be told what your minimum expected amount will be for each appointment. The amount could be more according to the procedures done. If you are unable to pay at the time of your visit, your appointment may need to be rescheduled. __________ (Patient or responsible party initials)

I have read the above and agree to the terms provided.

Signature: ____ **Date:** _______________

Receipt of Notice of Privacy Practices Written Acknowledgement

I, ___________________________________have received a copy of Aviva Health's notice of Privacy Practices.

____

(Signature of patient or legal guardian) (Printed patient or legal guardian)

Date:__________________________

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For Internal Purposes Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

-Individual refused to sign.

-Communication barriers prohibited obtaining acknowledgement.

-An emergency situation prevents us from obtaining acknowledgement.

-Other (please specify):____