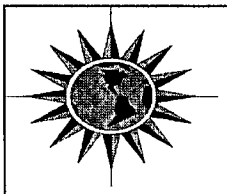

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# New Patient Information Sheet

## PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SSN: _____ Sex: M/F Date of Birth: _____/_____/_____

Preferred Phone: _____ Race: _____ Language Spoken: _____

Ethnic Group (circle): Hispanic Not Hispanic Unknown

## INSURANCE INFORMATION

*Primary Insurance*

Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Insurance Company's Address: _____

Insurance Company's Phone Number: _____

*Secondary Insurance*

Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Insurance Company's Address: _____

Insurance Company's Phone Number: _____

## SCHOOL & PHARMACY INFORMATION

School Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ City: _____ State: _____

*******Continued on other side →

## PARENT/GUARDIAN INFORMATION

*Parent/Guardian 1 - Primary Guarantor (person responsible for patient's bill):*

**First Name:** _____ **Middle:** _____ **Last:** _____

**Address:** _____

**SSN:** _____ **Sex: M/F** **Date of Birth:** _____/_____/_____

**Marital Status:** _____ **Relationship to patient:** _____

**Employer:** _____ **Job Position:** _____

**Home Phone:** _____ **Cell Phone:** _____

*Parent/Guardian 2:*

**First Name:** _____ **Middle:** _____ **Last:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**SSN:** _____ **Sex: M/F** **Date of Birth:** _____/_____/_____

**Marital Status:** _____ **Relationship to patient:** _____

**Employer:** _____ **Job Position:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Work Phone:** _____ **Email:** _____

## EMERGENCY CONTACT (OTHER THAN PARENT)

**Name:** _____ **Sex: M/F** **Relationship to patient:** _____

**Primary Phone:** _____ **Secondary Phone:** _____

## Assignment & Release

I hereby authorize payment directly to *Advocates for Children and its practitioner's* of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize *the above doctor and/or any provider or supplier of services in this office* to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**Signature of Responsible Party:** _____ **Date:** _____

# Financial Policy
# Advocates for Children, Ltd.
# 2919 Confederate Avenue
# Lynchburg, VA 24501

This is an agreement between Advocates for Children, Ltd., a Virginia Professional Corporation, as creditor, and the Patient/Debtor named on this form

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor or Guarantor for minor child. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Advocates for Children, Ltd.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a statement for **4** billing cycles only.

**Payments:** Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

**Payment terms if you have no insurance:**
You may pay by cash, check, or credit card on the day that treatment is rendered. We will make every effort to estimate the amount of your charges prior to your visit, and patients making full prompt payment will receive a 10% discount. We cannot guarantee that all charges will be captured at the time of service.

**Payment terms if you have insurance:**
Insurance is a contract between you and your insurance company. Unless we participate with the insurance company, we are NOT a party to this contract. If we participate, we follow the insurance company's fee schedule. Your cost is limited to your plan deductible, coinsurance, and co-pay amounts. It is the insurance company that makes the final determination of your eligibility and benefits. If you have any questions regarding participation, please ask our front office staff. Our office will bill your primary and one supplemental insurance as a courtesy to you. You agree to pay any portion o the charges not covered by insurance. **If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization OR to do so in a timely manner may result in a lower payment from the insurance company.**
Any co-payments, coinsurance, or deductible required by an insurance company is part of your contractual agreement and MUST be paid at the time of service.

**Credit History:** We have the option to report your account status to any credit reporting agency such as a credit bureau.

**Returned checks:** There is a fee (currently $35.00) for any checks returned by the bank.

**Past Due Accounts:** If your accounts become past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur plus all court costs. In case of suit, you agree the venue shall be in Lynchburg, VA. Please note that all accounts sent to collections will result in dismissal from the practice.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the **parent/guardian physically present at the time of service is responsible for any co-pays, coinsurance, or deductible owed.**

**Missed Appointments:** Appointments not cancelled 24 hours prior to the appointment time are subject to a $50.00 charge. We offer reminder calls to help you keep your appointment however you are ultimately responsible for keeping or cancelling your appointments.

## *****If your insurance is discontinued and you change to any form of Medicaid, we will be unable to continue to provide care.

********

If you have any concerns or questions regarding the signing of this agreement, please see our office manager.

Patient's Name: _____ Date: _____

Responsible Party: _____ Relationship: _____

ADVOCATES FOR CHILDREN
ADVOCATES FOR FAMILIES
INTEGRATIVE MEDICINE
*guiding families to good health*

2919 Confederate Ave 434.528.9075 ph
Lynchburg, VA 24501 434.528.9078 fx
www.rimlandcenter.com

# Medical Information Release Form

## (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

## Release of Information

[ ] I authorize the release of information including diagnoses, records, examinations, and billing information rendered to my child. This information may be released to:

[ ] Name of Parent(s) _____

[ ] Name of Grandparents _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

## Messages

Please call: [ ] my home_____

[ ] my work _____

[ ] my cell _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] do not leave any messages

Signed: _____ Relationship to child: _____

Date: _____

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Patient Medical History

Patient Name: _____ D.O.B. _____

**Past Medical History**

*Indicate whether your child has been diagnosed, or suffered from, any of the following conditions*

| | | | | | |
|---|---|---|---|---|---|
| Abdominal Pain | ☐ | Double Vision | ☐ | Mononucleosis | ☐ |
| Acne | ☐ | Down Syndrome | ☐ | Mumps | ☐ |
| ADHD | ☐ | Ear Infections | ☐ | Muscle Weakness | ☐ |
| Anemia | ☐ | Eczema | ☐ | Numbness | ☐ |
| Appetite Decrease | ☐ | Environmental Allergies | ☐ | PANDAS | ☐ |
| Asperger's Syndrome | ☐ | Facial Tic | ☐ | PE tubes | ☐ |
| Asthma | ☐ | Fatigue/Malaise | ☐ | Pneumonia | ☐ |
| Autism | ☐ | Febrile Seizures | ☐ | Posture Problems | ☐ |
| Autoimmune problems | ☐ | Food Allergy | ☐ | Premature Birth | ☐ |
| Bloody Stool/Urine | ☐ | Food Intolerances | ☐ | Rash | ☐ |
| Breathing Difficulties | ☐ | Frequent Colds | ☐ | Rectal Bleeding | ☐ |
| Bronchitis | ☐ | GERD | ☐ | RSV | ☐ |
| Cancer | ☐ | Hearing Problems | ☐ | Rubella | ☐ |
| Cellulitis | ☐ | Hernia | ☐ | Runny Nose | ☐ |
| Cerebral Palsy | ☐ | Immunization Reaction | ☐ | Seasonal Allergies | ☐ |
| Chest Pain | ☐ | Influenza | ☐ | Seizure d/o | ☐ |
| Chicken Pox | ☐ | Irregular Heart Beat | ☐ | Sinus Problems | ☐ |
| Chronic Fatigue | ☐ | Liver Problems | ☐ | Sore Throat | ☐ |
| Conjunctivitis | ☐ | Low Muscle Tone | ☐ | Speech Delay | ☐ |
| Constipation | ☐ | Lyme's Disease | ☐ | Strep Throat | ☐ |
| Cough | ☐ | Measles | ☐ | Vision Problems | ☐ |
| Croup | ☐ | Meningitis | ☐ | Whooping Cough | ☐ |
| Diarrhea | ☐ | Migraines | ☐ | Other | |

_____

**Medications**

*Please list any medications and supplements that your child is currently taking*

| Medication | Dosage | Start Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Continued on other side →

**Allergic Reactions/Sensitivities**

*Please indicate any allergies or sensitivities your child has to any of the following substances.*

| | | | | | |
|---|---|---|---|---|---|
| Aspirin | ☐ | Latex | ☐ | Pollen | ☐ |
| Cephalosporins | ☐ | Mold | ☐ | Shellfish | ☐ |
| Dairy Products | ☐ | Peanuts | ☐ | Sulfa Drugs | ☐ |
| Dust mites | ☐ | Penicillin | ☐ | Wheat | ☐ |
| Eggs | ☐ | Pet dander | ☐ | Other | ☐ |

_____

**Surgical History**

*Please list any surgeries your child has undergone, as well as any complications involved.*

| Surgery | Year | Complications - if any |
|---|---|---|
| | | |
| | | |
| | | |

**Social History**

*Please check all that apply.*

| | | | |
|---|---|---|---|
| Child in preschool | ☐ | Child in middle school | ☐ |
| Child in kindergarten | ☐ | Child in high school | ☐ |
| Child in elementary school | ☐ | Child in college | ☐ |

Father's occupation: _____

Mother's occupation: _____

Parents Marital Status: single married divorced (recently / past) separated

Household Members: _____

Pets in Home: yes no if yes specify_____

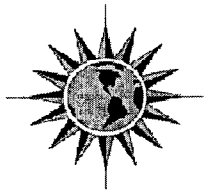
Home environment stressors: _____

Tobacco exposure Yes No

Child Care: None Babysitter Daycare (public / in-home)

Homeschooled: Yes No

Child is adopted: Yes No



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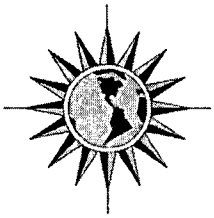
Patient's Name: _____

| Family Medical History | Father | Mother | Sibling(s) | Mother's mother | Mother's father | Father's mother | Father's father | 1st cousin | Other |
|---|---|---|---|---|---|---|---|---|---|
| ADD/ADHD | | | | | | | | | |
| Alcohol Abuse/Drug Abuse | | | | | | | | | |
| Allergy to Milk | | | | | | | | | |
| Allergy to Wheat | | | | | | | | | |
| Alzheimer's Disease | | | | | | | | | |
| Anemia | | | | | | | | | |
| Asperger's Syndrome | | | | | | | | | |
| Asthma | | | | | | | | | |
| Autistic Spectrum Disorder | | | | | | | | | |
| Auto-immune problems | | | | | | | | | |
| Bipolar Disorder | | | | | | | | | |
| Breathing problems | | | | | | | | | |
| Bronchitis | | | | | | | | | |
| Cancer - please specify type | | | | | | | | | |
| Celiac Disease | | | | | | | | | |
| Cough | | | | | | | | | |
| Crohn's Disease | | | | | | | | | |
| Cystic Fibrosis | | | | | | | | | |
| Depression | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Down Syndrome | | | | | | | | | |
| Ear Infections | | | | | | | | | |
| Eating Disorder | | | | | | | | | |
| Eczema | | | | | | | | | |
| Fungal Infections | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Hay Fever | | | | | | | | | |
| Headaches/Migraines | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| Hives | | | | | | | | | |
| Hypertension | | | | | | | | | |

[Continued on other side]

| Family Medical History | Father | Mother | Sibling(s) | Mother's mother | Mother's father | Father's mother | Father's father | 1st cousin | Other |
|---|---|---|---|---|---|---|---|---|---|
| Insomnia | | | | | | | | | |
| Irritable/Inflammitory Bowels | | | | | | | | | |
| Kidney problems | | | | | | | | | |
| Learning Disability | | | | | | | | | |
| Leukemia | | | | | | | | | |
| Light Sensitivity | | | | | | | | | |
| Lymphoma | | | | | | | | | |
| Manic Depressive | | | | | | | | | |
| Mood Swings | | | | | | | | | |
| Night Vision Problems | | | | | | | | | |
| Obesity | | | | | | | | | |
| Obsessive Compulsive Disorder | | | | | | | | | |
| Panic Attacks | | | | | | | | | |
| Psoriasis | | | | | | | | | |
| Reflux/Heart Burn | | | | | | | | | |
| Schizophrenia | | | | | | | | | |
| Seasonal Allergies | | | | | | | | | |
| Seizure disorder | | | | | | | | | |
| Sinusitus | | | | | | | | | |
| Speech Delay | | | | | | | | | |
| Stomach Problems | | | | | | | | | |
| Stroke | | | | | | | | | |
| Surgeries - please specify | | | | | | | | | |
| Thyroid Problems | | | | | | | | | |
| Other - please specify | | | | | | | | | |



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## Telephone Policy

- *We do not provide medical care over the phone*. If you have a medical need we advise you to make an appointment.
- Urgent medical problems will be addressed by phone *as needed*.
- Changes in *current medication* and prescriptions for *new medication* **require an office visit**.
- Lab results are often given over the phone by our nurses. Our nurses are only informing you of the results, *not* giving an interpretation of those results. If you have any questions regarding this information you must make an appointment to talk with the doctor.
- If you are having a medication side effect or ineffectiveness we will be happy to see you immediately.
- Do not call asking to talk to the doctors, or to have the doctors call you back. They see patients throughout the entire day. If you want to talk to the doctors you must make an appointment. Messages left for the doctors will be dealt with on an urgent basis and will usually result in a request for an office visit.
- Telephone consultations are reserved for Advocates for Families patients. Telephone consult fees will be based on Dr. Mumper's preparation and actual time on the phone.

We want to provide you excellent, personal, medical care, not telephone care!

I have read and understand this telephone policy.

Parent/Guardian's Signature: _____

Patient's Name: _____ Date: _____

# Notice of Non-Covered Services

Certain services may be recommended by your physician as a necessary part of your child's care. Please be advised that these procedures may be denied or the charge put toward your deductible by your insurance company. It is impossible for us to know the intricacies of every insurance policy prior to providing care. **Procedures commonly not covered include:**

***Hearing Screening**
***Vision Screening**
***Wart Freezing**
***Chemical Cauterization**
***Lysis of Penile Adhesions**
***Earwax removal/curetting**

**Also PLEASE NOTE** – well child visits are structured to discuss and provide preventive care only. They cannot be combined with sick visits, medication checks, or consultations. If your child is having any health problems that are addressed at his/her preventive care visits, your insurance company may request that you pay a copay to cover the additional services.

**By signing below you acknowledge that all procedures performed in the office are recommended by our practitioners in order to provide quality care and that coverage for these procedures is not guaranteed.**

**Parent's Name (please print):**_____

**Parent's Signature:** _____

**Child's Name (please print):** _____

**Date:**_____

# NOTICE OF PRIVACY PRACTICES

**To our patients:** This notice describes how health information about you or your child (as a patient of this practice) may be used and disclosed, and how you can get access to this health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

### For Treatment:

We may use medical information about you to provide you with medical treatment or service. We may disclose medical information about you to external doctors, nurses, technicians and other health care personnel who are involved in your care.

### For Payment:

We may use and disclose medical information about you so that the treatment and service you receive here may be billed to and payment collected from you, an insurance company or a third party.

### For Health Care Operations:

We may use and disclose medical information about you for health care operations. To evaluate the care and services we offer, we examine our medical services, treatment plans and options, record-keeping, and communication with other doctors and nurses involved in your care.

**The following special circumstances may require us to use or disclose your health information:**

1. To public health authorities and agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to your doctor at Advocates for Children, Ltd. or Advocates for Families, PLLC. For further information, call us at (434)528-9075.
4. You may ask us to amend your health information if you believe it in incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your doctor. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact your doctor or the office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your doctor or the office manager at (434)528-9075.

# AFTER HOURS CARE

The Rimland Center would like you to know that while we are not open after 5pm, or on the weekends, there are centers we recommend for you to visit if you are in need of immediate care after hours.

There is also a nurse or doctor on call every night that may be able to give you the advice you need about how to care for your child, or to decide whether he or she needs to be seen immediately.

We recommend the following centers for after hours treatment:

CVFP Urgent Care

Airport Immediate Care – 434-239-0132
Amelon Immediate Care – 434-929-1095
Blue Ridge Immediate Care – 434-845-4175

Physicians Treatment Center

Lynchburg – 434-239-3949
Amherst – 434-946-5532
Huddleston – 540-296-0534

*Patients with Medicaid will need to go to Lynchburg General Hospital Emergency Room for after hours care.