Patient Name: _____

Chart #: _____

NEW HOPE CHILDREN'S CLINIC

MEDICAL CONSENT FORM

Patient's Full Name: _____ Goes by: _____
First Name Middle Name Last Name

Address(es) where Patient lives:

_____ Zip: _____

_____ Zip: _____

Contact Phone Numbers:

Phone Number:	(Home/Cell/Work)	Whose Number is this? (Give Name)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent Email Address: _____

Patient's Sex: M F **Date of Birth** ____/____/_____ Social Security #_____

Current School: _____

Ethnicity: Please check ONE _____Hispanic or Latino _____NOT Hispanic or Latino _____Unknown

Race: Please check ONE _____American Indian or Alaska Native _____Asian _____Black or African American
_____Native Hawaiian or Other Pacific Islander _____White _____Unknown

Parents or Legal Guardians : _____

Address (if different from where Patient lives)

_____ Zip: _____

Brothers and Sisters: Names and Ages:

_____

_____

Insurance Information:

We accept Medicaid, BCBS and Tricare Standard **ONLY**. **WE CAN NOT SEE YOUR CHILD IF YOU HAVE ANOTHER PRIMARY INSURANCE.**

My child has Medicaid: _____Yes _____No Medicaid number _____

My child as AllKIDS: _____Yes _____No AllKIDS number_____

My child has other insurance: _____
(Blue Cross/Blue Shield, Tricare GIVE NAME OF COMPANY)

Insurance Contract #: _____Group #: _____

Insured Person's Name: _____Relationship to patient: _____

Insured is employed by: _____

Insured's Date of Birth: _____

Insured's SS#_____

NAME OF PHARMACY TO ePrescribe PRESCRIPTIONS: _____

If you have an answering machine or voice mail, may we leave detailed messages regarding appointment, treatment and/or other information concerning your child's healthcare at the New Hope Children's Clinic? **Please only check one.** _____Yes _____No

If your child is a student at NEW HOPE ELEMENTARY or HIGH SCHOOL, please check ONLY ONE:

_____ My child may receive medical services at the New Hope Children's Clinic **without me being present.** New Hope Children's Clinic clinical staff may see my child and will send a note home or will call to inform me of the visit. I give permission for my child to be escorted from the school to the clinic and back by any Clinic staff member or volunteer. I give my consent to the New Hope Children's Clinic to administer medications as needed to my child. In the event this occurs, I will be notified.

_____ My child may receive medical services at the New Hope Children's Clinic, but I would like to **be contacted first.** (*YOUR CHILD WILL NOT BE SEEN IF WE CANNOT REACH YOU*) I give my consent to the New Hope Children's Clinic to administer medications as needed to my child. In the event this occurs, I will be notified.

_____ My child may receive medical services at the New Hope Children's Clinic **only if I am present**, unless it is an emergency. I understand that unless it is an emergency, the New Hope Children's Clinic clinical staff will not see my child. The school office or school nurse will call me at home or at work in case of a medical emergency.

_____ My child **may NOT** receive medical services from the New Hope Children's Clinic.

MEDICAL AUTHORIZATION

I hereby give permission to the following individual(s) to be contacted in an emergency, who may receive medical information about my child, may bring my child to the New Hope Children's Clinic, and authorize medical care for my children, which may include consent for procedures, vaccines or administration of medicines.

Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____

I understand that all information in my child's health record is confidential. I give my consent for the New Hope Children's Clinic staff to speak with appropriate school personnel, including the school nurse, concerning my child's school and health records, attendance, academic performance and other information affecting his/her learning or behavior.

I authorize the New Hope Children's Clinic to release information regarding treatment to doctors and third party payers (insurance companies) for the purposes of obtaining authorization for services, for billing and/or for any reason in accordance with acceptable medical practice pursuant to the law. I authorize payment to be made directly to the provider of services.

I UNDERSTAND THAT I AM RESPONSIBLE TO PAY TO THE NEW HOPE CHILDREN'S CLINIC ALL INSURANCE CO-PAYS

Signature: _____ Relationship to Patient: _____ Date: _____

Patient's Signature: _____ Date: _____

Any patient fourteen (14) years and older must sign the Medical Consent form, regardless of who fills the form out

PATIENT HEALTH INFORMATION **Patient Name:** _____

Name and phone number of Primary Care **Doctor or Nurse Practitioner** (assigned by insurance or who your child normally sees when sick):

_____ Phone: _____

Date last seen by above Provider: (Month/Year): _____

Name and phone of child's **Dentist**: _____ Phone: _____

Date last seen by above Dentist: (Month/Year): _____

Name and phone of child's **Optometrist**: _____ Phone: _____

Date last seen by above Optometrist: (Month/Year): _____

Does your child have any **allergies** (bee stings, foods, medicines, etc.) Yes_____ No_____

Please list medicine/food/etc. and reaction:

Does your child have an allergy to **Latex**? Yes_____ No_____

Is your child taking any **daily medications**: Yes_____ No _____

Please list medications, how often taken and when the last dose was taken:

Date of child's last **tetanus** shot: _____

Has your child ever had any of the following illnesses or conditions:

	Yes	No		Yes	No
Tuberculosis (TB)			Asthma		
Pneumonia			Frequent ear infections		
Diabetes			Hypoglycemia		
Seizure (epilepsy)			Heart Problems		
Anemia (low iron)			Sickle cell disease		
Kidney problems			Frequent bed wetting		
Frequent stomach ache			Frequent constipation		
Frequent diarrhea			Frequent urine infection		
Skin problems			Frequent headaches		
Hearing problems			Vision problem		
Attention Deficit problem			Other learning problem		
HIV positive			Hepatitis		

Was your child born prematurely? Yes No

Please explain: _____

Has your child ever been in the hospital overnight or longer? Yes No

Please explain: _____

Has your child ever had surgery? Yes No

Please explain: _____

Has your child had any dental issues: Yes No

Please explain: _____

Do you have any concerns about your child's physical health? Yes No

Please explain: _____

Do you have any concerns about your child's emotional health? Yes No

Please explain: _____

Last visit to the ER? _____ **How many times a year is child seen in ER?** _____

Patient Name: _____

FAMILY MEDICAL HISTORY

	Parent	Grandparent	Uncle	Aunt	Sibling	
Substance Addiction	____	_____	____	____	_____	Name substances:
Cancer, specify type	____	_____	____	____	_____	
High blood pressure	____	_____	____	____	_____	
Heart disease	____	_____	____	____	_____	
Heart attack prior to age 50	____	_____	____	____	_____	
Stroke	____	_____	____	____	_____	
Depression	____	_____	____	____	_____	
Suicide	____	_____	____	____	_____	
Bleeding or clotting disorder	____	_____	____	____	_____	
Genetic disorders	____	_____	____	____	_____	
Asthma/COPD	____	_____	____	____	_____	
Diabetes: I or II?		_____	____	____	_____	
Other:		_____	____	____	_____	

SOCIAL HISTORY

Who lives at home with Patient?

Name	Age	Relationship	Highest Education Level
_____			
_____			
_____			
_____			
_____			
_____			

Are patient's parents _____Married ____Unmarried ____Separated ____Divorced

Mother's Occupation: _____

Mother's Employer: _____

Father's Occupation: _____

Father's Employer: _____

Child care situation: ____Parents ____Others (specify who and how often) _____

_____

Concerns about your child: Alcohol Use _____ Sexual Activity_____

Tobacco: ___current everyday smoker ___current some day smoker ___former smoker ___never smoker

Aggressive behavior____ Other:_____

Is violence at home a concern? No____ Yes____

Are there guns in the home? No____ Yes____

Did/does your child attend school or preschool? No____ Yes____

Current Grade____ Name of School _____

Any concerns about school performance_____

_____

Any concerns about relationship with:

Teachers No____ Yes____

Peers No____ Yes____

If more than 4 years old: Does your child have a best friend? No____ Yes____

Sports/exercises: Type_____

NEW HOPE CHILDREN'S CLINIC

REQUEST FOR RECORDS

Records Requested from: _____

Office #:_____ Fax #: _____

Patient Info:

Patient Name: _____ DOB: _____

Person Authorizing Release of Info:

Print Name: _____
(Parent or Legal Guardian)

Signature : _____

Dated: _____

Please **FAX** or **MAIL** the following Records:

_____ Growth Charts
_____ Immunization Record
_____ Last WCC/EPSDT
_____ Medications
_____ Newborn Records/Screenings
_____ Problem List
_____Specialist Reports
_____Most recent labs

Other:

TO:

New Hope Children's Clinic
P.O. Box 635
New Hope, AL 35760
FAX: 256-723-4674
OFFICE: 256-723-4673

Thank You!

NO-SHOW POLICY

Definition of a "No-Show" Appointment

New Hope Children's Clinic defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 15 minutes late and is consequently unable to be seen

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel an appointment

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year, you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider
2. If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled
3. Only emergency medical treatment will be offered within the first 30 days of dismissal

I have read and understood the New Hope Children's Clinic "No-Show" Policy as described above.

_____ _____

Parent Signature Date

RELEASE OF INFORMATION FOR MINORS AND HIPAA IN ALABAMA

CONSENT OF MINORS:

Alabama law (Code of Alabama, Section 22-8-3, 22-8-4 and 22-8-6) states that **ALL 14 year old minors MUST specify in WRITING that their parents may have access to their protected health information BEFORE it is given to them.**

Patient Consent for Parent Notification

I, (Patient Name)_____, authorize the New Hope Children's clinic to allow access to my protected health information as follows:

_____ I give consent for the NHCC to share protected health information with my parents.
_____ I DO NOT give consent for the NHCC to share protected health information with my parents.

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY POLICIES

I acknowledge that I have been provided a copy of the Notice of Privacy Policies for the New Hope Children's Clinic (attached). I understand that I have the right to review the Notice before I sign this acknowledgement and that the New Hope Children's Clinic reserves the right to change its notice and practices.

Child's Name: _____ Parent/Guardian Signature: _____
Date: _____

Patient Copy

NOTICE OF PRIVACY POLICIES AND PRACTICES for New Hope Children's Clinic

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

New Hope Children's Clinic is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how **New Hope Children's Clinic** is permitted to

- o Use and disclose PHI about you
- o How you can access and copy that information
- o How you may request amendment of that information
- o How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT Cindi Williamson, Executive Director, New Hope Children's Clinic at 256-723-4673.

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

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how **New Hope Children's Clinic** is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI: **New Hope Children's Clinic** *may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:*

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization. ***New Hope Children's Clinic*** *is permitted to use PHI without your written authorization, or opportunity to object in certain situations, including:*

- For **New Hope Children's Clinic**'s use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;

For health care fraud and abuse detection or for activities related to compliance with the law;

- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;

• For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;

• For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;

• For military, national defense and security and other special government functions;

• To avert a serious threat to the health and safety of a person or the public at large;

• For workers' compensation purposes, and in compliance with workers' compensation laws;

• To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law.

• If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;

• For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;

• We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it).

You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI. *This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.*

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

The right to amend your PHI. The right to request amending your PHI. *You have the right to ask us* to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an *accounting from* us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you.

We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. ***Y***ou have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a healthcare provider to provide you with emergency treatment. **New Hope Children's Clinic** is not required to agree to any restrictions you request, but any restrictions agreed to by **New Hope Children's Clinic** are binding on **New Hope Children's Clinic.**

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain *a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may* always request a paper copy of the Notice.

Revisions to the Notice: **New Hope Children's Clinic** reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

Revised Notice, effective March 26, 2013: Recipients have the right to receive security breach notification; health plans may not use genetic information for underwriting purposes; and Covered Entities must obtain patient authorization before using PHI for marketing purposes and before selling PHI.

Privacy Officer: Debra Rowles, Office Manager (256)723-4673