NEW HOPE CHILDREN'S CLINIC

MEDICAL CONSENT FORM

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

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

School Name: _____ Not in School___ Elem___Middle___High___ College___Home___

Ethnicity: Please check ONE
___Unknown
___Hispanic or Latino
___NOT Hispanic or Latino

Race: Please check ONE
___American Indian or Alaska Native
___Black or African American
___Native Hawaiian or Other Pacific Islander
___Asian
___White
___Unknown

Parent/Guardian #1: Relationship to patient (circle one) Mother, Father, Other: _____
Last name:_____ First name:_____ MI:_____ Sex: M / F
Street Address:_____ City: _____
State:_____Zip:_____Email: _____Date of Birth: _____
Cell #:_____ Home #:_____ Work #:_____
Does patient live here full time? _____ YES _____ NO
If NO, please explain: _____
_____

Parent/Guardian #2: Relationship to patient (circle one) Mother, Father, Other: _____
Last name:_____ First name:_____ MI:_____ Sex: M / F
Street Address:_____ City: _____
State:_____Zip:_____Email: _____Date of Birth: _____
Cell #:_____ Home #:_____ Work #:_____

For Non-Parents, we must have a copy of Court or DHR Documents granting custody/guardianship

Insurance Information:

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

Medicaid #_____ AllKIDS #_____
BCBS/TRICARE #_____ Group # _____
Insured Person's Name: _____Relationship to patient: _____
Insured is employed by: _____ Insured's Date of Birth: _____
Insured's SS#_____

NOTICE: Due to the increase in vaccine preventable diseases, we require all of our patients to be fully vaccinated.

_____ I agree to vaccinate my child according to the CDC's recommended guidelines.
Please initial

NAME OF PHARMACY TO ePrescribe PRESCRIPTIONS: _____

*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.

If you have an answering machine or voice mail, may we leave detailed messages regarding appointments, treatment and/or other information concerning your child's healthcare at the New Hope Children's Clinic? Check One: _____ YES _____ NO

New Patient: How did you here about our Clinic? _____

Authorized Care Givers (Other Than Parents)

The following people are authorized to discuss personal health information or bring my child to The New Hope Children's Clinic for evaluation and treatment, including immunizations:

Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____

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 AND AGREE TO COMPLY WITH ALL NHCC POLICIES AND NOTICES

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

SOCIAL HISTORY Patient Name:_____ _____

Are patient's parents: Married ____Unmarried ____Separated ____Divorced _____

If parents are divorced or separated, please fill out this section:

Who has legal custody? Joint: _____ Mother:_____ Father:_____

How often is child with Mother: _____ How often is child with Father: _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? _____YES _____NO

If YES, please provide a copy of any legal paperwork that supports this restriction

List everyone who lives with patient:

Name	Age	Relationship	Highest Education Level

Type of drinking water in the home: City: _____ Well: _____

Is there tobacco use in the home: No___ Yes: ____ (Smoking _____ Vaping _____)

Are there guns in the home: No ___ Yes: ___ (How are they secured: _____)

Is there violence in the home: No ___ Yes: ___ Please explain: _____

Mother's Occupation:_____ Mother's Employer: _____

Father's Occupation: _____ Father's Employer: _____

Child Care: Parent(s): ____ Daycare ____ (Name of Daycare):_____

Family Member (Please list name/relationship to child): _____

After School Care: _____

		Yes	No
Concerns:	Aggressive behavior	___	___
	Alcohol Use	___	___
	Drug Use	___	___
	Peer Relationships	___	___
	School Concerns	___	___
	Sexual Activity	___	___
	Teacher Relationships	___	___
	Tobacco Use	___	___
	Other: _____		
If more than 4 years old:	Does your child have a best friend?	___	___

Sports/exercises: Type(s)_____

YES	NO	PATIENT MEDICAL HISTORY
		Allergies:
		Foods:
		Medications:
		Insects: Other:
		ADHD:
		Other learning problems:
		Anemia
		Asthma/Wheezing
		Autism
		*Autoimmune Disorder: ***Specify:***
		*Birth Defect/Congenital Anomaly: ***Specify:***
		Bleeding or Clotting Problem: ***Specify:***
		Cancer: ***Specify Type:***
		Cystic Fibrosis
		Diabetes
		Eczema (Atopic Dermatitis)
		Constipation
		Bed wetting
		Frequent ear infections
		Headaches
		Urinary infections
		Genetic Disorder: ***Specify:***
		Seasonal Allergies
		Hearing Disorder
		Heart Problems
		Hepatitis
		HIV Positive
		Immune Disorder: ***Specify:***
		Inflammatory Bowel Disease (Crohns/Ulcerative Colitis)
		Kidney Disease
		Anxiety/Depression/etc. ***Specify:***
		Scoliosis
		Seizures
		Sickle Cell Disease
		Skin Problems
		Thyroid Disorders
		Tuberculosis
		Vision Problems
		Hospitalizations: Age(s): Reason(s):
		Surgery History:
		Does child see a Dentist? **Name:**

FAMILY MEDICAL HISTORY of (please write patient name here): _____

Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle	*Please indicate with a check mark, family members who have had any of the following conditions - **Please give details about any box you checked***
								Alcholism
								Anemia
								Asthma
								Autism
								*Autoimmune Disorder: ***Specify:***
								*Birth Defect/Congenital Anomaly: ***Specify:***
								Bleeding or Clotting Problem: ***Specify:***
								Cancer: ***Specify Type:***
								Diabetes
								Eczema (Atopic Dermatitis)
								Food Allergy
								*Genetic Disorder: ***Specify:***
								Hay Fever (Allergic Rhinitis)
								Hearing Disorder
								*Heart Attack/ Coronary Artery Disease: ***What Age?***
								High Cholesterol
								High Blood Pressure
								*Immune Disorder: ***Specify:***
								Inflammatory Bowel Disease (Crohns/Ulcerative Colitis)
								Kidney Disease
								Mental Retardation or Learning Disability
								Migraine Headaches
								*Psychiatric/Mental Illness/Depression: ***Specify:***
								Scoliosis
								Stroke
								Substance Abuse
								Thyroid Disorders
								Tobacco Use
								Tuberculosis
								Death before age 56 of reasons not listed above:
								Other:
								Other:
								Other:
								Other:

REQUEST FOR MEDICAL RECORDS OR INFORMATION

I hereby authorize and request:

_____

(Hospital, Physician, Dentist, Optometrist, Clinic or Health Department)

_____

(Fax Number)

To Release Medical Records and/or other information concerning the illness or treatment of:

Patient Name: _____

Patient Date of Birth: _____

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

Signed: _____

(Parent or Legal Guardian)

Dated: _____

Witness: _____

Information Requested:

_____

_____

_____

_____

_____

FOR PATIENTS AGED 14 AND OVER

Alabama law states that all 14 year old minors MUST specify, in writing, that their parents may have access to their protected health information (PHI), before any medical information is given to the parent or guardian.

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

___ I give consent for NHCC to share PHI with my parents or legal guardians.

___ I give consent for NHCC to share PHI with the following People:

_____Relation to Patient: _____

_____Relation to Patient: _____

___I **DO NOT** give consent for NHCC to share PHI with my parents. Please use this phone # to reach me regarding my PHI: (____) _____

Patient Signature: _____Date: _____

NO-SHOW POLICY

A "No-Show" Appointment is any scheduled appointment in which the patient either:

(1) does not arrive to the appointment, (2) cancels with less than 24 hours' notice or (3) arrives more than 15 minutes late and is consequently unable to be seen.

Avoid Getting a "No-Show" by confirming your appointment, arriving 5-10 minutes early, and giving 24 hours' notice to cancel an appointment

If you miss 3 or more appointments within a year, you may be dismissed from the clinic at the discretion of your medical provider. If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled. 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

MAKING APPOINTMENTS

We are in the office Monday – Thursday, between 8:00 a.m. and 4:00 p.m. It is necessary to make an appointment to have your child seen. We are **NOT** a Walk-In Clinic. Some appointments are available for same day sick visits. Call **EARLY**, as they do fill up quickly.

NIGHTTIME and WEEKEND COVERAGE

For after-hours advice, please call the clinic number, 256-723-4673, and wait for the answering service operator to come on the line. She will take your information and forward it to the ON-Call Provider, who will call you back as soon as possible. Please answer calls from numbers that you might not recognize at that time.

CHANGES IN INFORMATION

Please remember to call us as soon as you have new information like a new phone number, address, or insurance.

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. You 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