PEDIATRIC
Offices at Willow Bend

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Dear young Adult,

When you turn 18, seeking medical care is a new responsibility. Your parents can help guide you in seeking medical care, however as an adult you have the right and responsibility for medical care. This means that you may now seek medical care without your parent's consent and call for your own appointment as needed.

In this packet you will find our forms that you will need to fill out and a few things you will need to know about being responsible for your own medical care.

Forms and Descriptions

The following forms can be found in this packet and will need to be filled out by you and returned to the front office.

Patient Information

Please fill out this form so we can add it to your chart. While you may still be on your parent or guardian's insurance policy, any statement will be mailed under your name, and you will technically be responsible for payment or for charges not covered by insurance.

Consent to use and Disclose Health Information (HIPPA)

This form needs to be filled out only if you want your parent or any other individual access to your medical records. If we do not have this signed form on file Pediatric Offices at Willow Bend **WILL NOT** be able to give any of your medical information out, even an immunization record.

FINANCIAL AGREEMENT

This form outlines our financial policies. By signing this form, you acknowledge that **YOU** as an adult are responsible for any payment that needs to be made at the time of services at our office.

THING TO KNOW:

- Under the Federal Health Information Portability and Accountability Act or HIPPA, your medical records are now records between you and your healthcare provider. Access to your medical records and any discussion about your health is only provided to people that you consent to allow access, including your parent or guardian. If you wish your parent or guardian to discuss your health on your behalf, you must provide written consent to your healthcare provider by completing a form. This form is called a **CONSENT to use DISCLOSED HEALTH INFORMATION** form and is within the packet of information.
- **PEDIATRIC OFFICES AT WILLOW BEND** will continue to provide medical care for you until you are off your parent or guardian's insurance. At this time, PEDIATRIC OFFICES AT WILLOW BEND will help you make a smooth transition from pediatric to adult healthcare.
- When calling for an appointment (provide the most honest description of why you need to come in so we can schedule you at the appropriate time), when you need the appointment.
- Your parents may come to the appointment with you, but you will need to check in and sign forms yourself. Some of the forms you may be asked to complete, and sign are contact information (called demographics) financial responsibility and medical treatment consent forms.
- You will need to pay for any co-payments or billing portions required.
- You will need to sign for any vaccinations, your parent or guardian can no longer sign for you.
- Unless specified consent is given, we are not permitted to talk to parent or guardian about your healthcare. You will need to have the discussion with your provider. Your parent or guardian may only be involved if you provide consent to do so.
- You have the right to be informed of your medical care and treatment. You also have the right to refuse medical treatment.

PATIENT IDENTIFICATION DATA 18 YEARS OR OLDER

Patient's Name: _____ Sex M/F DOB _____

Address _____

Your Cell: _____ Email _____

Parent #1 Name _____

Address _____

Your Cell: _____ Email _____

Parent #2 Name _____

Address _____

Your Cell: _____ Email _____

Authorization for Treatment and Release of Information

I authorize PEDIATRIC OFFICES AT WILL OW BEND to evaluate and treat me and to release to my insurance company any information acquired during my examination or treatment, and to receive all payments for such as examination or treatment, PEDIATRIC OFFICES AT WILL OW BEND has my permission to release any diagnostic studies, reports, etc.to a specialist involved in my care. _____ **INITIAL**

Acknowledge of Receipt of Consent to Use and Disclose Health Information

I acknowledge that I have received the consent to Use and Disclose Health Information, which explains how my health information will be handled in various situations. _____ **INITIAL**

ATTENTION

Though you may still be covered under your parent's insurance, you as an adult are solely financially responsible for all payments: co-pay, coinsurance or deductible that your insurance deems as your responsibility.

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge, and I understand and agree to the above.

Patient's Signature **Date**

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

18 YEARS of Age or Older

This office is required by Federal Regulations to inform our patients to the use of your health information accordance to Health Insurance Portability and Accountability Act of 1996 or HIPPA.

I understand that as a part of my healthcare, PEDIATRIC OFFICES AT WILLOW BEND originates and maintains paper and/or electronic medical records describing my health history, symptoms, examinations, test results, diagnosis, treatments, and my plan of care or treatment for the future. I understand that this is information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and treatments information to my bill
- A means by which a third-party can verify the services billed to me actually took place

I understand and have been provided access to Notice Privacy Practices that provides a more complete description of information uses and disclosures. This notice is located on our website www.pedswb.com and in the sick area waiting in plain view. I understand that I have the following rights and privileges:

- The right to review the Notice Privacy Practices prior to signing consent, allowing treatment, or making payment for services rendered and the right to a paper copy of the Notice Privacy Practices
- The right to object the use of my health information for directory purposes
- The right to request confidential communications
- The right to inspect and copy
- The right to amend or supplement
- The right to an accounting of disclosures

I authorize PEDIATRIC OFFICES AT WILLOW BEND and its staff to discuss my medical information as follows (INITIAL BELOW ALL THAT APPLY)

- For financial purposes, I allow my parent or guardian(s) to access my diagnosis and treatment information and to discuss my account. _____ INITIAL
- I allow my immunization records to be released by fax or mail to: _____ Parent _____ School _____Self
- I allow my treatment plans (i.e.: medication, asthma, epi-pen, etc.) to be disclosed to _____ Parent _____ School _____Self

- I allow my office visits to be accessed by _____ Parent _____ School
- I allow my labs to be released to _____ Parent _____ School
- With my consent, I allow any confidential information including results of STD testing, AIDS, and Pregnancy testing to be shared with _____ Parent _____ School _____ Self Only

Parent/Guardian **Relationship**

Parent/Guardian **Relationship**

Other **Relationship**

I understand that as a part of PEDIATRIC OFFICES AT WILL OW BEND treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these **permitted uses. I also hereby consent to such disclosure via fax.**

Patient's Signature **Date**

Revoke Consent (DO NOT SIGN BELOW UNLESS REVOKING THE ABOVE CONSENT)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

Patient's Signature **Date**

Patient's Printed Name **Date**

FINANCIAL AGREEMENT AND CONSENT

18 YEARS OF AGE AND OVER

We are committed to providing you with the best possible medical care. Your signature at the end of this document will indicate that you have read, understand, and agree to the policies outlined below.

BILLING YOUR INSURANCE:

- Please present your current health insurance car. We will scan your insurance card at your visit. Please inform upon your arrival if your insurance has changed since your last visit.
- If you have NO INSURANCE, then payment in FULL is required at the time of service.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days, we reserve the option to refer the account to an outside collection agency. Pediatric Offices at Willow Bend reserves the right to reschedule or deny future appointment for delinquent accounts. If your account is sent to a collections agency you may be asked to find a new provider.

LATE ARRIVALS CANCELLATION AND NO SHOWS:

- We require a 24-hour notice to cancel or to reschedule an appointment. As a courtesy, a reminder of your appointment time will go out to you 2 days prior to your appointment.

Failure to give us proper notice for cancellation will result in:

- We will courtesy charge of $50.00 for the first missed appointment
- $50.00 charge for each missed appointment after the first.
- After 3 missed appointments within a 3-year time frame, could lead up to dismissal from the practice.

I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize to pay PEDIATRIC OFFICES AT WILLOW BEND directly. A copy of this authorization can be considered an original for insurance.

I do hereby consent and authorize the performance of all examinations, treatments, and medical services by PEDIATRIC OFFICES AT WILLOW BEND and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand, and agree to policies outlined in this document.

_____

Patient's Signature **Date**

_____

Patient's Printed Name **Date**

PATIENT PORTAL ENROLLMENT FORM OVER 18 YEARS

To register for our patient portal please complete the following information below.

Please check all your inbox/spam folders for a confirmation email with temporary password. The email will then prompt you to reset your temporary password. The password is time sensitive, and you have 24 hours to create a new password. Your "login" will be the email you provided along with the new "password" you create.

Email Address: _____

First & Last name: _____

☐ I attest this information is correct. I understand PEDIATRIC OFFICES AT WILLOW BEND may call to verify email address.

☐ I authorize PEDIATRIC OFFICES AT WILLOW BEND to enroll the above email address for PEDIATRIC OFFICES AT WILLOW BEND Patient Portal **INSTEAD** of my email account.

OR

☐ I authorize PEDIATRIC OFFICES AT WILLOW BEND to enroll my parent's email account _____ for PEDIATRIC OFFICES AT WILLOW BEND Patient Portal **INSTEAD** of my email account.

Patient's Signature **Date**

PARENT ACKNOWLEDGEMENT FORM OVER 18 YEARS

I, _____ the parent of _____

have received the information regarding my rights to my adult child's medical records and their responsibilities regarding their medical record and financial obligations.

I agree to call the clinic with any questions, but understand that without written permission form my child, they may not discuss any medical or financial concerns.

_____

Parent's Signature **Date**