Chantilly Pediatrics

a Chantilly Family Medicine, LLC company

Child's Full Name:_____ DOB:_____

Sex:_____Nickname:_____

Ethnicity:_____ Race:_____

Language Spoken:_____

If parents are separated, with whom do the children reside: _____Primary caregiver: _____

Father's Full Name:_____DOB:_____SSN:_____

Home Address:_____City:_____ State:_____Zip:_____

Occupation:_____ Employer:_____Email:_____

Work Address:_____ City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Mother's Full Name:_____DOB:_____SSN:_____

Home Address:_____City:_____ State:_____Zip:_____

Occupation:_____ Employer:_____Email:_____

Work Address:_____ City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

IN CASE OF EMERGENCY, NOTIFY:_____PHONE:_____

PRIMARY INSURANCE INFORMATION:

Company:_____ Effective Date:_____

Address:_____City:_____ State:_____Zip:_____

Policyholders Name:_____ DOB:_____

Policy or ID #:_____ Group #:_____Phone:_____

SECONDARY INSURANCE INFORMATION: (if applicable)

Company:_____ Effective Date:_____

Address:_____City:_____ State:_____Zip:_____

Policyholders Name:_____ DOB:_____

Policy or ID #:_____ Group #:_____Phone:_____

ADDITIONAL PARENT/GUARDIAN INFORMATION:

Full Name:_____DOB:_____SSN:_____Relation to patient:_____

Home Address:_____City:_____ State:_____Zip:_____

Occupation:_____ Employer:_____Email:_____

Work Address:_____ City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

SIGNATURE: _____ DATE:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHANTILLY PEDIATRICS USES AND DISCLOSES YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF PRIVACY PRACTICES (NPP). IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT DR KANIKA GOVIL, PRIVACY OFFICIAL FOR CHANTILLY PEDIATRICS AT 703-956-6757. This NPP applies to CHANTILLY PEDIATRICS and all its locations, employees. All entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or hea1thcare operations.

OUR PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of tile care and services you receive from us. We need this record to provide you with quality healthcare and to comply with certain legal requirements. This notice applies to all of the records of your healthcare services by CHANTILLY PEDIATRICS, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to (1) make sure health information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. By submitting to our care you give us the right to use your information for treatment, to be reimbursed for the services rendered in order to care for you, and to operate our organization within the parameters of legality. We may use or disclose your information for the following reasons: appointment reminders; to evaluate the quality of the medical care we provide; to coordinate reimbursement for the services we provide to you; to fulfill requirements of subpoenas, lawsuits, and disputes; various uses as required by law or to avert a serious threat to health or safety. We coordinate some of your services by telephone. While every attempt is made to maintain quiet, private modes of conversation, passersby may overhear words or phrases regarding you or your treatment.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding the medical information we maintain about you: right to inspect and copy; right to amend; right to an accounting of disclosures; right to request restrictions; right to request confidential communications; and the right to a paper copy of this notice. Information about how to exercise these rights can be obtained from Dr. Kanika Govil, Privacy Official for CHANTILLY PEDIATRICS, at 703-956-6757.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date. In addition, each time you register for medical treatment, we will offer you a copy of the current notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Hea1th and Human Services. To file a complaint with us, contact Dr. Kanika Govil, Privacy Official for CHANTILLY PEDIATRICS, at 703-956-6757. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OFMEDICAL INFORMATION: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Initial _____ Date _____

NOTICE OF PRIVACY PRACTICES PATIENT (Continued)
ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge that I have received the *Notice of Privacy Practices* for Chantilly Pediatrics. I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, and obtaining payment for my healthcare. I understand that my medical record is property of Chantilly Pediatrics, who will follow recordkeeping guidelines of the Commonwealth of Virginia, Virginia Board of Medicine, Title of Regulations: 18 VAC 85-20-16; Statutory Authority: 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia.*

I may be contacted by telephone or text messaging at the following phone numbers or emails. Messages to return the office call and appointment reminders can be left at these numbers. (Sensitive Personal Health Information such as abnormal test results WILL NOT be left on an answering machine. Personal Health Information can only be shared with other people authorized by the patient.)

HOME#_____

CELL# _____

WORK# _____

EMAIL _____

EMAIL _____

I authorize the following people to receive my Personal Health Information (test results, prescription information, appointment information, specialist appointments, diagnostic testing, treatment plan, hospital care, etc.): This authorization will remain in effect from today until I request in writing that it be amended.

NAME _____ RELATIONSHIP _____ PHONE_____

EMAIL: _____

NAME _____ RELATIONSHIP _____ PHONE_____

EMAIL: _____

NAME _____ RELATIONSHIP _____ PHONE_____

EMAIL: _____

_____ _____

Signature of Patient or Guardian Date

_____

PRINT Name of Patient or Guardian

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. The **Bill for Chantilly Pediatrics will appear as Chantilly Family Medicine** on your Insurance Explanation of Benefits (EOB) statement, as Chantilly Pediatrics is a company registered under Chantilly Family Medicine LLC.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time i.e. 24 hours prior to your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. DBA (Doing Business As). Our office also operates under the names of Aldie Family Medicine, Stonesprings Pediatrics and Chantilly Pediatrics. Though you make an appointment at one of these, your insurance EOBs and SuperBill might show the name as Chantilly Family Medicine or the Physician's name.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Please sign below signifying that you have read and understand the above payment policy and that this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical, to the above insurance carrier when a written request has been received by Chantilly Pediatrics/ Chantilly Family Medicine LLC. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer or employer.

_____ _____

Signature of patient or responsible party **Date**