Town Pediatrics, PC

Patricia F. Rappaport, MD, FAAP
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PATIENT RESPONSIBILITIES

1. Notify us of any changes in your address or insurance information at the time of the change.
2. All appointments must be scheduled in advance. **NO WALK-IN'S ARE AVAILABLE (except for the Monday morning walk-in clinic).** If you need to cancel or reschedule an appointment, please call 24 hours before your scheduled appointment. There will be a $50.00 fee for all missed or cancelled physicals, and $25.00 for all missed or cancelled office visits without 24-hour notice.
3. Co-payments and all overdue bills must be paid at the time services are rendered. We do not send bills for less than $20, therefore, you will be asked for those balances at future visits.
4. Notify us forty-eight hours or more before referrals are needed. If your insurance requires a prior authorization for services or medications, notify us three or more business days in advance. We will not back date any referrals and we will not fax or mail any referrals. You must **pick the referral up from the front desk. If your insurance company requires you to have a referral and you do not, you are responsible for that bill.**
5. Your doctor may order tests that are medically necessary. It is **your** responsibility to contact your insurance company to determine the facility/lab you can use and to notify our staff.
6. Pay your bill promptly, if there is financial hardship, please call the billing office at (703) 777-5222 option 5, to arrange a payment plan. There is a $50 fee on all returned checks. Please resolve billing issues before your next appointment.
7. There is a fee for copying medical records. We charge a processing fee of $10.00 and .50 per page, not to exceed $25.00 per patient. Medical records can take up to 10 business days to be processed so please allow enough notice to ensure you receive them before the time they are needed. Medical records are to be picked up at our office unless you are already out of state by the time they are ready. We will not fax any medical records. Postage and handling will be charged for mailing medical records.
8. Unless otherwise stipulated by your physician, please wait 5 days after a test is performed to call us for your results. This ensures that final results are available in the office. Your doctor may ask you to schedule a follow-up appointment to discuss test results. You will **not** be notified of any negative strep tests or **normal** routine urinalysis, lead levels or cholesterol results from checkups.
9. When requesting a prescription refill, please call your pharmacy so they can fax a refill request to us. We require 3 business days, not including Saturday or Sunday, from the time of your request to process your refill. Please make sure you return for follow-up appointments in the time frame stipulated by your physician. For proper medication monitoring, prescriptions for narcotic and stimulant medications are not mailed and must be picked up at the front desk during regular business hours but not during our lunch hour which is 12:30-1:30. You can speak with the physician writing your prescription if alternative arrangements need to be made and the physician will be responsible to carry out the alternative plan. Any alternative arrangements will be made on a case by case basis by the physician writing your prescription.
10. We will only provide written prescriptions for you to mail to the mail-order pharmacies. We do not call in or mail these prescriptions. We can fax a prescription to a mail order pharmacy only if you provide us all the contact information and any required cover sheet.

I have read and understand the responsibilities:

Patient Signature _____ Date _____

Thank you for your cooperation and understanding.

Town Pediatrics, P.C.

Assignment and Release & Financial Agreement

ASSIGNMENT AND RELEASE

I, the undersigned, certify that the information I have provided is correct and do hearby authorize Town Pediatrics, PC and/or it's physicians (hereafter referred to as Town Pediatrics, PC) to apply for benefits from my insurance company to Town Pediatrics, PC. I permit a copy of this authorization to be used in place of the original on all insurance claim submissions, whether manual, electronic, or telephonic.

I further authorize Town Pediatrics, PC to release any and all of my children's medical records and/or other records and information: (1) needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Town Pediatrics, PC, and (2) to any hospital, lab, doctor, or other healthcare provider to release their medical records of my child/children/self to Town Pediatrics, PC.

_____Date Signature of Insured / Parent / Guardian / Patient

FINANCIAL AGREEMENT I agree to pay the co- payment at the time of treatment, unless other arrangements are made. If co-payment is not received at time of service, I understand that my account will be charged an additional $15 out of pocket service fee. This fee will be waived for accounts where payment is received within 7 days of the date of service. I further agree that I (parent/guardian/self) am responsible for all fees and services rendered for treatment of my child/children/self. As a courtesy, Town Pediatrics, PC will file claims for most major insurance carriers. Town Pediatrics, PC will not file claims to a secondary insurance company. I (parent/guardian/self) agree to verify with the insurance company that Town Pediatrics, PC is a participating provider. I agree to adhere to the 30 day insurance policy of Town Pediatrics, PC. I understand that it is my responsibility to provide current insurance information within 30 days of the date of service. If I fail to do so, I will be responsible for the charges in full and Town Pediatrics, PC will not file the claim to the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and their insurance carrier. Should any balances arise due to insurance copayments, co-insurance, deductibles, termination of coverage, non-selection of a primary care physician or not adding a dependent to insurance plan, non-payment at the time of service and / or any other reason I agree to promptly pay all charges. I agree that if for any reason my check is returned that I will be responsible for a $50.00 fee in addition to the amount of the claim. If the balance is not paid and / or timely payments of this account are not made, I authorize Town Pediatrics, PC to retain the services of an attorney and / or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility. This agreement is made this day in the County of Loudoun and shall be governed by the laws of the Commonwealth of Virginia.

_____Date Signature of Insured / Parent / Guardian / Patient

Understanding My Bill and Co-Pays

- No co-pays are required for most preventive care services (or care provided to Medicaid-enrolled children.)
- Many times parents have extra concerns about their child's health or behavior that requires extra time and is not part of a routine preventive care visit.
- For the convenience of children and families, and when schedules permit, we try to address these added problems as part of your child's "check up" visit.
- In this situation, as per guidelines developed by the AMA and American Academy of Pediatrics, we will bill for the added office visit time.
- Several insurance companies are now asking that we collect a co-pay from families when we address these extra problems in addition to the check-up visit. For some families these additional services will be subject to your plan deductible.
- if more convenient, we can also schedule a separate appointment to address these additional health concerns.
- Our goal is to deliver the very best care to your child and family-comprehensive, convenient and fairly priced.
- If you ever have any questions about your bill, please feel free to speak with our billing team or Office Manager. Your pediatrician is always available to answer questions about your child's care, health, diagnosis and bill.

Patient Name(s):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

_____
Parent/Guardian Signature

_____
Date

Town Pediatrics, PC
823 S. King St., Ste F
Leesburg, VA 20175

TELEPHONE CARE BILLING

Date:_____

Patient Names: _____, _____, _____

_____, _____, _____

Town Pediatrics, PC is committed to providing our patients and families access to quality medical care every hour of the day. Giving you the option of telephone care is just one of the ways that we meet this commitment. In the past we have provided telephone care free of charge to manage immediate medical needs, adjust medications, address chronic illness or assist you with questions about your child's normal growth, development and behavioral concerns. Telephone care involves physician time, expertise and documentation of the medical care delivered and it is now recognized as a medical encounter. The American Medical Association (AMA) and the American Academy of Pediatrics (AAP) agree that when telephone care takes the place of a face-to-face visit it is a billable service comparable to any other medical encounter.

As of March 1, 2013 Town Pediatrics, PC will bill your health plan for the following types of telephone calls between you and a physician:

1. Provide after hours care management for illness or injury that you have determined requires a call to the doctor
2. Provide follow-up care and management of a chronic illness or exacerbation of a chronic illness that may not require an office visit at the doctor's discretion
3. Provide care management and coordination that is beyond the ability of our telephone nurse

The typical telephone care fee is $15, however, depending on the complexity of the problem, medical decision making needed, the treatment/advice provided, and the time on the telephone the fee could be up to $25. You may be responsible for all or part of this fee, depending on your individual health plan coverage. We encourage you to contact your health plan to determine their coverage for telephone care.

We hope you appreciate the convenience of telephone care and the professional expertise required to safely deliver this care. We look forward to continuing our relationship with you and your family.

I understand that if my insurance plan does not pay for the telephone care charges I will be financially responsible.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to patient

Town Pediatrics is contracted with the following Insurance Payors:

Anthem Blue Cross Blue Shield(PPO)
Anthem Healthkeepers (HMO)
Anthem Healthkeepers Plus(MCO)
Anthem Federal Employee Plans
Aetna (all plans)
Assurant Health
Acordia
Allegeant (formerly LBA)
Association Benefit Plan
BlueCrossBlueShield PPO
Carefirst (all plans)
Celtic Individual Healthcare
Cigna PPO POS HMO
Cigna Healthcare Beechstreet
Cigna-Greatwest Healthcare
Cigna NALC
Combined Government Health Plan
Compass Rose Health Plan
Coventry Health
GuardianPHCS
GEHA
GHP-CMR
Group Benefit Services
Golden Rule
Harvard Pilgrim Healthcare
HealthEZ
Health Net Federal Services-Tricare
Humana
InforMed
Kaiser Permanente PPO only
Mail Handlers Benefit Plan
MedSense Guaranteed Plan
MediShare
Mega Life and Health
Meritain Health
Mountain State BCBS
MVP Healthcare
OneNet
Oxford
PHCS
PHCS Loomis
Preferred Healthcare
Southern Health Services
The Hartford
UMR
UHC Integrated Services
United Healthcare PPO POS
UHC-Optima Health MDIPA
(established patients only)
United Medical Resources
Virginia DMAS-Medicaid
Wells Fargo 3rd Party Admin

We are out of network with:

Kaiser Pemanente HMO
Out of State Medicaid Plans

You are required to provide our office with a copy of your current insurance card within 30 days of your initial visit. After 30 days all charges incurred will be the responsibility of the guarantor for the patient. Our billing office will be glad to answer any of your questions concerning your insurance.

Patient Name:_____ **DOB:**_____

Parent/Guardian:_____

Signature:_____ **Date:**_____

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ATTENTION MEDICAID APPLICANTS:

As a courtesy we will see your child while your application is pending approval by the Department of Medical Assistance Services. You must provide your child's Medicaid identification number within 30 days of their initial visit in our office. Should you fail to provide the information in a timely manner, all charges incurred at our office will be the responsibility of the parent/guardian. The charges will be due in full 30 days from the initial visit.

The Department of Medical Assistance Services, upon approval of your application will provide your child with a Medicaid policy. They will often then transition that policy to a Managed Care Organization. Once that occurs, you are required to provide the updated Managed Care policy information to our office as soon as the transition occurs. We can only treat patients who are enrolled in a Medicaid plan or an Anthem Healthkeepers Plus managed care plan. Parents may designate which Managed Care Organization their child is enrolled in by contacting their social worker.

Participating Networks:
Medicaid/FAMIS
Anthem Healthkeepers Plus

If your child is enrolled in any of the following plans at the time of the visit the parent/guardian will be responsible for paying for all charges incurred on that date of service.
Out of Network (MCO):
InTotal
CareNet
Majesticare
Optima
VA Premier

Patient Name_____**DOB**_____

Parent/Guardian_____

Signature_____**Date**_____

823-F South King Street • Leesburg, Virginia 20175 • Phone: (703) 777-5222 • Fax: (703) 777-5144

TOWN PEDIATRICS, PC

CONSENT for LEAVING MESSAGES

CONSENT to LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

Patient Name(s):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

I understand that my healthcare information at Town Pediatrics, PC is protected and I have received a copy of a Notice of Privacy Practices.

I further understand that, in order for Town Pediatrics, PC to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Town Pediatrics, PC to do so.

Consent for Leaving Messages

I consent to information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminders/instructions be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded. ☐ **Yes** ☐**No**

Consent for Shared Information with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my healthcare providers and their representatives at Town Pediatrics, PC to verbally discuss my or my child's care using their best judgment, and grant them permission to disclose health information that is relevant to my or my child's care or relevant for payment. ☐ **Yes** ☐**No**

Under the HIPPA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your or your child's best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Records form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check boxes in order for my provider or his/her designee to discuss any "sensitive" information with the listed family member or friend.

☐ Mental Health/Psychiatric Disorders (including depression)
☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
☐ Pregnancy information
☐ HIV/AIDS Virus
☐ Sexually Transmitted Disease

NAME	RELATIONSHIP & Phone Number
1_____	_____
2_____	_____
3_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent I must provide written notice to the staff at Town Pediatrics, PC.

_____

Patient/Parent/Guardian Signature Date

Town Pediatrics, PC
Patient Portal Consent Form

Patient Name: _____
Patient Name: _____
Patient Name: _____
Patient Name: _____

Town Pediatrics, PC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

☐Please register me for portal using the following email address: _____

☐I choose not to enroll at this time.

_____ _____
Patient/Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIIPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name_____

Relation to Patient_____

Signature _____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____Initials_____Reason_____

Children's IQ Network®

The **Children's IQ Network®** serves the children of the metropolitan Washington area through the electronic exchange of critical healthcare information. The **Children's IQ Network®** interconnects the Children's National Medical Center hospital, emergency department, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories. Health data pertaining to you or your child are shared between important health care providers within the **Children's IQ Network®** to ensure that accurate and complete information is available for quality health care decisions.

Pediatric care providers will be able to easily find important health information including your visit histories, allergies, medications, health problem summaries, physician notes, vaccine information and x-ray results from the **Children's IQ Network®** Having this information readily available will make your care safer, more efficient and less costly.

Pediatric providers in the **Children's IQ Network®** will be providing care for you through the use of a computerized electronic medical record (EMR). Whenever and wherever you visit your doctor, the EMR will be used to enter information about your health conditions, allergies, test results, treatments, etc. Once the information is entered into the EMR, it will flow into a secure, confidential and private regional health record known as the Continuity of Care record. From that point on, every time you see another care provider within the **Children's IQ Network®**, your health care information will be available to ensure ideal care delivery.

Through participation in the **Children's IQ Network®**, you can be assured that important information will be available to your pediatric care provider when it is most needed. Here are some examples where this could prove to be very important:

You are visiting a new physician but cannot remember details regarding a recent hospitalization or home medications. The physician can easily access your record to determine this information and avoid unnecessary test ordering or duplicate medication prescriptions while at the same time benefitting from previous diagnoses and test result information.

You are taken to an Emergency Room. Your injuries or condition may be such that you cannot communicate with the doctors and nurses taking care of you. The **Children's IQ Network®**, contains important medical information that can be quickly retrieved to find out what medications you are on, what you are allergic to, important contact information and other essential information.

Your physician is going to see you today for follow-up after your recent hospitalization. The doctor has no information on your hospital visit and wants to find out more. The doctor can go to the **Children's IQ Network®** and obtain good information to help him quickly understand what needs to be done when you are seen.

Your health care information in the **Children's IQ Network®** is protected in a highly secure data center with state-of-the-art monitoring and 24 hour each day security. The data is encrypted (encoded) and can be accessed only by health care providers who are caring for you and have a need to know.

Your health information will automatically be included in the **Children's IQ Network®** however you do have the option to opt out (not share) your information. If you choose to opt out, only your primary care provider will be able to see your health information. Your health care information will not be shared with other care providers in the **Children's IQ Network®**

For additional information regarding the **Children's IQ Network®**, please contact your health care provider.**See back of this sheet to opt out of sharing your health record with Children's Network.**

Children's National Medical Center®

Children's IQ Network®

CIQN Opt In/Out Form

Patient Name: _____ **Patient DOB:** _____
Patient Name: _____ **Patient DOB:** _____
Patient Name: _____ **Patient DOB:** _____
Patient Name: _____ **Patient DOB:** _____

Please make a selection in one of the check boxes below:

☐CIQN Opt In

- I understand that all of my health care information collected by my health care provider will be submitted to the **Children's IQ Network®**, it will be able to be seen by or shared with other health care providers within the **Children's IQ Network®**.
- I understand that my health care information will continue to be available to my primary health care provider as this information makes up my personal medical record.
- I further understand that I will be permitted to change my decision and not allow sharing with other health care providers at any time in the future.

☐CIQN Opt Out:

I hereby request to **not** have my health care information shared with other health care providers within the **Children's IQ Network®**.

- I understand that all of my health care information collected by my health care provider will continue to be submitted to the **Children's IQ Network®** however, it will no longer be able to be seen by or shared with other health care providers within the **Children's IQ Network®**.
- I understand that my health care information will continue to be available to my primary health care provider as this information makes up my personal medical record.
- I further understand that I will be permitted to change my decision and allow sharing with other health care providers at any time in the future.

Patient or Guardian Signature: _____

Relationship of Guardian to Patient: _____

Date: _____

Individual Receiving this Form: _____