Patient Name: _____

Patient Date of Birth: _____

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at All About Children Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

All About Children Pediatrics is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to All About Children Pediatrics. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with All About Children Pediatrics to get payment for my care. This includes clearing up any disputes about charges. If I am eligible for payment from more than one type of coverage, All About Children Pediatrics will return any extra payments to the payor. If I have an unpaid bill at All About Children Pediatrics, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from All About Children.

Release of Information for Treatment, Payment and Health Care Operations

I consent to and authorize All About Children Pediatrics to use and disclose my protected health information for **treatment**, **payment** and **healthcare operation purposes**, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to consultants who are being advised or consulted in connection with my treatment, insurance companies, health plans, e-prescribing services, record locator services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to All About Children Pediatrics and/or a clinically integrated network or accountable care organization in which All About Children Pediatrics participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within All About Children Pediatrics. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or All About Children's Privacy Officer.

Other Third Party Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to the recommended medical care for my child (e.g., grandparent, daycare provider, etc.):

Name:	**Relationship to child:**
1. _____	_____
2. _____	_____

Mobile Phone Consent

Yes, All About Children Pediatrics may call my provided mobile phone number about the care, treatment, services and accounts using pre-recorded messages, automatic telephone dialing systems and/or text messages. Standard text message and minute usage rates may apply. I am aware information in a voice or text message may not be secure and that providing this consent is not a condition of receiving treatment.

Consent to Photograph/Video (print/social media, etc.)

I consent to the taking of photographs/video for any and all promotional activities related to All About Children Pediatrics.
(Check here only if refusing to consent) _____

My signature below means I have read this information and understand it. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Print Patient/Parent/Guardian Name:_____ **Date:**_____

Patient/Parent/Guardian Signature:_____

Relationship to Patient:_____ **Name of Interpreter (if used):**_____

Email Address for Notifications:_____

All About Children Pediatrics

Patient Registration/Information Form

Please complete the entire form with current accurate information

*List **ALL** children dzyŘŜ ŭKŜ I·ƎŜ 2₮ my Patients 18 and older need to fill out their own form.*

Child (patient) 1

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) 2

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) 3

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child's/Children's Primary Home Address (*circle who they live with*) **If you circle one of the below, please write their address on the back of this form*

Both Parents ☐ *Mom* ☐ *Dad* ☐ *Grandparent* ☐ *Sibling* ☐ *Legal Guardian* ☐

Parent Information

Mother's Full Legal Name:	**Father's Full Legal Name:**
Address:	**Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Birthdate: **SS #**	**Birthdate:** **SS #**
Home Phone: (612) **Cell Phone:** (612)	**Home Phone:** (612) **Cell Phone:** (612)
Employer:	**Employer:**
Email Address for Portal Access:	**Patient Portal:** Sign us up for Portal Access (email address is required): **Yes** ☐ **No** ☐

Parent's Marital Status (circle)

Married ☐ *Widowed* ☐ *Divorced* ☐ *Not Married* ☐ *Legally Separated* ☐ *Partner* ☐ *Other(state)* ☐

Billing Information (Please be prepared to present your insurance card – Co-pays are due at the time of service)

Name of Person Responsible For Account Bills:

Primary Insurance Name:	**Policy Holder:**	**Effective Date:**
Secondary Insurance Name:	**Policy Holder:**	**Effective Date:**

Emergency Contact – ***Other than Parent***

Contact:	**Relationship to child/children:**
Home Phone:	**Cell Phone:**

Parent/Legal Guardian Signature:_____ **Date:**_____

Printed Name of Signer:_____ **Relationship to Child:**_____

All About Children Pediatrics

Patient Registration/Information Form (page 2)

*** Please list your additional Children below ***

Child (patient) **4**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **5**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **6**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **7**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **8**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

**** If you specified that the patient(s) live with a Grandparent, Sibling, or Legal Guardian, please write their address below:***

Relative/Guardian's Legal Name:	**Relative/Guardian's Legal Name:**
Address:	**Address (if different):**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Home Phone: **Cell Phone:** ( ) ( )	**Home Phone (if different):** **Cell Phone:** ( ) ( )

FAMILY HISTORY FORM

Family Last Name _____

Child's Legal Name:	Birth Date:	Child's Legal Name:	Birth Date:
1._____	_____	3._____	_____
2._____	_____	4._____	_____

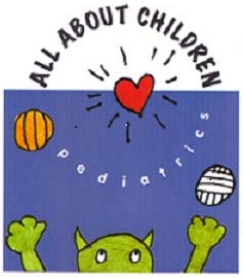
Please answer the following in regards to your child's/children's family history.
Fill out a separate form for children who are adopted or have a different biological parent.

Immediate family member has or has had the following illness/condition:

				Siblings		***Paternal***		***Maternal***	
ADD/ADHD	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Allergies (food)_____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Allergies (other) _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Anesthesia Reactions	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Anxiety	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Asthma	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Autism / Aspergers	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Bleeding Disorders (Hemophilia)	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Breast	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Leukemia	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Other _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Congenital Heart Disease	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Depression	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Diabetes	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Drug/Substance Abuse	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Eating Disorder (type) _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Factor V Leiden Deficiency	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Heart Attack	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
High Blood Pressure	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
High Cholesterol	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Kidney Stones	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Overweight	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Rheumatoid Arthritis	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Seizures/Epilepsy	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Stroke/Cerebrovascular Accident	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Sudden Cardiac Death	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Sudden Infant Death Syndrome (SIDS)	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Thyroid Disease	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Ureteral/Kidney Reflux	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Other _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM

Parent Signature _____ **Date** _____

*We will ask you to update this information at your child's yearly wellness check-ups.
***B = Brother S = Sister GF = Grandfather GM = Grandmother**



Billing Policy

We strive to serve our patients efficiently and effectively. In order to do so, we request that each patient do their part to help us by following the policies outlined below regarding insurance and payment.

It is the patient's responsibility to:

- Know your insurance plan. Bring your insurance card to each visit.
- Know what's covered by your insurance plan. Not all insurance contracts are the same. It is your responsibility to be aware of your insurance company's provision of payment for all visits. This includes all office visits, well-child exams, sports physicals, labs and immunizations.
- You are responsible to make co-pays at the time of your visit. All other patient responsibilities for deductible, coinsurance and non-covered services are expected no later than 30 days from the receipt of your statement. If you need to make alternate payment arrangements, please call our billing department promptly at 952-943-0027. Unpaid balances may be subject to collections.
- If your insurance requires a primary care plan, please choose "All About Children Pediatrics" as your primary care physician.
- Please advise the front desk staff of any changes to insurance coverage, home address, and telephone numbers at the time of check in.
- Notify your insurance company and/or your employer's Human Resources Department about the birth of any new baby within **30 days of their birth.**
- All About Children Pediatrics expects the parents to work out payment arrangements with each other. We will not get involved in any disputes that arise between the parents regarding responsibility for payments.

All About Children Pediatrics

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you and/or your child, as a *patient* of this practice, may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Our practice is dedicated to maintaining the privacy of your and/or your child's health information. If you feel that your medical information privacy rights have been violated, please contact our Privacy Officer, Dr. Erika Malvey-Dorn, at (952) 943-8200.

All About Children Pediatrics, P.A.
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www.allaboutchildren.net

Effective September 23, 2013