AMERICAN KIDS CARE, PC

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CHILD/CHILDREN INFORMATION: *New Patient* ☐

	First Name	M.I	Last Name	Sex:	DOB:	SSN/Ins ID:
1						
2						
3						
4						
5						
6						

PARENT(S)/ LEGAL GUARDIAN INFRMATION: *Please provide a valid I.D. for office copy*

MOTHER'S NAME: _____ DOB: _____ SSN: _____

Home #: _____ Cell #: _____ Work #:_____

Occupation/Employer: _____

FATHER'S NAME: _____ DOB: _____ SSN: _____

Home #: _____ Cell #: _____ Work #:_____

Occupation/Employer: _____

Home Address: _____City: _____State, Zip: _____

(Required) **Ethnicity :** Hispanic / Non-Hispanic / Refused to Report **Race:** African American / White / Hispanic / Asian / Others

Email : _____ **Language:** _____

INSURANCE INFORMATION: *Please provide the insurance card for the official record*

Insurance Name: _____ Policy #: _____ Group # :_____

Subscriber's Name: _____ Subscriber ID: _____ Secondary/Other Insurances: *If Yes* ☐ *pls. provide info*

TREATMENT AUTHORIZATION

Authorization is hereby granted for my child/children to have examinations, immunizations, or routine screening procedures as recommended by the providers at **American Kids Care.** The authorization shall be continuous unless revoked by your office, the parents or guardian. I also authorize **American Kids Care** to initiate any medical treatment required in an emergency situation.

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical/surgical benefits to **American Kids Care** for services rendered by them in person or under their supervision I further Authorize **American Kids Care** to release my medical or incidental information that may be necessary for processing of medical claims or applications for financial benefits. A photocopy of this assignment shall be valid as the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

PAYMENT POLICY

I understand and agree that, (regardless of my insurance status): I am ultimately and financially responsible for the balance of my child's/children's account for all professional services rendered including services not covered by my insurance company.

I have read all of the information and certify that the information provided by me to **American Kids Care** is true and current to the best of my knowledge. I will notify this office of any changes in child's/children's health status or the above information.

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

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT.

This disclosure contains information regarding the privacy of healthcare information. Please read it carefully before signing. **American Kids Care** will **NOT** continue treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge and agree that **American Kids Care** may use or disclose my medical information for the purpose of my treatment, obtaining payment for services rendered and healthcare operations. I am aware that **American Kids Care** may disclose my medical information to a Business Associate for the same reasons, and the Business Associate will be bound by all appropriate legal restrictions.

Further, by signing this document, I acknowledge that I have been provided and read a copy of the Notice of Privacy Practices containing a complete description of my rights and the permitted uses and disclosures under **The Health Insurance Portability and Accountability Act (HIPAA) of 1996.**

The Federal Government now restricts this office from discussing your health information and condition with other family members and persons unless you specifically give your written permission. By my signature below, I grant **American Kids Care** permission to discuss my child/children's protected medical information with the following individuals:

Name	Relationship	Address and Phone

Acknowledge and agreed by:

Name Parent/Guardian/Patient 18 or older :

Signature: **Date:**

AMERICAN KIDS CARE, PC

Single Consent to Share Medical Information with Children's IQ Network Providers
CHILDREN'S NATIONAL MEDICAL CENTER, WASHINGTON DC

INTRODUCTION

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, AMERICAN KIDS CARE, PC has elected to participate in the Children's National Health System's IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child's health care provider and one of the country's leading children's hospitals.

This SINGLE CONSENT will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child's healthcare information is encrypted (encoded) **and can be accessed only by health care providers who are caring for you or your child and have a need to know**.

As AMERICAN KIDS CARE, PC is a part of the Children's IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child's treatment. You do have the option to opt out of the Children's IQ Network. If you choose to opt out, you will need to sign a separate consent form each and every time you or your child need to be seen by another member of the Children's IQ Network other than those at AMERICAN KIDS CARE, PC.

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PATIENT RIGHTS: I have received a copy of the **Children's IQ Network** (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN.

PROTECTED DISCLOSURE OF INFORMATION: I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child's treatment as defined in the Notice of Privacy Practices. I agree to Children's National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

Patient Name **Date of Birth**

Patient Name **Date of Birth**

Patient Name **Date of Birth**

Patient Name **Date of Birth**

Signature of Parent/Legal Guardian/Patient 18 yrs of age or older **Date**