

OLYMPIA PEDIATRICS, PLLC
3434 12th Ave NE
Olympia, WA 98506
(360) 413-8470

Welcome to Olympia Pediatrics

Thank you for choosing our clinic for your child's healthcare. Olympia Pediatrics is dedicated to providing quality medical care for children. We want to work with you to assure your child's well being.

As you are aware, the business of providing healthcare is increasingly complex. For our office to operate effectively and provide the best service to you and your child, we need your cooperation with the following policies. Your clear understanding of these policies is important. Please let us know if you have any questions.

FEES AND PAYMENTS

Payment is due at the time services are provided. Co-pays will be collected at the time you check in for an appointment. There is a \$25 charge if the co-pay is not paid the day of the appointment. We accept cash, check, Visa and MasterCard. Proof of current insurance coverage is required at the check in for every visit. Those paying at the time of service or those without proof of coverage will be required to make a payment of \$50 before the visit. You may be asked to reschedule your appointment if the co-pay or \$50 is not provided. After the visit the total charge will be determined and the balance minus the \$50 is expected. A 15% discount will be given for the current charge if the account is paid in full. All balances not paid after 60 days will accrue a 1 % per month rebilling fee. Balances over 120 days due may be sent to a collection agency unless other arrangements for payment are made with our office. All accounts sent to collections will be asked to seek medical care for their children elsewhere. A fee of \$25 will be charged to any account with a check returned unpaid by the bank.

INSURANCE AND INSURANCE FORMS

If you intend to pay your bill through your medical insurance we will be happy to assist you. Billing your insurance does not guarantee payment by the insurance company nor does it release the patient/parent from their financial obligation to our office for any unpaid balance. To ensure the billing process is timely and complete it is essential that you provide all the necessary information about the insurance, both primary and secondary, that covers your child's health care. Since changes of insurance coverage are more frequent, it is our policy to obtain a copy of your cards for all applicable insurances at each visit. To communicate with the insurance company and be paid on your behalf, a Release of Information/Assignment of Benefits needs to be signed by the parent at each visit. If we are unable to verify your insurance coverage you may be asked to reschedule or make a \$50 payment toward the visit.

MOTOR VEHICLE ACCIDENTS

We are not able to bill motor vehicle insurance. If we are contracted with your health insurance, we are required to bill them. If we are not contracted with your health insurance you will be required to pay for your visit and seek reimbursement from them directly.

PATIENT PRESENTING WITHOUT PARENTS

We require a signed consent form by a parent or legal guardian to legally provide medical care to any child who is seen by one of our physicians when the parent or legal guardian cannot be present. A "Consent for Care" form is available if you need one. If a friend, relative or day care provider brings your child to our office for care they must provide a signed consent, all required insurance information, payment for any co-pay or charges due, and a phone number where a parent can be reached. This policy also applies to teenage patients, less than 18 years of age, presenting for care.

WALK-INS

The needs of every sick child are urgent. We make every effort to provide prompt medical care to all our patients. If you are a walk-in patient please understand that there are patients that have scheduled appointments. Every attempt to work your child into the schedule will be made. However, as we try to work your child into the schedule you may be asked to wait until we can fit you in depending on the severity of the child's illness or injury.

FAILURE TO KEEP AN APPOINTMENT, CANCELLATIONS AND LATE APPOINTMENT ARRIVALS

If you are unable to keep a scheduled appointment please let us know at least 24 hours in advance, for same day cancellations we require a minimum of 1 hour notification. Your child may receive more immediate care because of another parent's considerate cancellation. If we do not receive a notice of cancellation as noted above, a \$25 fee will be charged to your account. This fee must be paid within 30 days from the date of service. Families who fail to keep three appointments without prior notification will be asked to find their medical care elsewhere. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Delays of more than 10 minutes may require the visit to be rescheduled.

SUPERVISION OF CHILDREN

We have made an effort to create an office that appeals to children. While we welcome their enjoyment, for safety reasons we depend on the parent to properly supervise their children at all times. Please do not allow excessively loud or aggressive play. Our office staff cannot watch your children. Under no circumstances should a child be left unattended in the waiting area or exam rooms. Children should remove their shoes to play on or in the log. Jumping from the log and standing on the chairs are not permitted. Please do not tap on the fish tank or place any object within it. The children are welcome to play with the toys or read the children's books within the exam rooms. Please do not let them handle the medical equipment, take supplies from the storage areas or remove the information brochures. Help us make the toys and books last for the enjoyment of our many patients by treating them like your own. Pets are not allowed at any time. Repeated failure to properly supervise your children will result in being asked to find your medical care elsewhere.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service the health care needs of children often do not lend themselves to an exact schedule. Delays happen. We appreciate your understanding and patience. If you have a complaint or suggestion for our office, please ask to speak to our office manager. Treating our staff and physicians with respect is required. Angry or foul language is not tolerated and will be grounds for immediate dismissal from our practice.

WAITING PERIODS

Due to the risk of anaphylactic reaction, a waiting period of 30 minutes is required for any patient receiving any allergy shot or certain medication injections within our office. This waiting period is for your child's safety. The wait can be completed in the waiting area if preferred. The parent must be with the child at all times. The child cannot leave the office, even momentarily, during the waiting period. The parent must immediately alert our staff if the child's condition changes in any way during the waiting period. Before leaving, the child must be checked by the nurse at the end of the waiting period.

MEDICAL RECORDS

All patients' medical records are strictly confidential. A medical release form, signed by the patient/parent (if the patient is over the age of 14, they must sign the medical release) is required for copies of medical records to be released. The Immunization record and growth chart are provided at no charge. The current fee for record copying is \$1.02 per page for the first 30 pages, \$.78 per page over 31 pages for search and handling charge, plus tax. Payment in advance and 48 hours notice is required.

- Fees are subject to change without notice.

OLYMPIA PEDIATRICS NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about our patients may be used and disclosed, and how this information may be accessed. Please review it carefully. Why? Because your legal rights and private information may be affected. Since our patients are minors, this notice is addressed to their parents or legal guardians who must sign on behalf of those minors.

Olympia Pediatrics respects our patients' privacy. We understand that our patients' personal health information is very sensitive. We will not disclose your information to others unless:

- You tell us to do so, or
- The law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, and health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Your Health Information Rights

The health and billing records we create and store are the property of Olympia Pediatrics. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive a copy of this Notice and ask questions about it.
- Ask us to restrict certain uses and disclosures. You must deliver this request to us in writing.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice");
- Request to see and to receive a copy of your protected health information. You must make this request in writing. We have a form available for this type of request. Payment is required prior to receiving your medical record.
- Gain access to your health information except within the exceptions granted by law.
- Ask us to change your health information. You must give us this request in writing. You may write a statement of disagreement if your request is denied. Your statement of disagreement will be stored in your medical record, and included with any further release of your records.
- A list of disclosures of your health information upon your request in writing. You may receive this information without charge once every 12 months. If you request this information more than once in 12 months, payment is required prior to receiving the list. This list will not include disclosures to third-party payers, such as motor vehicle insurance.
- Ask that your health information be given to you by another means or at another location. You must sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. You cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you a copy of this Notice;
- Designate a privacy officer;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may request the most recent copy of this Notice by telephone, mail or during an office visit.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.OlympiaPediatrics.com

Examples of Uses and Disclosures of Protected Health Information for Treatment, Payment, and in the course of Health Care Business

For Treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans require information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care business:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or to arrange for services, including but not limited to:
 - Medical quality review by our health plan;
 - Accounting, legal, risk management, and insurance services;
 - Audit functions, including fraud and abuse detection, and compliance programs.

Disclosures and Uses of Protected Health Information Not Considered In The Course of Treatment

Notification of Family and Others

- We may release health information about you to a family member who is involved in your medical care if the law allows.

- We may also give information to someone who helps pay for your care.
- We may tell your family your condition or that you're in a hospital.
- We may disclose health information about you to assist in disaster relief efforts.

We may use and disclose your protected health information without your authorization as follows (this list may be periodically modified):

- **To Medical Researchers** if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** that obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
 - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public;
 - To public health or legal authorities
 - To protect public health and safety;
 - To prevent or control disease, injury or disability;
 - To report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities as required by law.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and for the health and safety of others.
- **For Law Enforcement Purposes, Judicial/Administrative Proceedings** when we receive a subpoena, court order, or other legal process, or if you are the victim of a crime.
- **For Health and Safety Oversight Activities** we may share health information with the Department of Health.
- **For Disaster Relief Purposes** we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **To Employers For Work-Related Conditions That Could Affect Employee Health**
- **To the Military Authorities of U.S. and Foreign Military Personnel** the law may require us to provide information necessary to a military mission.
- **For Specialized Government Functions** such as national security purposes.

For Assistance or For More Information

If you have questions, want more information, or want to report an issue regarding the handling of your protected health information, you may contact: *OLYMPIA PEDIATRICS PRIVACY OFFICER*

If you believe your privacy rights have been violated, you may:

- Discuss your concerns or deliver a written complaint to the designated Privacy Officer at Olympia Pediatrics;
- File a complaint with the U.S. Secretary of Health and Human Services.

Effective Date:

- **April 14, 2003**

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Policy Summary

Thank you for choosing our clinic for your child's healthcare. Olympia Pediatrics is dedicated to providing quality medical care for children. We want to work with you to assure your child's well being.

As you are aware, the business of providing healthcare is increasingly complex. For our office to operate effectively and provide the best service to you and your child, we need your cooperation with the following policies. Your clear understanding of these policies is important. Please let us know if you have any questions.

Below is a summary of our polices outlined on the attached pages. These policies have been written using insurance contractual requirements and Washington state law.

1. Payment is due at the time services are provided. You may be asked to reschedule your appointment if the co-pay or payment is not provided.
2. A fee of \$25 will be charged to any account with a check returned unpaid by the bank.
3. A copy of your insurance card/s is required at each visit.
4. We require a signed and dated consent form by a parent or legal guardian to legally provide medical care to any minor child unaccompanied by a parent or a guardian.
5. For cancellations please let us know at least 24 hours in advance. If you fail to contact our office a \$25 fee will be charged to your account. Arriving more than 10 minutes late may require the visit to be rescheduled.
6. Under no circumstances should a child be left unattended in the waiting area or exam rooms.
7. Angry or foul language directed at our staff is not tolerated and will be grounds for immediate dismissal from our practice.
8. Due to the risk of anaphylactic reaction (severe allergic reaction), a waiting period of 30 minutes is required for any patient receiving any allergy shot or certain medication injections in our office.
9. All patients' medical records are strictly confidential. A medical release form, signed by the patient/ parent/legal guardian (if the patient is over the age of 14, he/she must sign the medical release) is required for copies of medical records to be released. The immunization records & growth charts are provided at no charge. The current fee for record copying is \$1.02 for the first 30 pages, plus \$.78 per page for 31 or more pages, plus tax. Payment in advance and 48 hours notice is required.

My signature on this form acknowledges that I have read and understand the policies stated above. I have had the opportunity to ask questions. By not adhering to these policies I may be asked to leave Olympia Pediatrics. I have received a copy of the policies.

Signature of Parent/Guardian

Date

PATIENT NAMES(S) _____

**OLYMPIA PEDIATRICS
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

Our **Notice of Privacy Practices** describes how the protected health information of our patients may be used and disclosed, and how that information can be accessed. If you have questions about this notice, want more information or want to see a record, contact the Olympia Pediatrics Privacy Officer. This form will be retained in the medical records of the patient(s) indicated below.

By my signature below I acknowledge receipt of the Notice of Privacy Practices given to me by a representative of Olympia Pediatrics.

Print Patient name(s)

Signature of parent or legal guardian

Indicate Relationship to minor child(ren)

Printed name of parent or legal guardian

Date

(Notation, if any, by Staff)

PARENTAL ADVANCE CONSENT TO TREAT MINORS

In the event that you are unable to accompany your child to their doctor's appointment, we are required to obtain parental consent prior to treating a child. When parents are not immediately available, this can take time, and delay treatment.

This is to certify that the person/s listed below has my permission to authorize necessary medical care for my child. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

Childs Name _____
First middle last Date of Birth

Other Children Covered under this authorization _____

Persons (**not Parent**) authorized to seek medical care for the above mentioned child

Parent/ Legal Guardians Name (*please print*) _____

Signature _____ Date _____

OLYMPIA PEDIATRICS, PLLC.

HEALTH QUESTIONNAIRE

Reviewed By _____

Date _____

Patient Name _____ Date of Birth _____

Dear Parent:

Please fill out this questionnaire to give us a more complete record of your child. Skip any questions you can't answer or that don't apply.

Thank You.

A. PREGNANCY & BIRTH

1. Any problems with the pregnancy, labor or delivery? Yes _____ No _____
2. Was the baby premature? Yes _____ No _____
If yes, how many weeks was the pregnancy? _____ Weeks
3. Birth weight _____ lbs. _____ oz
4. Was the baby breech? Yes _____ No _____
5. Did your baby have any medical problems while in the hospital as a newborn? Yes _____ No _____
Please explain _____

6. Did the baby stay in the hospital longer than the mother? Yes _____ No _____
If yes, why? _____

B. PAST MEDICAL HISTORY

1. Has your child ever been hospitalized? Yes _____ No _____
2. Any surgeries? Yes _____ No _____
If yes, describe _____

3. Any allergies to foods or medicines? Yes _____ No _____
If yes, please explain _____
4. Is your child currently on medicines? Yes _____ No _____
Is yes, please list _____

5. Any serious accidents, broken bones, stitches? Yes _____ No _____
If yes, please explain _____
6. Any chronic medical problems e.g. asthma, allergies, diabetes, seizures, cystic fibrosis, urinary tract infection, ear infections Yes _____ No _____
Please explain _____

C. IMMUNIZATIONS - If you have your child's immunization records, please give it to the nurse or receptionist.

1. Is your child behind on his or her immunizations? Yes _____ No _____
Please explain _____
2. Any previous reactions to immunizations? Yes _____ No _____
Please explain _____

D. FEEDING

1. Was the baby breast fed or bottle fed? _____
If breast fed, for how long? _____
2. Is your child still on a bottle? Yes _____ No _____

(Turn Over)

E. SOCIAL

- 1. Is your child in daycare? Yes _____ No _____
- 2. Does anyone in your home smoke? Yes _____ No _____
- 3. Do you live or visit regularly a house built before 1960 (including daycare)? Yes _____ No _____
- 4. Do you have pets at home? Yes _____ No _____
If so, what kind: _____
- 5. Do members of the household travel to foreign countries? Yes _____ No _____
If so, name the countries: _____
- 6. Who lives at home with your child? _____

F. DEVELOPMENT & GENERAL MANAGEMENT

- 1. Do you have any problems managing your child? Yes _____ No _____
- 2. Does your child have any difficulties in school? Yes _____ No _____
- 3. Is your child in a special class? Yes _____ No _____
- 4. What grade is your child in? _____
- 5. Have you been concerned with your child's development? Yes _____ No _____

G. FAMILY HISTORY

- 1. Does anyone in the family blood-related to your child (siblings, biologic parents of your child, grandparents, aunts, uncles, first cousin) have the following medical problems?
Please circle

- | | | |
|-----------------------------|----------------------------|---------------------|
| STROKES | ASTHMA | CANCER |
| SEIZURES | BEDWETTING | DIABETES |
| BIRTH DEFECT | TUBERCULOSIS | DEPRESSION |
| EARLY DEATHS | THYROID PROBLEMS | HIGH CHOLESTEROL |
| RHEUMATIC FEVER | OTHER HEART PROBLEMS | HAY FEVER/ALLERGIES |
| SUBSTANCE ABUSE | CHILDHOOD HIP PROBLEMS | HIGH BLOOD PRESSURE |
| HEART ATTACKS BEFORE AGE 50 | ATTENTION DEFICIT DISORDER | |

- 2. Does the child's mother have any health problems? Yes _____ No _____
If yes, explain _____
- 3. Does the child's father have any health problems? Yes _____ No _____
If yes, explain _____
- 4. Has either parent ever had any serious illness? Yes _____ No _____
If yes, explain _____
- 5. List ages, sex, and general health of your child's brothers and sisters:

How did you find out about our office? _____

THANK YOU

Date

Parent Signature

Date _____



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Patient Information:

Physician _____

Patients First Name	MI	Last Name	Date of Birth	SS #	M or F
Street/PO Box	City	State	Zip	Home Phone Number	

Other Children (to be seen as patients):

First Name	MI	Last Name	Date of Birth	SS #	M or F	Insurance	Physician
First Name	M I	Last Name	Date of Birth	SS #	M or F	Insurance	Physician
First Name	MI	Last Name	Date of Birth	SS #	M or F	Insurance	Physician
First Name	MI	Last Name	Date of Birth	SS #	M or F	Insurance	Physician

Parent or Guardian information:

(Living in same household as patient)

Relationship to Patient: _____

First Name	Middle Initial	Last Name	Date of Birth	Social Security #
Street/PO Box	City	State	Zip	
Home Phone Number	Work / Cell Phone Number	Employer Name & Address		

Is the above address the correct one for statement billing? Yes No

Parent or Guardian (other contact):

Relationship to Patient: _____

First Name	Middle Initial	Last Name	Date of Birth	Social Security #
Street/PO Box	City	State	Zip	
Home Phone Number	Work / Cell Phone Number	Employer Name & Address		

Is the above address the correct one for statement billing? Yes No

Continued on other side

Insurance Information:

Is Patient Covered by Medicaid or Healthy Options? YES NO
If patient is a newborn, have they been added to your insurance? YES NO

Primary Insurance _____
Insurance Name Subscribers Name Subscribers DOB
Subscribers ID# Group, Member or Claim# Effective Date Patients Physician

Subscribers relationship to Patient: Mother Father Self Other (explain)_____

Secondary Insurance

Insurance Name Subscribers Name Subscribers DOB
Subscribers ID# Group, Member or Claim # Effective Patients Physician

Subscribers relationship to Patient: Mother Father Self Other (explain)_____

Emergency Contact Information:

(Nearest relatives/friends outside of your household)

First Name Last Name Day Phone Eve Phone Relationship to Patient

The contact information will be in place until changed in writing by you.

How did you hear about our office? Friend Family member Physician Website Phone book

Who may we thank? _____

I, _____, the parent or legal guardian of my child, _____, authorize and consent to emergency and routine medical treatment and procedures to be performed for my child by licensed medical personnel when deemed necessary or advisable and I cannot be contacted. Regarding financial responsibility for this child/ren, he/she will remain on my account and I will be responsible for his/her medical bills regardless of changes in family situation, (i.e.; divorce, custody issues etc.) until he/she is 18 years of age. I also authorize the release of the minor's PHI (Private Health Information) for payment purposes. Authorization and financial responsibility shall continue and be in full force and effect until revoked in writing by me.

Signature _____ Date _____

I authorize **Olympia Pediatrics PLLC**, or my insurance company to release any PHI information required for processing any insurance claim(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by Olympia Pediatrics PLLC and that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that Olympia Pediatrics PLLC will submit claims to my insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect or that I was assigned to a Primary Care Physician (PCP) elsewhere. If being signed by a parent or guardian, I understand that these provisions apply to the patient named above.

Signature _____ Date _____

*****IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN BENEFITS*****

Updated:

Initials: _____ **Date:** _____ / **Initials:** _____ **Date:** _____ / **Initials:** _____ **Date:** _____