Initial Visit Documentation

CHILD'S INFORMATION

Childs Name: ___________________________ Gender: M / F Date of Birth: _____/______/__________

PARENT'S INFORMATION

Mother's First Name: ____________________________ Mother's Last Name: ___________________________________

Father's First Name: ____________________________ Father's Last Name: ___________________________________

Street Address: ____ Phone Number: ____________________________

Address Line 2: ____

City: _________________________ State: __________________________ ZIP: ______________________

Emergency Contact Name: ______________________________ Relation: ________________ Phone: Number: ___________________

TREATMENT AUTHORIZATION

Authorization is hereby granted for my child/children to have examinations, routine-screening procedures as recommended by OWC. This authorization shall be continuous unless revoked by you, parents or guardian, I also authorize OWC to initiate any medical treatment required in an emergency.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize The One World Center for Autism / One World Pediatrics, to directly receive payment of pertinent insurance benefits; to release information including protected health information to insurance companies and other related third parties as needed in relation to the filing for or collection of payment for provided services; to obtain records from other sources as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I acknowledge that I must give a 24-hour notice to cancel an appointment. If I do not call within 24 hours of my appointment, a $25.00 charge (not billable to my insurance) will be billed to my account (unless Medicaid). I understand that this fee must be paid before I reschedule any appointment.

I hereby acknowledge that I am personally responsible for all co-payment, deductibles, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I also agree that I am responsible for any collection and/or attorney fees. I agree that I am responsible to promptly alert The One World Center for Autism, should there be any changes related to insurance and other information I provided above. A photocopy of this assignment shall be valid as the original. I certify that the information I have provided is current and correct. Either my insurance carrier or I may revoke this authorization at any time in writing.

PAYMENT POLICY

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance of my child's/children's account for all professional services rendered. I have read all the information and certify that the information I have provided OWC is true and correct. I will notify this office of any changes in my child's/children's health status or the above information.

EDUCATIONAL RELEASE/EXCHANGE:

I Hereby give permission to The One World Center for Autism / One World Pediatrics to release information and/ or exchange information with the educational team for the mentioned school/educational placement stated below

Educational Placement (School): ____

School System:
- ☐ Prince George's County School System
- ☐ Montgomery County School System
- ☐ Anne Arundel County School System
- ☐ Other Private/Non-Public Educational Agency: _________________________

Signature of Parent/Guardian

Date

HIPAA NOTICE OF PRIVACY

The One World Center of Autism, Inc. (OWCA) / One World Pediatrics has implemented the following policies and procedures to ensure the confidentiality of your personal and/or medical information. Federal and state laws require us, to maintain the privacy of your health information.
Your provider(s) and all other employees working at OWC will keep any information related to you (medical and/or non-medical) in a confidential manner. However, so that we may provide you with appropriate medical care, for general practice operations and or for the purposes of obtaining payment, we will, at our discretion provide information pertaining to the treatment you received at OWC, the charges for this treatment and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms: US Postal Service, fax submission, Internet submission, voice mail and/or personal communications. The following is a list of the most common types of entities that we most typically would provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

- Physicians, non-physician providers that work outside of this practice.
- Other professionals providing support services related to your medical condition (i.e. community service/programs, health department services, educational services and nutritional counselors).
- Medical facilities (i.e. hospitals, outpatient centers).
- Laboratories for the purposes of running medical tests.
- Other health care providers, such as pharmacies, durable medical equipment suppliers, ambulance services.
- Insurance companies (or third-party administrators) for the purpose of obtaining payments, reviewing medical necessity and or general case management.
- State or Federal agencies that require the submission of specific health related information
- Billing services.

We may need to contact you, by phone, to discuss your appointments, test results, treatments, referrals, account balance and/or to return your phone call. We will first attempt to contact you at home, however if you are not available and you provide us with your work number, we will attempt to contact you at work. If you are not available, we will leave a message for you to either call the office for a specified reason (i.e. discuss test results, account balance) or we will remind you of your appointment time.

In the event you do not pay all your charges in full at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail recall cards to your home noting that you need to contact the office to schedule an appointment. Periodically, we may mail test result information to your home. We will use the home address you provided us with at the time you register with the practice.
We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirements. If necessary, for obtaining payment, we will provide credit bureaus and/or collection agencies with your account information.
When you arrive at our practice for your appointment, we will ask you to sign in and note your arrival time. We will do our very best to see you promptly. However, there may be times when your provider is running behind schedule and you will need to wait in the waiting room.
If you would like information sent to another physician or medical facility, you may be asked to authorize the release of this information, in writing (we will provide you with the necessary form to complete). Also, you must provide written authorization for the release of information to your life or disability insurer.
You may review and/or obtain a copy of your medical record. You may request, in writing, changes be made to your medical record. We will review your reason(s) for such a request and if we agree, will make the change(s). If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purposes other than treatment, payment and health care operations.
Please provide us with current phone numbers (work and home) and home billing address. This will allow us to make the correct contact when trying to reach you.
When necessary these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.
If you have any questions or concerns with the policies and/or procedures noted above, please contact our HPAA privacy officer at the above address and phone number to report any and all concerns. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. If you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for filing a complaint.

Signature of Parent/Guardian Date

PROVIDER/PATIENT AGREEMENT

I acknowledge that I have read and understand the items given to me that describe the rules set by The One World Center of Autism, Inc. (OWCA) / One World Pediatrics: Patient Responsibilities, Doctor's/Healthcare providers responsibilities, arrival time and late policy, walk ins, insurance and payments, cancellations/ closings, vaccines, refills, forms, letters, after hours, and other miscellaneous rules set forward.

Signature of Parent/Guardian Date

EMAIL CONSENT

I acknowledge that I have read and understand the items below which describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, the caregiver of the child/ youth identified above, authorize the staff and representatives of The One World Center for Autism, Inc. with organizational addresses (i.e.- staff or representative name @worldforautism.org) to communicate with me at my e-mail address. BY PROVIDING YOUR EMAIL YOU CONSENT TO EMAILS ENCRYPTED OR UNENCRYPTED

Email Address

☐ Encrypted ☐ Non-Encrypted