PEDIATRIC Gastroenterology of Richmond, PC

PATIENT INFORMATION

Child's Last Name__________ First__________ M.I._____

Nickname__________ Age _____ Date of Birth __________ Sex _____

Address__________ Apt #__________

City__________ State__________ Zip Code__________

Home Phone__________ Alternate Phone__________

E-Mail Address__________

Referring Physician__________ **Primary Care Physician**__________

Parent/Guardian Last name__________ First Name __________

Sex_____ Date of Birth__________ SSN__________

Employer__________ Work Phone __________

Parent/Guardian Last name__________ First Name __________

Sex_____ Date of Birth__________ SSN__________

Employer__________ Work Phone __________

Emergency Contact's Name (Other than parents)__________

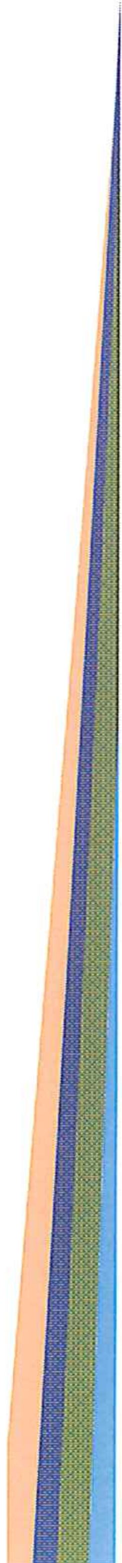
Contact Number__________ Relationship to Patient__________

Preferred Pharmacy__________

Address__________ Phone Number__________

Compounding Pharmacy__________

Address__________ Phone Number__________



PEDIATRIC
Gastroenterology
of Richmond, PC

INSURANCE AND PAYMENT INFORMATION

Primary Insurance Company______________________________

ID#____________________ Group Number____________________

Policy Holder Name____________________ Relationship to Patient __________

Policy Holder D.O.B. ____________________ Policy Holder SSN____________________

Secondary Insurance Company______________________________

ID#____________________ Group Number____________________

Policy Holder Name____________________ Relationship to Patient __________

Policy Holder D.O.B. ____________________ Policy Holder SSN____________________

Tertiary Insurance Company______________________________

ID#____________________ Group Number____________________

Policy Holder Name____________________ Relationship to Patient __________

Policy Holder D.O.B. ____________________ Policy Holder SSN____________________

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. We do bill secondary insurance companies as a courtesy to you. It is your responsibility to provide accurate insurance information to us at time of service. If you do need assistance or have questions, please contact us between 8:00am to 5:00pm Monday through Friday at (804)888-7337.

As a recipient under an insurance program, I authorize to Pediatric Gastroenterology of Richmond, PC, to submit claims to my insurance company for reimbursement of benefits. In assistance with my claims submission, I also authorize release of any medical records. I understand I am responsible for payment of the following:

- Yearly deductible (if applicable)
- 20% Co-Insurance (if applicable) –**ALL CO-PAYMENTS AND CO-INSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE**
- Any non-covered services not covered under my insurance.
- I understand that it is my responsibility to obtain any referrals from my primary care physician for office visits to Pediatric Gastroenterology of Richmond, PC or any visits Pediatric Gastroenterology of Richmond, PC may refer me.

Also have made aware that of any associated costs that may be charged to me if any of the following applies:

- I don't have insurance at this time.
- My insurance company is or may be out of network.
- I do not have my current insurance information at the time of my visit.
- Insurance on file is no longer active at the date of service.

I understand that I am responsible for payment on my account and agree to pay any and all court costs, interests, legal fees, and collection agency fees in the amount of 33.3% of the total amount due in the event my account is placed for collections.

Parent/Guardian Signature____________________ Date____________________

NOTICE OF DEEMED CONSENT TO HIV AND HEPATITIS BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV and Hepatitis antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may, according to certain medical authority, transmit human immunodeficiency virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) related disorders, and Hepatitis. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However if such exposure occurs, you will be informed before any of the your blood is tested for HIV and Hepatitis antibodies. Pursuant to the provision, the testing will be explained to you, and you will be given the opportunity to ask any questions you might have.

The law also provides that if you should be exposed to body fluids of a health care provider in a manner which may, to certain medical authority, transmit HIV and Hepatitis, the health care provider is deemed to have consented to such testing and to the release of the test results to you.

I have read and understand the above "Notice of Deemed Consent to HIV and Hepatitis Blood Testing."

Patients Name____ Patients Date of Birth________________

Parent/Guardian Signature____

Pediatric Gastroenterology of Richmond, PC enforces the following fees and policies:

Fees

- $35.00 fee for returned or non-sufficient funds checks.
- $35.00 fee for "no show/missed" appointments.
- $20.00 fee for signed forms (example: formula coverage letter for insurance approval, school forms and letters, homebound forms, etc.)
- $150.00 cancellation fee if you do not notify us of cancellation before 9:00AM the day prior to any surgical procedures.
- $5.00 fee for WIC forms.

Policy

- If you are more than 10 minutes late to an appointment, you may be asked to reschedule.
- We ask that you silence all cell phones during your appointment.
- Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge a $35.00 fee for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may results in discharge from the practice.

Obtaining Medical Records

- To transfer records, we must have a written consent signed by the parent or guardian due to HIPPA laws and regulations.
- Printed records are $0.50 per page for the first 50 pages, and $0.25 per page after.

Collections Policy

You are responsible for payment on your account and agree to pay any and all court costs, interests, legal fees, and collection agency fees in the amount of 33.3% of the total amount due in the event your account is placed for collections.

Please sign below to show that you have read and understand the above terms and fees.

______________________________	______________________________
Print Patient Name	Patient Date of Birth
______________________________	______________________________
Patient/Guardian Signature	Today's Date

Pediatric Gastroenterology of Richmond, PC
The Highland II Medical Office Building-7229 Forest Avenue, Suite 106-Richmond, VA 23226
Tel.804.888.PEDS(7337)-Fax804.888.9738

PEDIATRIC
Gastroenterology
of Richmond, PC

PATIENT CONTACT AND COMMUNICATION

Telephone Contact

Primary number (including area code) ______________________________

Name of contact______________________________
Is this a **MOBILE**, **HOME**, OR **WORK** number?
Can we call you at this number? **YES/NO**
Can we leave a message on your voicemail to return our call? **YES/NO**
Can we leave a message on your voicemail with lab results? **YES/NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES/NO**
Can we text appointment reminders to this number? **YES/NO**

Secondary number (including area code) ______________________________

Name of contact______________________________
Is this a **MOBILE**, **HOME**, OR **WORK** number?
Can we call you at this number? **YES/NO**
Can we leave a message on your voicemail to return our call? **YES/NO**
Can we leave a message on your voicemail with lab results? **YES/NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES/NO**
Can we text appointment reminders to this number? **YES/NO**

Alternate number (including area code)______________________________

Name of contact______________________________
Is this a **MOBILE**, **HOME**, OR **WORK** number?
Can we call you at this number? **YES/NO**
Can we leave a message on your voicemail to return our call? **YES/NO**
Can we leave a message on your voicemail with lab results? **YES/NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES/NO**
Can we text appointment reminders to this number? **YES/NO**

E-Mail Contact

We use Patient Portal to communicate with patients. We will send you a link for Patient Portal to the e-mail address you provide. Once you sign up, you will be able to send questions directly to clinical staff and be able to view patient charts and notes. You will also receive appointment reminders via e-mail.

E-mail address______________________________

Message and data rates may apply for any and all text, e-mail, or phone calls. Check with your carrier to determine all applicable fees. Pediatric Gastroenterology of Richmond, PC is not responsible for any charges that may apply.

Patient Name______________________________ Date of Birth______________________

Parent/Guardian signature______________________________ Date__________________

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Patient's Name______________________________________ **DOB**____________________________

Based on federal guidelines, we have started to collect the information below on our patients. Please check next to the appropriate answers for each section and sign at the bottom.

Race	**Ethnicity**	**Language**
o Black or African American o American Indian or Alaska Native o Asian o Hawaiian or Other Pacific Islander o White o Other Race	o Hispanic or Latino o Not Hispanic or Latino o Unknown	o English o Spanish o Other ________ ____________

Parent/Guardian Signature________________________________**Today's Date**____________________

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Written Acknowledgement Form

Our Notice of Privacy Practices (See form on the Home Page of our website, or ask to see one at the front desk) provides information about how we may use and disclose Private Healthcare Information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, ______________________________, have read and/or received a copy of Pediatric Gastroenterology of
Please print patient name

Richmond, P.C. Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to **The Practice** if I do not understand any information contained in the

Notice of Privacy Practices.

Patient Name____ DOB_______________________

Parent/Guardian Name__________________________________ Relation to Patient____________________

Parent/Guardian Signature______________________________ Date______________________________

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CONSENT FORM FOR MINORS
Pediatric Gastroenterology of Richmond, PC
Juan F. Villalona, MD, FAAP

I am the parent/guardian/personal representative of ____.
Please print name of minor/child.

There are currently no court orders in effect that prohibit my from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, including but not limited to blood work, X-Rays, and other care/treatment, which are deemed advisable by the doctor, whether or not I am present when the treatment/service is rendered.

______________________________	______________________________
Signature of Parent/Guardian	Today's Date
______________________________	______________________________
Please Print name of Parent/Guardian	Relationship to Patient

Please list the names of family/friends that have permission to bring your child to our clinic for medical care, or discuss patients plan of care.

Name	**Relation to Patient**	**Phone Number**

MEDICAL RECORDS RELEASE REQUEST

PREVIOUS DOCTOR:

Name:______________________________

Address:______________________________

____

Phone Number:______________________________

Fax Number:______________________________

DEAR DOCTORS:

Please send the following information for the listed patient.

____Shot Record ____Most Recent Physical

Any other listed Records: ____________________

____

CHILD'S NAME______________________________ DOB____________________

Please send records to **804-888-9738** ASAP. Thank you.

I understand that I have the right to access my medical records in accordance with the law and policies of Pediatric Gastroenterology, P.C. I understand that Pediatric Gastroenterology, P.C. may charge me for copies of my medical records, and I have been provided a fee schedule. I understand that Pediatric Gastroenterology, P.C. has the right to deny me access to my records in certain circumstances in accordance with the law. If the Practice denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of Pediatric Gastroenterology, P.C. and may be subject to re-disclosure by the recipient and may no longer by protected by federal or state law.

____
Printed Parent/Guardian Name

____
Parent/Guardian Signature

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INITIAL VISIT MEDICAL HISTORY FORM

Patients Name________________________________ Patients DOB________________

Name previous gastroenterologist, if any ______________________________________

Circle previous procedures and testing done by previous Gastroenterologist:
Blood work, CT Scan, X-ray, UGI, MRIs, ultrasound, EGD, Colonoscopy

REASON FOR THIS VISIT ____

____

____

____

When was this problem first noted?____

Has your child had any previous surgeries? Yes or No

If yes, please list name and date of the surgical procedure. (List any additional surgeries on the back of this page.)

____ Date__________________

____ Date__________________

____ Date__________________

____ Date__________________

Is your child currently on any medications (including prescription and non-prescription drugs, herbal remedies, oral contraceptives, and vitamins) **? Yes** or **No**
List all medications below, use the back of this page for any additional medications.

<u>Name of Medication</u> <u>Dosage</u> <u>Frequency</u>

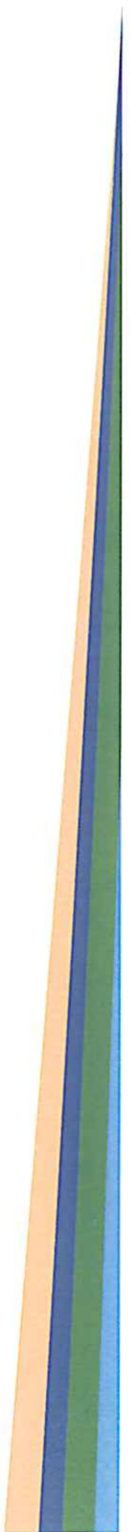
____

____

____

____

____



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INITIAL VISIT MEDICAL HISTORY FORM pg 2 of 4

Please list all allergies and reactions. If none, please write "none".

____

____

____

____

Past Medical History

_____ ADHD or Learning Disabilities

_____ Anxiety/Depression

_____Arthritis

_____ Asperger's Syndrome

_____ Bleeding Tendencies

_____ Blood in Stool

_____ Blood with Vomiting

_____ Bone Fractures
List location(s)______________

_____ Breathing Difficulties
Asthma? Yes or No
Shortness of Breath Yes or No

_____ Cancer
List type:__________________

_____Diabetes
Type I or Type II?

_____ Ear problems

_____ Eczema

_____ENMT Problems

_____ Excessive weight gain

_____Fast Weight Loss

_____ Genetic Syndrome

_____ Headaches

____Heart Problems

____Hospital Admissions
Date:_________________
Reason:_______________
____

____ Intestinal Issues

____ Liver Problems

____ Low Birth Weight

_____ Muscle Weakness

_____ Orthopedic Problems/
Assistive Devices

_____ PPD Test

_____ Problems with Anesthesia

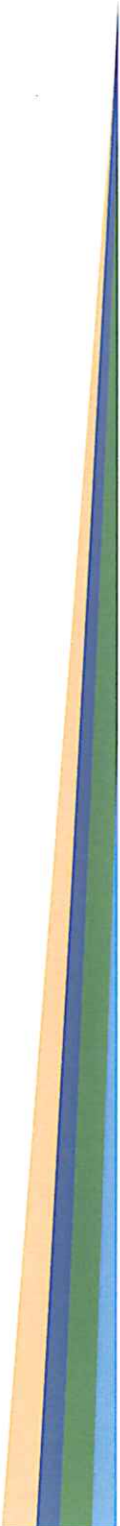
_____Recent Hospitalizations/ER
Date__________________
Reason________________
____

_____ Seizures

_____ Stomach Problems

_____ Urination Incontinence

_____ Urination Pains



PEDIATRIC Gastroenterology of Richmond, PC

INITIAL VISIT MEDICAL HISTORY FORM

Social History: Please fill out each section completely.

Diet: ___Regular ___Vegetarian ___Vegan ___Gluten Free

___Specific ___Cardiac ___Diabetic ___Carbohydrate Free

Parents Marital Status: ___Married ____Unmarried ___Separated

___Divorced ____Widowed

Home Situation: ___Both Parents ___Mother (___%) ___Father (___%)

___Relatives ___Adoptive/Foster Parents ___Group Home

Siblings, state amount of each ____ Sisters ____ Brothers

Animal Exposure, list type ____

Child Care ___None ___Relatives ___Private Sitter ___Daycare ___Preschool

Smoking Status ___Never Smoker ___Current Smoker ___Second-Hand Smoke Exposure

Pregnancy/Perinatal/Post-Natal History
(Only if patient is 2 years old or younger, fill out completely)**

Due date for this child ___/___/_____ Delivery date ___/___/_____

Delivery: ___Vaginal ___Cesarean (If C-Section, why? _______________________)

Birth weight: ___lbs ___oz

List any complications during your pregnancy________________________________

Did the baby pass first bowel movement (meconium) by: __24 hours __24-48 hours __>48 hours

Was the baby nursed? __Y __N If so, for how long? ___________________________

Was the baby formula-fed? __Y __N Which formula(s)?_________________________

How often?____

At what age was cereal introduced? ____________ Which one?__________________

Development: ___Normal ___Abnormal (Explain:_____________________________)

Family Health History

IN THESE COLUMNS, STATE MATERNAL (M) OR PATERNAL (P)

	Mother	Father	Sister	Father	Grandmother	Grandfather	Aunt	Uncle
Lactose Intolerance								
Gas								
GERD								
Acid Reflux								
Hiatal Hernia								
Barrett's Esophagus								
Constipation								
Irritable Bowel								
Spastic Colitis								
Polyps								
Crohn's Disease								
Ulcerative Colitis								
Food Allergies								
Asthma								
Eczema								
Liver Disease								
Jaundice								
Celiac Disease								
Gall Bladder Disease								
Pancreas Problems								
Cystic Fibrosis								
Peptic Ulcer								
H.Pylori								
Cancer**								
Psychiatric Illness **								
Diabetes								
Hypertension								
Heart Disease								
High Cholesterol								
Epilepsy								
Neurologic Problems**								
Bleeding Tendencies								
Hereditary Disorders**								

** Please list ______________________________