Liberty Pediatrics & Family Medicine, LLC

Thomas Hickey, MD • Brett Linck, MD • Manuel Datiles, MD • Amy Paulino, CRNP • Lori Kropfelder, NP • Anna Turpin, CRNP • Joanne Desmond, CRNP
Elizabeth Hall, CRNP • Erin Picotte, CRNP • Zoe Ajebon, DO • Sherry Dulling, CRNP • Jessica Kovolenko, CRNP • Evan Dickstein, CRNP-PMH
Samantha Schuyler, CRNP • Francesca Carhart, CRNP • Maximilian Herwig, CRNP

NEW PATIENT REGISTRATION

Patient's Legal Name: _____

Date of Birth: ____ / ____ / _____ **Legal Gender:** ☐ M ☐ F **Pronouns:** _____

Preferred Name: _____ **Address:**_____

Phone # (____) – _____ **Email:** _____

Emergency Contact

Name: _____ **Phone:** (____) - _____

Relation: _____

State Insurance PCP Requirement (Read & Acknowledge)

State insurances require you to choose a Primary Care Physician (PCP). We validate insurance coverage for every visit. **If we are not the PCP on record, we will not be able to see you until it is changed.** You will need to call the insurance to change the PCP and provide our office with a reference number. If the PCP is not changed by the 1st visit, we may not be able to see you. Please include a photo of your insurance card or email the photo to newpatient@libfamilymed.com Thank you.

PRIMARY INSURANCE

Name of Insurance Company: _____

Address for Claim Submissions: _____

Phone # (___) - _____

Policy Holder's Name: _____ **DOB:** ____/____/____

Employer: _____ **Membership ID #:** _____

Group #: _____ **Effective Date:** _____ **Copay:** _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Address for Claim Submissions: _____

Phone # (___) - _____

Policy Holder's Name: _____ **DOB:** ____/____/____

Employer: _____ **Membership ID #:** _____

Group #: _____ **Effective Date:** _____ **Copay:** _____

MEDICAL RECORDS REQUEST

AUTHORIZATION TO RELEASE INFORMATION TO LPFM

Patient Name: _____ **Date of Birth:** ____/____/____

Home Address: _____

Phone Number: (___) - _____ **Alternate Number: (___) -** _____

Patient/Parent/Guardian Email (circle one): _____

I, _____ (name), hereby authorize

_____ (previous physician's name) to **send all enclosed and protected information** to Liberty Pediatrics & Family Medicine for the following reason: _____

_____

PREVIOUS PHYSICIAN(S) INFORMATION

Physician Name(s): _____
Phone Number: (___) - _____**Fax Number: (___) -** _____

Description of information to be disclosed (check one or more):

☐ **Complete records** (may include mental health, HIV, and/or substance records; cross out any items you do not authorize)
☐ **Abbreviated records** (immunizations, growth charts, summaries of visits, most recent physical exam)
☐ **Records regarding treatment** for the following condition/injury: _____
on/around (date) ____/____/____
☐ **Records covering the period** from ____/____/____ to ____/____/____
☐ **Other (specify & dates):** _____

Please read and sign below.
WE CANNOT REQUEST RECORDS WITHOUT A SIGNATURE AND DATE.

1. I may revoke this authorization at any time by providing written notice.
2. I may not be able to revoke if the practice has already acted on it.
3. The practice will not condition treatment or payment on signing this authorization.
4. Disclosed information may be subject to re-disclosure and no longer protected by federal law.
5. I have had an opportunity to review this authorization and understand its intent and use.
6. I am signing this authorization freely; no one has pressured me.
7. I have received a copy of this authorization.

Signature: _____ **Date:** ____/____/____ **Relation:** _____

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider. I authorize my provider, or any holder of medical information about me or the patient named below, to release to my health insurance plan such information needed to determine the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses, and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in a reduced benefit or denial, and that I will be responsible for all balances due.

Consent to Treatment

I voluntarily consent to the rendering of such care and treatment as my provider and their professional judgment deem necessary; however, I may refuse any treatment or procedure at any time.

Consent for Telehealth Services

If I request or initiate a telehealth visit (a "virtual visit"), I acknowledge that I have reviewed the **Informed Consent for Telehealth Services**.

My consent shall cover medical examinations, procedures and testing (Including testing for sexually transmitted infections and or HIV, if separate consent is not required by law), including (but not limited to) minor surgical procedures (such as stitches), cast application/removal, and vaccine administration. My consent shall also cover the carrying out of the orders of my treatment provider by care center staff acting under my provider's supervision and direction. I acknowledge that neither my provider nor any of their staff have made any guarantee or promise as to the results I will obtain. My consent shall also cover the use of photography and internal recording devices for the purpose of scribing and clinical documentation improvement. All internal recording adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

Consent to Call, Email & Text

I understand and agree that my provider may contact me using automated calls, emails, and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt out of receiving such communications by notifying my provider, by visiting "My Profile" on my MyPrivia Patient Portal, or by emailing the Privacy Officer at **privacy@priviahealth.com**.

HIPAA

I understand that my provider's **Privacy Notice** is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/, and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy, the Informed Consent for Telehealth Services (if applicable), and my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy and the Informed Consent for Telehealth Services. I also agree to the sharing of my information via HIE and consent to my treatment by my provider. This form and my assignment of benefits apply and extend to subsequent visits and appointments with all Privia Health-affiliated providers.

Printed Name of Patient: _____

Email: _____

Signature: _____ **Date:** ____ / ____ / _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.)

Name and Relationship of Person Signing (if not patient): _____

*Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.

HIPAA COMMUNICATION

Preferred Communication & Contacts:

The HIPAA Privacy Rule Gives individuals the right to direct how and where their health care provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. You may update or change this information at any time: please do so in writing.

Patient Name: _____ Date of Birth: ____/____/____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send ALL communication through my Patient Portal**

Phones

☐ **Cell Phone: (___) - _____**

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Home Telephone: (___) - _____**

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Phone: (___) - _____**

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication

☐ Please send all my mail to the preferred address on file, or

☐ Please send all mail to this different address:

Street Address: _____

City: _____ State: _____ Zip: _____

My Preferred Contacts

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication such as sharing your test results. **You can control access to your patient portal.** Please indicate the person(s) with whom you prefer to share your information with below. Please update this information in writing promptly if your preferences change. Please note that in some situations it may be necessary and appropriate for us to share your information with other individuals. This may include information about General Medical conditions and diagnosis (including information about your care and treatment), billing payment information, prescription information, and scheduling appointments.

Note: We generally do **not** share your information via email. You can give another person access to your secure patient portal (set up via the portal or by calling our Patient Experience team at 1-888-774-8428, M-F 8AM–6PM EST).

1. **Name: _____ Relationship: _____**
   Contact Number: (___) - _____ Email: _____
2. **Name: _____ Relationship: _____**
   Contact Number: (___) - _____ Email: _____
3. **Name: _____ Relationship: _____**
   Contact Number: (___) - _____ Email: _____

ACKNOWLEDGEMENT: I understand that HIPAA may permit my provider to share my information with persons **not** named on this form when needed for my care, treatment, and/or payment for services.

Patient Signature: _____ Date: ____/____/____