LIBERTY MOUNTAIN MEDICAL GROUP
PEDIATRIC AND YOUNG ADULT MEDICINE

Patient Information Form – Multiple Minor Children

Patient's Name: _____ DOB_____

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Caregiver/Patient's Email Address: _____

If your Mailing address is a P.O. Box, please enter your home address for emergent situations:

Address Including unit/ apartment#: _____

City, State, Zip: _____

Phone Number: _____

Patient's Demographics

Language: □ English □ Spanish □ Other _____ □ Patient Declined

Race: □ Asian □ Black/ African American □ European □ White □ Other_____ □ Patient Declined

Ethnicity: □ Hispanic □ non-Hispanic □ Patient Declined

Patient's Emergency Contact (must be over 18 and not be self (please print clearly))

Name: _____

Relationship: _____

Mobile Phone: _____

Insurance Information

Insurance Carrier: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Member ID#: _____

Preferred Pharmacy

Name/ Location: _____

Preferred Provider (Please circle one): **Raul Barroso, DO** **Karina Espinoza, MD** **Olubukola Ojuola, MD**

PRIVIA MEDICAL GROUP

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 and its health care providers. 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 these benefits or 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 reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic 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 (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

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 preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, 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 as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends 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.***

my PRIVIA™
YOUR HEALTH YOUR WAY

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare 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:

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

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

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

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____
_____

☐ **Other:**_____

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 to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information 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 your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Consent for Medical Treatment of Minor Child(ren) Absence of Parent(s) or Legal Guardian

I am the parent or legal guardian, of the child(ren) listed below (collectively "my child(ren)"):

Name:_____ Birthdate: _____

Name:_____ Birthdate: _____

Name:_____ Birthdate: _____

Name:_____ Birthdate: _____

There are no court orders currently in effect which would prohibit me from exercising the power that I now seek to convey.

In the event that I am absent and unable to provide consent at the time:

- I hereby consent to and authorize any urgent or emergency medical, dental, or diagnostic procedure and/or treatment, surgical care and/or hospitalization that my child(ren)'s health care provider determines, in his or her best judgment, is necessary for the health and well-being of my child(ren), including, but not limited to, provision of prescription and non-prescription medication.

- In my absence, I authorize my child(ren)'s health care provider to disclose my child(ren's) medical information to the individual(s) designated below as necessary for such individual(s) to assist in the care of my child(ren).

- In my absence, I request that my child(ren)'s health care provider discuss my child(ren)'s health needs with the individual(s) designated below;

- In my absence, I authorize those persons, to the extent state law permits me to do so, to care for my child(ren) and to consent to recommended care and treatment for my child(ren).

- I designate the individual(s) on the following list, in the order of priority listed, to act on my behalf when I am not reasonably available to provide consent necessary for any non-urgent or non-emergency medical, dental, or diagnostic procedure and/or treatment for my child(ren):

1) Name:_____ Phone:_____
Address:_____

Relationship to Child(ren):_____

2) Name:_____ Phone:_____
Address:_____

Relationship to Child(ren): _____

3) Name:_____ Phone:_____
Address:_____

Relationship to Child(ren): _____

In the event I cannot be reached in an emergent situation I authorize my child(ren)'s health care provider to act in the best interest and wellbeing of my child(ren).

To the extent I have authorized the above individual(s) to act on my behalf in my absence, I hereby release and hold harmless my child(ren)'s health care providers, including any physician, hospital or hospital personnel, or other health care provider rendering care to my child(ren), arising from the failure to obtain consent from me.

Signature of parent _____ Date _____

Printed Name _____ Telephone _____

Address_____

Witness
Signature_____Date_____

Printed Name _____

PRIVIA MEDICAL GROUP

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code | **Any Other Name(s) Used**

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

   _____
   Name

   _____
   Address

   _____
   City **State** **Zip Code** **Email Address**

3. I hereby authorize disclosure of the following information:

   ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only: _____ to _____

   ☐ Specific Information Only: _____

   _____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED. 2) IF YOU REQUEST RECORDS BE SENT TO A TREATING PROVIDER AND YOU DO NOT WANT YOUR ENTIRE RECORD SENT, WE WILL SEND YOUR RECORDS TO YOU FOR DELIVERY TO YOUR PROVIDER; WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.

☐ **PLEASE EXCLUDE THE FOLLOWING INFORMATION:** _____

_____ **Signature:** _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; or ☐ other (please specify) _____.
5. If I have requested records be sent **unencrypted**, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
7. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
8. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____.
10. This authorization expires on _____ ____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	**Date of Patient's Signature**	**Patient's Date of Birth**
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	**Date of Legal Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**