To Our New Patients:

Woodinville Pediatrics would like to welcome you and your family to our pediatric practice. Established in 1979, we are dedicated to providing pediatric care of the highest quality delivered with compassion, respect and true affection for children and their families. We believe the care of children is best accomplished as a partnership between parents and care providers. Therefore we believe you can have certain expectations of us, and we, in turn can provide the service and quality care you deserve.

We encourage you to read this information thoroughly and ask us any questions you may have. We will work with you to provide information and educate about each stage of your child's growth and development, required immunizations and other health related concerns.

A copy of your child's immunization history, plus medical records from your previous physician are helpful in providing consistent health care to your child. You can make this request at your previous physician's office, or you can use our Request for Medical Records Release form included in this packet.

Office Hours
Monday – Friday: 9:00 AM to 6 PM
Phones are open from 8 AM to 6 PM, closed for lunch from 12 to 1 PM
Saturday (sick visits only): 8:30 AM to 12 PM
Sunday: Closed

After regular office hours, depending on the time, phone calls may be answered by our nurses, the doctor on call, or nurses from Seattle Children's Hospital.

If you have questions regarding billing or insurance, please call (425) 483-5437, option 4.

Well Child Visits:

Please call (425) 483-5437) to schedule a well child visit for your child. Please complete the New Patient Health History form included in this packet.

Well Child appointments may be scheduled up to 3 months in advance. Woodinville Pediatrics follows the American Academy of Pediatrics' recommendations for frequency of well child examinations.

- Children under 3 years of age are seen at 7-10 days, 2 months, 4 months, 6 months, 9 months, 12 months 15 months, 18 months, 24 months, and 30 months.
- Annual exams are recommended for children 3 years to 19 years.

Other special age considerations.

- The 12 month exam must be completed after the child has turned 12 months of age for immunization purposes.
- 4 year old annual physical exams must be completed after the 4th birthday for the immunizations to be recognized for kindergarten enrollment.

Sick Visits

- Call our office when your child is ill to schedule an appointment. We will schedule an appointment for you or offer you an opportunity to speak to one of our specially trained nurses if necessary.
- Give a brief statement of your child's symptoms so the appointment can be scheduled for the appropriate amount of time.
- Woodinville Pediatrics often schedules sick appointments on the same day for urgent issues.
- Each child in the family will need an individual appointment. Please let the scheduler know if you have multiple children needing appointments. Each patient requires additional time and unexpectedly adding patients can cause delays.
- Arriving at the office without an appointment will result in a wait until an appointment time becomes available.
- Urgent concerns should be discussed with our specially trained nurses to determine the appropriate time and location for services.
- Follow up appointments can be scheduled at the desk following your appointment.

With your help, we can better serve your needs:

- Always call for an appointment so we can best schedule you with a provider for your care.
- Please inform us when scheduling if you have more than one child that needs to be seen. Each patient requires additional time and unexpectedly adding appointments can cause delays for other patients.
- Call us in advance if you must cancel your appointment. Your cooperation allows us to use this time to see a another child.
- Be on time for your appointment. We believe your time is valuable, and we strive to see you and your child at the scheduled time. If you are late for an appointment we may ask you to reschedule your appointment. If you are unable to keep your appointment, please call in advance to let us know, allowing us to schedule another patient. Not calling to cancel an appointment may result in termination of services.
- Note the location of your appointment. Some of our providers rotate between offices so our schedulers will confirm the location of the appointment with you.

Triage Nurse Telephone Care

Our nursing staff is trained to handle routine questions and help determine if an appointment is needed or if advice can be given over the telephone. Our nursing staff will also determine if your physician's involvement is necessary in answering the question. The nurses will discuss your questions with your physician between patient examinations and call you back with their instructions. This allows a quick response to your questions. All calls to our nurse line will be returned the same day. If the nurse determines your physician needs to speak to you, the physician will return your call over the lunch hour or at the end of the day. Calls are processed in that way to keep our physicians on time for scheduled appointments.

We appreciate the trust you have placed in us.

Woodinville Pediatrics

PATIENT'S NAME ____________________ GENDER _______ DATE OF BIRTH _________

PATIENT LIVES WITH ____

SIBLING'S NAME(S) ____

FATHER: HOME PHONE:

ADDRESS: CELL PHONE:

CITY/ZIP: DATE OF BIRTH:

E-MAIL:

MOTHER: HOME PHONE:

ADDRESS: CELL PHONE:

CITY/ZIP: DATE OF BIRTH:

E-MAIL:

FATHER'S EMPLOYER: WORK PHONE:

MOTHER'S EMPLOYER: WORK PHONE:

Emergency Contact: ___________________________ **Phone:** ______________________

Preferred Pharmacy: __________________________ **Phone:** ______________________

PRIMARY: Insurance Company __________________ Effective Date _______ Copay _____

Insured Parent's Name ___________________ ID# ______________________

Group # ________________ Claims Address __________________________

SECONDARY: Insurance Company __________________ Effective Date _______ Copay _____

Insured Parent's Name ___________________ ID# ______________________

Group # ________________ Claims Address __________________________

****By my signature below I acknowledge that I have received the WPHC Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information.**

****I am <u>NOT</u> receiving state Medicaid, (DSHS, Medical Coupons) at this time, I will inform your office before being seen if I receive medical coupons in the future.**

****A no-show fee of $25 will be added to any no show appointment and/or appointments that are not canceled more than 24 hours of the appointment time.**

Please note: In order to control the costs of billing we request that office visits be paid at the time of service unless appropriate insurance information is provided. A finance charge of 1.0% will be added to your account on a monthly basis if your balance is 60 days or older. A minimum finance charge will be $.50 per month on any account older than 60 days. Total annual finance percentage will equal 12% on any account balance that is older than 60 days. (RCW 19.52)

I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I agree to pay for any charges not payable by my insurance plan. I furthermore, have read the above and understand that I am responsible for all medical and financial charges.

Signed: ______________________________________ **Date:** ______________________________

PEDIATRIC HEALTH HISTORY

Child's Name: ____________________ Date of Birth: __/__/__ Nickname:____________________

Mother's Name: __________________ Date of Birth: __/__/__ Occupation:__________________

Father's Name: __________________ Date of Birth: __/__/__ Occupation:__________________

Siblings' Names and Birthdates: ____

____

Referred By: ____

IS YOUR CHILD ON ANY MEDICINES?____

ALLERGIES TO MEDICINES:____

SMOKERS AT HOME?____

IMMUNIZATIONS: O up to date **O** not up to date Received at:______________________

BIRTH HISTORY Birthplace:______________________ OB: _____________________

Due Date:____________________ Birth Weight: ________ Vaginal or C-Section?__________

Any problems with the pregnancy, delivery, or nursery stay?__________________________

Feeding: **O** Breast_______months Any problems?__________________________________

O Formula_____months Brand:____________ Any problems?________________

PAST MEDICAL HISTORY: (please check if the child has a history of)

O Allergies	**O** Chickenpox	**O** Lazy Eye	**O** Injuries
O Asthma	**O** Constipation	**O** Pneumonia	**O** Hospitalizations
O Bladder Infections	**O** Chronic Cough	**O** Snoring	
O Cavities	**O** Eczema/skin problems	**O** Seizures	
O Headaches	**O** Ear Infections	**O** Vision/Hearing Problems	**O** Surgeries
O Speech Problems	**O** Other		

FAMILY HISTORY: (check if in family)

	Relative		**Relative**
O Allergies		**O** High Blood Pressure	
O Asthma		**O** High Cholesterol	
O Diabetes		**O** Early Death/Sudden Death	
O Heart Attack/Stroke		**O** Cancer	
O Kidney Disease		**O** Other	

SOCIAL HISTORY

Who does the child live with?____

If the parents are divorced, what is the custody arrangement?__________________________

Does anyone besides the parents and siblings live in the house? If so, whom?_____________

Who cares for the child while the parents are working?_____________________________

Child's School? _________________________Grade:_______ Days missed last year:_________

Any problems at school?____

Primary source of water:_________________________ Pets:________________________

PARENT SIGNATURE_____________________________________ Date:__________________

CONSENT FOR MEDICAL CARE FORM

The undersigned hereby authorizes: ________________________________

to obtain medical care for: ______________________________ ____________

Name Birthdate

______________________________ ____________

Name Birthdate

______________________________ ____________

Name Birthdate

______________________________ ____________

Name Birthdate

including medical and surgical treatment as ordered by the attending physician, x-ray, examinations, laboratory procedures, and hospital treatment.

________________ _________________________________

Date Signature of Parent or Guardian

Woodinville Pediatrics
www.woodinvillepediatrics.com

17000 140th Ave NE, Suite 102
Woodinville, WA 98072
Phone: (425) 483-5437 Fax: (425) 488-4919

Authorization for Release of Medical Information

Patient's name: ___________________________ Date of Birth: ______________
Address: ____
City/State/Zip Code: ___________________________________
Patient's phone #: ( ) _____________________
Date of Request: ________________ **Date Needed:** ________________

OR

❒ I authorize Woodinville Pediatrics **to release information to**:	❒ I authorize Woodinville Pediatrics **to obtain information from**:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #/Fax # (include area code)	Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Other ❒ Transfer of Care

TYPE OF RECORDS REQUESTED:

❒ Immunization History ❒ All Records ❒Include records submitted to Woodinville Pediatrics.
❒ All medical records related to a specific illness or injury.

Specify illness/injury ______________ Date(s) of treatment ______________

❒ Records for the following date(s)________________________
❒ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
❒ Specific information (Select one or more, as applicable)
- ❒ Procedure report ❒ History & physical ❒ Physical Therapy ❒ Laboratory test results
- ❒ X-ray reports ❒ Sports Forms and Medication Forms to Schools:______________
- ❒ Other:________________________ (Please describe.)

❒ Entire copy of the record checked above.

YOU MAY DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS, AND TREATMENT FOR (INITIAL ALL THAT APPLY):

❒ HIV (AIDS virus)__________ ❒ Psychiatric disorders/Mental Health__________
❒ Sexually transmitted diseases__________ ❒ Drug/Alcohol use__________

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed..
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative ________________________ Date __________
Printed Name of Patient or Representative________________________.
Relationship to Patient (if requester is not the patient)________________________

Request expires one year from the date the Authorization is signed.

NOTICE OF PRIVACY PRACTICES
WOODINVILLE PEDIATRICS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Woodinville Pediatrics respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless 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, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected heath information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information to Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other members 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 you care. This will help them stay informed about your care.

For payment:

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

For health care operations:

- 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 your information about treatment alternatives or other health-related benefits and services.

We may use and disclose your information to conduct or arrange for services, including:

- medical quality review by your health plan;
- accounting, legal, risk management, and insurance services;

- audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

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

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information – except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please 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. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For helps with these rights during normal business hours, please contact: the office manager.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- 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 receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to a report a problem about the handling of your protected health information, you may contact: *the office manager.*

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the office manager at Woodinville Pediatrics. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

- [Hospitals] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
    - your name,
    - location,
    - general condition, and
    - religion (only to clergy)

You have the right to object not his use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With 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 Organization (tissue donation and transplant)** or persons who 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 allows 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

- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.

- **For Law Enforcement purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

- **For Health and Safety oversight activities.** For example, we may share health information with Department of Health.

- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.

- **To the Military Authorizes of U.S. And Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.

- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.

- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

•Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.