Pediatric Specialists of Virginia

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE

Date: ________________

Patient Legal Name: ____________________________________ Date of Birth: _____________________
(Last Name, First Name) (Month/day/year)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices and Statement of Patient and Family Rights for this healthcare facility.

The HIPAA privacy rule gives individuals, parents or guardians the right to request a restriction on uses and disclosures of their (their child's) protected health information (PHI). See the PSV Notice of Privacy Practices.

The individual/parent/guardian is also provided the right to request **confidential** communications of PHI or other sensitive information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST PSV MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE PATIENT'S HEALTH INFORMATION
(This includes step parents, grandparents and any care takers – PHOTO ID REQUIRED):

I hereby give permission to the person(s) listed below to receive confidential information about the care of the above-named patient.

Printed Name: ____________________________________ Relationship to Patient: ___________________

Contact Phone/Email: ____

Printed Name: ____________________________________ Relationship to Patient: ___________________

Contact Phone/ Email: ____

MY PREFERENCE FOR CONTACT FROM THIS OFFICE REGARDING **MY CHILD'S CARE** IS:
□ Cell Phone □ Home Phone □ Work Phone □ Any method listed

I AUTHORIZE **INFORMATION ABOUT MY HEALTH, TREATMENT & BILLING INFORMATION** BE CONVEYED VIA:
□ Cell Phone □ Home Phone □ Work Phone □ E-mail □ Any method listed

____ Date: _________________________
Signature of Patient, Parent, Guardian or Personal Representative

____
Printed Name of Patient, Parent, Guardian or Personal Representative

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual, parent, guardian or personal representative.
Note: In an emergency, uses and disclosures of PHI for treatment, payment or healthcare operations may be permitted without prior consent.

Patient Identification

If label is not available, please complete:

Patient Name ___________________________________

DOB: ______________ MR# ____________________

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___It was emergency treatment
___I could not communicate with the patient
___The patient refused to sign
___The patient was unable to sign because
___Other (please describe)

Signature ____

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AUTHORIZATION FOR CLAIMS, PAYMENTS AND REVIEWS

For Medicare Recipients: I certify that the information provided to me in applying for payment under Title XVIII of the social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to PSV for any services furnished to me during the applicable periods of medical care.

Assignment and Coordination of Insurance Benefits: I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to PSV for services rendered to the patient. I hereby authorize payments directly to Pediatric Specialists of Virginia (PSV), including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to PSV for services rendered to me during the applicable period(s) of medical care.

Unauthorized, Non-Covered, or Out-of-Plan Services: I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay; and I agree to pay for these services. I also understand and acknowledge that in the case where PSV is deemed out-of-plan/network, there may be reduced benefits; and I may be required to pay a higher co-pay, deductible or co-insurance amount.

Authorization to Release Information: I hereby authorize PSV to release any information acquired during the course of treatment necessary to process insurance claims and/or follow up for healthcare operations and securing payment for services rendered.

Responsibility for Payment: In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to, health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

Automobile Accident Patients: Notice regarding the assignment of medical expense benefits may be provided to you by your Auto Insurance Company.

By signing below, I certify I have:

- Read and understand the foregoing;
- Had the opportunity to ask questions and have them answered;
- Accepted the above conditions and terms; and
- Read the notice, if applicable, regarding assignment of medical expense benefits for automobile accident patients.

I, therefore, agree:

- To pay all charges for which I may be legally responsible including, but not limited to, health insurance deductibles, co-payments, and non-covered;
- To pay the reasonable attorneys' fees and other collection costs incurred by PSV in the event my account must be placed with an attorney or collection agency to obtain payment; and
- And understand that this document will remain in effect for my present visit and any future outpatient or physician office visits to PSV, unless specifically rescinded by me in writing.

____ _______________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____

Printed Name of Patient, Parent, Guardian or Personal Representative

Notice: It is not required to sign this Authorization for Claims, Payments and Reviews Form. If this Form is not signed, all charges will be billed to you directly instead of to your insurance plan.

Patient Identification

If label is not available, please complete:

Patient Name ___________________________________

DOB: ______________ MR# _____________________

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AMERICANS WITH DISABILITIES ACT (ADA) / SPECIAL NEEDS ASSESSMENT

PSV Staff: At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

Patient or Companion: If you or any companion assisting in your care has a special need, please indicate below:
Patient's medical condition does not allow completion at this time.

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other special needs or disability that require services or accommodations during your visit today?	☐ Yes ☐ No	☐ Yes ☐ No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	☐ Yes ☐ No	☐ Yes ☐ No

Please describe type of accommodation requested:

____

____

Do you have any special instructions for care providers? If so, please describe below:

____

____

Staff Notes regarding accommodations given: (PSV Staff: Please document in detail accommodation(s) requested and services given.)

____

____

By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion has a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Pediatric Specialists of Virginia will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the Patient Rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

____ ______________________
Signature of Patient/Patient Representative/Companion Date Time

Print: ____

Relationship to Patient: ❑ Self ❑ Parent ❑ Family Member ❑ Friend ❑ Other______________________

____ ______________________
Signature of Employee Witness Date Time

Print: ____

Patient Identification
If label is not available, please complete:

Patient Name ______________________________
DOB: ______________ MR# __________________

Patient Label Here

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Pediatric Specialists of Virginia Ambulatory Surgery Center

AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVE OR MEDICAL POWER OF ATTORNEY

All patients have the right to participate in their own health care decisions and to make advance directives or educate powers of attorney that authorize others to make decision or are unable to communicate decisions. Pediatric Specialists of Virginia respects and upholds those rights.

However, unlike in an acute hospital setting, PSV Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedures with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy regardless of the contents of any advance directive or instructions from a health care surrogate or attorney, in fact, that if an adverse event occurs during you or your child's treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer the patient to an acute care hospital for further evaluation. At the acute hospital further treatment or withdrawal of treatment measures which have already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney. Your agreement with this policy with your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we are pleased to assist you in rescheduling the procedure at another facility.

Have you executed an advanced health care directive for the patient?

☐ Yes, the patient has an advance directive, living will, or health care power of attorney.

☐ No, the patient does not have an advance directive, living will or health care power of attorney.

By signing this document, I acknowledge that I have read and understood its contents and agree to the policy described.

Patient or Guardian Signature ______________________ Date ______________

Patient Label Here

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ASC
Acknowledgement Form

I have been given a copy of the Pediatric Specialists of Virginia ASC:

- **Notice of Privacy Practices & Statement of Patient Rights and Responsibilities**
- **Advance Directive Policy**
- **Complaints and Grievance Policy**

By signing this document, I acknowledge that I have had the opportunity to ask questions and have my questions answered and I understand the information provided.

______________________________________ _________________________

Patient / Guardian / Surrogate Signature Date