NOTICE OF PRIVACY PRACTICES

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.

How we may use and disclose your medical information: Except where such use or disclosure is otherwise prohibited by state or federal law, the Clinic is permitted or required to use or disclose your medical information without your authorization (permission) in the following situations. Some, but not all, specific examples of the different types of disclosures have been listed.

Treatment. To provide you with medical treatment or services (e.g., provide information to doctors, nurses technicians, students or personnel who are involved in your care).

Payment. To collect payment from you, an insurance company or a third party for the treatment and services you receive (e.g., submitting a claim to your insurance company).

Health Care Operations. For Clinic health care operations (e.g., to evaluate our staff and internal processes). As part of the Clinic's health care operations, certain limited information may be used or disclosed to conduct fundraising activities on behalf of the Clinic. You have the right to request that you not receive fundraising materials from the Clinic.

Appointments and Health Care Services. To provide you with appointment reminders or to notify you of possible treatment alternatives or health-related benefits or services.

Friends and Family. To a friend or family member involved in your medical care or payment for your care. If you are available, such disclosures will be made only if we have obtained your permission. If you do not object to the disclosure after having the opportunity, or if it is reasonable for us, based on the circumstances, to assume you have no objection to such disclosure. If you are unavailable, incapacitated or in an emergency situation, the Clinic may disclose limited information to these persons if the Clinic determines disclosure is in your best interest.

Health Care Providers. To another health care provider involved in your treatment in order for that provider to treat you, bill for its services and conduct certain of its healthcare operations.

Disaster Relief. To a public or private entity assisting in a disaster relief effort (e.g., to notify your family about your location, condition or death).

Public Health Activities. To public heath authorities for public health activities as permitted or required by law (e.g., to report child abuse and neglect, immunizations and communicable diseases).

Abuse, Neglect and Domestic Violence. The clinic may notify the appropriate government authority if it believes you or your child has been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law, the Clinic will only make this disclosure if you agree or under other limited circumstances when such disclosure is authorized by law.

Health Safety Risks. Under certain circumstances, when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person.

Legal Proceedings. If you are involved in a lawsuit or dispute, in response to a court or administrative order. The Clinic may also disclose medical information about you in response to a subpoena or other lawful process by someone else involved in the dispute, but only if the party seeking the information demonstrates that reasonable efforts have been made to notify you of the request or to obtain a protective order from the court.

Law Enforcement. To law enforcement authorities for law enforcement purposes, such as (1) in response to a court order, subpoena, warrant, summons or similar process. (2) To identify or locate a suspect, fugitive, material witness or missing person (3) about a death which is believed to be the result of criminal conduct, (4) to report a crime that occurred on Clinic premises. The Clinic must comply with federal and state laws in making such disclosures.

Deceased Individuals. To a coroner or medical examiner as necessary to carry out their duties (e.g., to identify a deceased person or determine the cause of death), or to funeral directors as authorized by the law.

Research. For research-related activities that meet all privacy law requirements.

Required by Law. When required to do so by federal, state or local law (e.g., to report child abuse and violent wounds.)

Incidental Disclosures. Occasional incidental, unintended disclosures of your medical information which might occur during a permitted use or disclosure (e.g., information overheard during a discussion regarding your care with you or a member of you family). We will take reasonable steps to avoid these types of disclosures.

You and Your Rights. The Clinic must also disclose your medical information to you, as described later in this Notice. Uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons set forth in your written authorization. We are unable to take back any disclosures we have already made with your permission.

Your Rights

Access to Medical Information. You may request to inspect and copy much of the medical information we maintain about you; with some exceptions this includes most medical and billing records, but does not include psychotherapy notes. We may charge a fee for the costs of copying, mailing, and other supplies associated with your request.

Request for Restrictions. You have the right to request a restriction on how we use or disclose your medical information for treatment, payment, or health care operations, or to certain family members or friends identified by you who are involved in you care or the payment for your care. We are not required to agree to your request, but will notify you if we are unable to agree.

Amendment. You may request that we amend certain portions of your medical information if you believe that it is incorrect or incomplete. We may require you to give a reason to support your request. We are not required to make all requested amendments, but we will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

Accounting. You have the right to receive a list of certain disclosures of your medical information make by us or our business for your request, which may not be longer than six years and may not include dates before April 14, 2003. The first list in any 12-month period will be provided to you for free; you may be charged a fee for each subsequent list you request within the same 12-month period.

Confidential Communications. You have the right to request that we communicate with you about medical matters in a different manner or at a different place. We will agree to your request if it is reasonable, and you specify an alternative means or location to contact you.

Paper Notice. You are entitled to receive a written copy of this notice at any time.

How to Exercise These Rights. All requests to exercise these rights must be in writing. We will follow written policies to handle requests, and we will notify you of our decision or actions and your rights. Contact the clinic manager or Privacy Officer at the contact information at the end of this Notice for more information or to obtain request forms.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Clinic using the contact information at the end of the Notice. You may also submit a complaint to the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Questions. If you have questions about this Notice, please contact the clinic manager or the Privacy Officer at the telephone number listed below.

About This Notice.

The clinic is required to abide by the terms of the Notice currently in effect. The Clinic reserves the right to change the terms of this Notice and make the new Notice provisions effective for all of your medical information that it maintains, including that which it created or received while the prior Notice was in effect. If the clinic makes a material change to its privacy practices, it will amend its Notice. We will post a copy of the current Notice in the Clinic. The Notice will state the effective date.

Contact Information

Privacy officer:
*Missy
Pediatric & Young Adult Clinic
1417 A Avenue East, Suite 100
Oskaloosa, IA 52577
(641) 673-7537

THE PEDIATRIC AND YOUNG ADULT CLINIC
1417 A AVENUE EAST, SUITE 100
OSKALOOSA, IA 52577
641-673-RKDS
641-673-7537

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, ________________________, hereby give my consent to the Pediatric and Young Adult Clinic

(name of patient or authorized agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of

________________________.

(patient's name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ________________________________ Date: ____________________

If you are not the patient, please specify your relationship to the patient ____________.

Receipt of Notice of Privacy Practices Form

I, ________________________, hereby acknowledge receipt of the physician's

(Patient's Name)

Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: ________________________________ Date: ____________________

If you are not the patient, please specify your relationship to the patient ____________.

Pediatric & Young Adult Clinic
1417 A Avenue East, Suite 100
Oskaloosa, IA 52577
Ronda Dennis-Smithart, MD, FAAP   Christine Doyle, ARNP, CPNP

This agreement is between Pediatric & Young Adult Clinic as creditor and the patient/guarantor named on this form.

Payment/Insurance:

We require all patients to pay at the time of service. We can discuss arranging payment plans if necessary. We will gladly submit your insurance claims and assist you in receiving the maximum benefit from your plan. All plans, however, may have limitations and may not cover 100% of all our fees. Your contract with your insurance company requires you to pay all applicable co-pays and deductibles. These fees must be paid to Pediatric & Young Adult Clinic at the time of service.

Your insurance plan is based on a contract between your employer or benefit group. It is not based on your individual medical needs. You are responsible for all charges your insurance does not cover.

Divorce:

In the case of divorce or separation, the parent authorizing treatment for a minor will be the person responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will not collect from them.

Past Due Accounts:

We will take necessary steps to collect any debt by means of a collection agency or attorney. If a patient refuses to pay charges, they may not be able to continue as a patient in this office.

Scheduling:

Every effort will be made to schedule your appointments at times that work best for you. As a result, we ask that you show up for your appointments on time. If you need to reschedule an appointment, let us know promptly. If a patient repeatedly misses appointments without providing notice, we may not continue scheduling them at this office.

Other Caretakers:

We understand that schedules get busy, and sometimes a friend or a relative must bring your child. Please send a note authorizing them to seek care. Please send your insurance card along with your applicable copayment or coinsurance. We can accept cash, checks, or debit/credit cards. If you are unable to send money with them, we can accept a payment over the phone.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Patient's Name:______________________________________ DOB:____________

Responsible Party Signature:____________________________ Date:____________

Witness for PYAC:___________________________________ Date:____________

Pediatric & Young Adult Clinic
Patient Registration Form

- **Patient Information**

Patient's Full Name________________________________ Date of Birth____________ M F
Address______________________ City______________ State_____ Zip Code__________
Home Phone____________________ Cell Phone______________ SSN____-_____-______
Race______________ Ethnicity______________ Preferred Language______________

- **Parent Information**

Primary Guardian Full Name____________________________ Date of Birth__________ M F
Address______________________ City______________ State_____ Zip Code__________
Home Phone____________________ Cell Phone______________ SSN____-_____-______
Patient Relationship__________________ Employer______________________________
Email____

Secondary Guardian Full Name__________________________ Date of Birth__________ M F
Address______________________ City______________ State_____ Zip Code__________
Home Phone____________________ Cell Phone______________ SSN____-_____-______
Patient Relationship__________________ Employer______________________________
Email____

- **Sibling Information** (Use reverse side of page if needed)

Name________________________________ Date of Birth____________ M F
Name________________________________ Date of Birth____________ M F
Name________________________________ Date of Birth____________ M F

- **Emergency Contacts**

Name__________________________ Relationship____________ Phone______________
Name__________________________ Relationship____________ Phone______________
Name__________________________ Relationship____________ Phone______________

- **Pharmacy**

Name________________________________ City______________________

Signature______________________________ Date________

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY DATE COMPLETED

BIRTH DATE AGE M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. ______

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight ______ Was the baby born at term? ______ OR ______ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain ______

Was a NICU stay required? ☐ Yes ☐ No Explain ______

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What ______ When ______

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? ______

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain ______

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ______

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ______

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ______

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain ______

Biological Family History DK = don't know

Have any family members had the following?

Condition					
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Asthma	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Anemia	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Dental decay	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Initial History Questionnaire

Biological Family History *(Continued from front side.)* DK = don't know

Condition					
Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______

Past History DK = don't know

Does your child have, or has your child ever had,

Condition				
Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain ______
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ______
HIV	☐ Yes	☐ No	☐ DK	Explain ______
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ______
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ______
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ______
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ______
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ______
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ______
Cancer	☐ Yes	☐ No	☐ DK	Explain ______
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ______
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ______
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ______
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ______
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ______
Obesity	☐ Yes	☐ No	☐ DK	Explain ______
Diabetes	☐ Yes	☐ No	☐ DK	Explain ______
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ______
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ______
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ______
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ______
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ______
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ______
Dental decay	☐ Yes	☐ No	☐ DK	Explain ______
History of family violence	☐ Yes	☐ No	☐ DK	Explain ______
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ______
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ______
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain ______

Has had first period ☐ Yes ☐ No Age of first period ______

Any other significant problem ______

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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