Jennifer L . Burns, MD, FAAP
Adrienne Harmel, CPNP
Amy Mathew, MD, FAAP
3534 A Urbana Pke
Phone: (240) 341-1090

Patient Information

Patient's First Name:	Middle:	Last:	Preferred Name:
Date of Birth:	Sex: ☐ Male ☐ Female		
Street Address:			
City:	State:	Zip:	
Preferred Phone:	Work Phone:		

Siblings

Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:

Primary Insurance

Insurance Name:	Member ID:	Group#
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient:		

Secondary Insurance

Insurance Name:	Member ID:	Group#
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient:		

Parent/Guardian #1

Name:	DOB:	
Sex: ☐ Male ☐ Female	Relationship to Patient:	
Address **(If Different from Child):**		
Primary Phone:	Cell Phone:	Work Phone:
Email:	Employer:	
Choose one way to receive appointment reminders & other notices: ☐Call Cell ☐Text Call ☐Email ☐Opt Out		

Parent/Guardian #2

Name:	DOB:	
Sex: ☐ Male ☐ Female	Relationship to Patient:	
Address **(If Different from Child):**		
Primary Phone:	Cell Phone:	Work Phone:
Email:	Employer:	
Choose one way to receive appointment reminders & other notices: ☐Call Cell ☐Text Call ☐Email ☐Opt Out		

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VACCINE POLICY STATEMENT

- We believe that vaccinating our patients is one of the most important things that we can do as medical providers because vaccines help prevent many serious and life-threatening illnesses.
- Vaccines are safe and effective and do not cause autism or other neurodevelopmental conditions.
- We follow the American Academy of Pediatrics and the Center for Disease Control's vaccination schedule and do not allow children who follow alternative vaccination schedules in our practice.
  - Recommended vaccinations for infants and children from birth to 6 years old
  - Recommended vaccinations for children and adolescents 7 to 18 years old
- We do not allow unvaccinated children in our practice unless they have a true medical contraindication to receiving vaccines.
- We know that there is a lot of information on the internet about vaccines. The following are some of the websites that we recommend visiting to obtain information about vaccines:
  - vaccinateyourfamily.org
  - vaccine.CHOP.edu
  - vaccineinformation.org
- We will always discuss the vaccines that your child is due to receive at his or her visit and will provide you with Vaccine Information Sheets (VIS) to review. We are happy to answer any questions that you may have about the vaccines that your child is due to receive.

I acknowledge that I have read Urbana Pediatrics, LLC's Vaccine Policy Statement and understand Urbana Pediatrics, LLC's Vaccine Policy.

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Responsible Party:

Print Name: ______________________________________ Relationship to Patient: ______________________

Signature: _______________________________________ Date: ______________________________________

Patient Name: ___________________________________ Patient's Date of Birth: _______________________

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ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby authorize payment directly to Urbana Pediatrics, LLC the health insurance benefits otherwise payable to me. I consent to apply to my account(s) all monies received by Urbana Pediatrics, LLC on my behalf. I authorize the use of my signature on all insurance submissions, whether manual or electronic.

I also give permission to Urbana Pediatrics, LCC to release medical information about my child when required by the Insurance Company or the government agencies responsible for the payment of my child's medical bills. I understand that I am financially responsible for charges not covered by the insurance benefits hereby authorized.

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Signature of Guarantor   Date

CONSENT FOR MEDICAL CARE

Permission is granted to the physicians, nurse practitioners and employees of Urbana Pediatrics, LLC to do such procedures as may be necessary to diagnose, treat, and care for the needs of my dependent minor child including but not limited to routine office and laboratory procedures such as strep tests and throat cultures, urine studies, hemoglobins, lead tests, bladder catheterization, removal or cerumen (ear wax), removal or foreign bodies, drainage of abscess, fracture care, injections of vaccines and medications, and treatment of skin lesions, warts, burns and lacerations.

Patient Name: _______________________________________ Date of Birth: ________________

Signature of Custodial Parent or Guardian: ____

Date: ___________________________

**This authorization shall remain effective until such time that it is revoked in writing and delivered to Urbana Pediatrics, LLC.

ACKNOWLEDGEMENT OF RECIEPT OF THE NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices for Urbana Pediatrics, LCC. Urbana Pediatrics, LLC is authorized to use and disclose health information about the following patient for treatment, payment, health care operations and other purposes consistent with its Notice of Privacy Practices.

Patient's Name: _______________________________________ D.O.B: __________________

____ Date: __________________

Signature of Parent/Guardian

MISSED APPOINTMENTS AND CANCELLATIONS

- We understand that there are occasional circumstances that may keep you from coming to a previously scheduled appointment. When this happens, we request 24 hours advance notice when you are cancelling routine exams/checkups, consults, behavioral health visits, and medication checks. We request 2 hours advance notice for cancellation of sick visits. It is our policy to charge $25 for an office visit that is missed without advance notice for all visits except for consults and behavioral health visits. Consults and behavioral health visits are subject to a $50 no show or late cancellation fee. We reserve the right to dismiss a patient from the practice who misses more than two appointments without notice. If you arrive late to your scheduled appointment, we reserve the right to reschedule the appointment.

ADMINISTRATIVE FEES

- Form completion (not at the time of a routine exam/ checkup): $15 per form
- Note: Forms take 7 days to complete
- Form completion at the time of a routine exam/ checkup: No charge
- URGENT form completion (to be completed within 24 hours): $25 per form
- Immunization records only: No charge
- Returned check fee: $35.00
- After hours telephone call charge: No charge for urgent calls; $17 for nonurgent calls
- Missed appointment – Routine exam, sick visit, follow up $25
- Missed appointment – Consult or behavioral health visit $50
- Medical Records: $6.50 (on disk); $25 (on paper)
- Note: The fee for medical records is an out of pocket expense and cannot be billed to your insurance carrier. Upon receipt of fee and completed request for medical records, your child's medical records will be released within 7 business days. Please see our website for a medical record release form.

INTERPRETING SERVICES:

- For visual and hearing-impaired parents or guardians and/or patients, we will provide appropriate means of communication, including written materials and/or qualified interpreters. We require at least 1-week advance notice if you or your child needs interpretation services for a routine exam, extended visit or consult visit.
- If you or your child needs foreign language translation, you may want to bring your own translator to the visit. The office has limited language translation services.

SEPARATED/DIVORCED PARENTS

- For parents who are separated or divorced and need care for their child/children, the parent bringing the child to the office authorizes treatment
- Unless Urbana Pediatrics, LLC has a court order that states the contrary, Urbana Pediatrics, LLC is legally obligated to disclose medical information to all parents/legal guardians. If at any time legal matters become too intrusive or disruptive for our staff, we reserve the right to dismiss the patient from the practice.

VACCINE ADMINISTRATION

- Urbana Pediatrics, LLC administers vaccines in accordance with the American Academy of Pediatrics and the Center for Disease Control's guidelines. Our staff will provide you with information about the vaccines that are being recommended for your child and you will have the opportunity to discuss the vaccines that are being recommended for your child with your child's medical provider prior to their administration.
- If you do not wish for your child to follow the American Academy of Pediatrics and the Center for Disease Control's schedule for vaccine administration, then we will not be able to be care for your child at Urbana Pediatrics, LLC. Please see our vaccine policy statement for additional information.

Responsible Party:

Print Name: ____ Relationship to Patient: _____________________

Signature: ____ Date: ___________________________________

Patient Name: ____ Patient's Date of Birth: ______________________

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NOTICE OF PRIVACY POLICIES

EFFECTIVE DATE: October 28, 2021

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

This Notice of Privacy Practices is not an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your child's protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your and your child's rights to access and control your child's protected health information. "Protected Health Information" (PHI) is information about your child, including demographic information, that may identify your child and that relates to your child's past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your child's protected health information may be used and disclosed by your child's medical provider, our office staff and others outside of our office that are involved in your child's care and treatment for the purpose of providing health care services to your child, reimbursement for your child's health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your child's protected health information to provide, coordinate, and/or manage your child's health care and any related services. This includes the coordination or management of your child's health care with a third party. For example, your child's protected health information may be provided to a physician to whom your child has been referred to ensure that the physician has the necessary information to diagnose or treat your child.

Payment: Your child's protected health information will be used, as needed, to obtain payment for your child's health care services. It may also be used to get pre-approval for a test to be done.

Healthcare Operations: We may use or disclose, as needed, your child's protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, and licensing. We ask that you check your child in when you arrive at the office. We then will call your child by name in the waiting room when your child's provider is ready to see him or her. We may use or disclose your child's protected health information, as necessary, to contact you to remind you of your child's appointment and inform you about your child's treatment alternatives or other health-related benefits and services that may be of interest to your child. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, inmates, and other required uses and disclosures. Under the law, we must make

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disclosures to you about your child upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your child's protected health information for marketing purposes. We may not sell your child's protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your child's medical record. We will not use or disclose any of your child's protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your child's medical provider or practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your child's rights with respect to protected health information.

After submitting a written request, you have the right to inspect or copy your child's protected health information whether in paper or electronic format (fees may apply). Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to have your child participate, information whose disclosure may result in harm or injury to your child or to another person, or information that was obtained under a promise of confidentiality (this applies to adolescent patients).

You have the right to request a restriction of your child's protected health information. This means you may ask us not to use or disclose any part of your child's protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your child's protected health information not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in this Notice of Privacy Practices. For example, if your child's babysitter brings them to their visit in our office, it is likely that some of your child's PHI will be disclosed to them during the visit. If you do not want any of your child's PHI disclosed, you must submit a request that states the specific restriction requested and to whom you want the restriction to apply. Your child's physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

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You have the right to request an amendment to your child's protected health information. If we deny your request for the amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures pursuant to an authorization, for purposes of treatment, payment, and healthcare operations that occurred up to six years prior to the date of the request.

You have the right to receive notice of a breach. We will notify you if your child's protected health information has been breached.

Health Information Exchange: We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer and you will be given a copy to review at your child's next appointment.

COMPLAINTS

You may file a complaint with us by notifying our Privacy Officer, Dr. Jennifer Burns, in writing or verbally.
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You will not be retaliated against if you file a complaint.