REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient Last Name:	First Name:	Birthdate:
Street Address:	City:	State:

ZIP Code:	Gender: ❑Female ❑Male	Phone #: ( )	Alternate #: ( )	SS#:

Parent/Guardian last name:	Parent/Guardian First Name:	Parent/Guardian DOB:
Parent/Guardian Social Security#:	Relationship to Patient:	Email (Optional):

PATIENT HISTORY

Patient Medical History(Check all that applies:

❑Heart Condition ❑Asthma ❑Skin Condition ❑Migraines/Severe Headaches ❑Diabetes ❑Low/High Blood Pressure

❑Cancer ❑Seizures ❑Kidney Disease ❑Other(Please specify):_____

Is there any other medical history?

List any Medications/Allergies:

_____

_____

PHARMACY NAME:
PHARMACY ADDRESS/PHONE#:

LIST ANY PERSONS AUTHORIZED TO BE ACCOMPANIED BY YOUR CHILD:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Name:	Policy #:	Group #:	Effective Date: / /

Policyholders Name:	Birth date: / /	Subscriber's S.S. #:	Phone #: ()

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policyholder's Address (if different):

Employer Name:	Occupation:	Employer address:	Employer Phone #: ( )
Secondary Insurance Name:	Policy #:	Group #:	Effective Date: / /
Policyholders Name:	Birth date: / /	Subscriber's S.S. #:	Phone #: ()
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other			

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nova Pediatrics or insurance company to release any information required to process my claims.			
Parent/Guardian signature		*Date*	

Nova Pediatrics

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") as amended is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contract you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.
Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you we are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and coy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 22, 2014, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by Asking to speak to our Privacy Officer or for Written inquiries, note "Attention Privacy Officer", Nova Pediatrics, 6901 Lenox Village Drive, Ste 104, Nashville, TN 37211

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

_____ (Parent initials) **Consent for Treatment,** I the undersigned, hereby consent to the following: administration and performance of general treatments, use of prescribed medications, performance of diagnostic procedures/tests and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. A photocopy of this consent shall be considered as valid as the original.

_____ (Parent initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nova or insurance company to release any information required to process my claims.

_____ _____

Parent/Guardian signature *Date*