PEDIATRIC DAY HEALTH CENTER

# PATIENT REGISTRATION FORM

**How did you hear about us?**

| | | |
|---|---|---|
| ☐ | Physician Referral, Please List: | _____ |
| ☐ | Friend / Family | _____ |
| ☐ | Website | |
| ☐ | Facebook | |
| ☐ | Other, Please Specify: | _____ |

## CLIENT INFORMATION

Child's Full Name: _____

Date of Birth: _____ Sex (Circle One): Male Female

Language(s): _____

Patient Address: _____

City / State / Zip: _____

Pharmacy Name / Number: _____

Diagnosis: _____

_____

## PARENT INFORMATION:

Parent / Guardian: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Best Contact (Circle One): Home Cell Email

Parent / Guardian: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Best Contact (Circle One): Home Cell Email

PEDIATRIC DAY HEALTH CENTER

**PRIMARY INSURANCE**

Insurance Provider: _____
Insurance Group #: _____
Member ID #: _____
Name of Guarantor: _____
Insured's Date of Birth: _____
Insured's SS #: _____
Employer (if Group): _____
Insurance Phone #: _____
**Primary Care Physician:** _____
Physician Address: _____
City / State / Zip: _____
Phone #: _____

**SECONDARY INSURANCE**

Insurance Provider: _____
Insurance Group #: _____
Member ID #: _____
Name of Guarantor: _____
Insured's Date of Birth: _____
Insured's SS #: _____
Employer (if Group): _____
Insurance Phone #: _____
Date of Last Visit: _____
Fax #: _____

**PAYMENT OF BENEFITS AND REFERRAL:**

I direct payment of any medical benefits for services otherwise payable to me to Joycare Pediatric Day Health Center, not to exceed the reasonable and customary charges for those services. Further, I would like to request that a completed Patient Referral Form along with the most recent history and physical for the above listed patient be sent to Joycare Pediatric Day Health Center ***via fax to 832.240.3387 or via secure email to info@joycarekids.com***

Parent / Guardian: _____ Relationship: _____
Signature: _____ Date: _____

Parent / Guardian: _____ Relationship: _____
Signature: _____ Date: _____

**RELEASE OF INFORMATION:**

I hereby authorize Joycare Pediatric Day Health Center to release any information acquired in the course of treatment provided to my child, as necessary.

Parent / Guardian: _____ Relationship: _____
Signature: _____ Date: _____

Parent / Guardian: _____ Relationship: _____
Signature: _____ Date: _____

*If you would like to speak with a Joycare representative directly or need an additional copy of the Joycare Patient Referral Form, please call (713) 929-2273 or email info@joycarekids.com*

# NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)
# JOYCARE PEDIATRIC DAY HEALTH CENTER

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

Joycare Pediatric Day Health Center ("Center") is required by applicable federal and state laws to maintain the privacy of Client's health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to Client. Such information may include documentation of Client's symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose Client's PHI, without written authorization, for purposes of treatment, payment, and health care operations.

## Examples of Using Client's Health Information for Treatment Purposes:

- Our nurse obtains treatment information about Client and records it in Client's medical record.
- During the course of Client's treatment, the nurse determines he will need to consult with Client's primary care provider. He will share the information with the specialist and obtain his/her input.

## Example of Using Client's Health Information for Payment Purposes:

- We submit requests for payment to Client's health insurance company. We will respond to health insurance company requests for information from about the medical care we provided.

## Example of a Using Client's Information for Health Care Operations:

- We may use or disclose PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews or student training. We may share information about Client with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services. Client's health information is also subject to electronic disclosure for treatment, payment and health care operations.

## Client's Health Information Rights

**The health and billing records we maintain are the physical property of the Center. The information in them, however, belongs to you. You have a right to:**

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of Client's unsecured PHI (i.e., PHI that is not electronically encrypted);
- Request restrictions on certain uses and disclosures of Client's health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending Client's PHI to Client's health plan for payment or operations purposes if at the time an item or service is provided to Client, you pay in full and out-of-pocket and the disclosure is not otherwise required by law;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Center's designated record set. You may exercise this right by delivering your request, in writing, to our Center;
- Appeal a denial of access to Client's PHI, except in certain circumstances;
- Request that Client's health care record be amended to correct incomplete or incorrect information by delivering a written request to our Center. We may deny Client's request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Center, (c) is not part of the information that you would be permitted to inspect and

copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial within 60 days and will have an opportunity to submit a statement of disagreement to be placed in Client's record;

- Request that communication of Client's health information be made by alternative means or at alternative locations by delivering a written request to our Center;
- If we engage in fundraising activities and contact you to raise funds for our Center, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared Client's health information with outside parties, as required by the HIPAA Rules;
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Center (except to the extent action has already been taken based on a prior authorization).

## Our Responsibilities

### The Center is required to:

- Maintain the privacy of Client's health information as required by law;
- Notify you following a breach of Client's unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about Client and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about Client's health information and comply with your written request to refrain from disclosing Client's PHI to Client's health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Center.

## Other Uses and Disclosures of Client's PHI

### Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in care or payment for care, if you do not object or in an emergency.

### Notification

- Unless you object, we may use or disclose Client's PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for care about location, general condition, or death of Client.

### Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of Client's PHI. We may also disclose Client's information if the researchers require only a limited portion of Client's information.

### Disaster Relief

- We may use and disclose Client's PHI to assist in disaster relief efforts.

### Food and Drug Administration (FDA)

- We may disclose to the FDA Client's PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

### Public Health

- We may disclose Client's PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

### As Required by Law

- We may disclose Client's PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

### Law Enforcement

- We may disclose Client's PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if Client is a victim of a crime; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

### Health Oversight

- Federal law allows us to release Client's PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

### Judicial/Administrative Proceedings

- We may disclose Client's PHI in the course of any judicial or administrative proceeding as allowed or required by law, with Client's authorization, or as directed by a proper court order.

### For Specialized Governmental Functions or Serious Threat

- We may disclose Client's PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose Client's PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

### Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Clients to funeral directors as necessary for them to carry out their duties.

Other uses and disclosures of Client's PHI not described in this Notice will only be made with Client's authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of Client's PHI for marketing purposes, and disclosures of Client's PHI that constitute a sale of PHI will require Client's authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Client's Health Information Rights.")

## How else can we use or share your health information?

We are allowed or required to share your child's information in other ways, usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your child's

information for these purposes. For more information see https://www.healthit.gov/patients-families/your-health-information-privacy

## To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe Client's (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer (713) 929.2273, or in writing to us at:

**Compliance Department**
**Joycare Pediatric Day Health Center**
**6440 Sands Point Drive**
**Houston, TX 77074**
**admin@joycarekids.com**

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Client's complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 1-877-696-6775.

More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

Parent / Guardian: _____ Relationship: _____

Signature: _____ Date: _____

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**For Practice Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

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*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.