Liberty Pediatrics & Family Medicine, LLC

Thomas Hickey, MD / Manuel Datiles, DO / Lori Kropfelder, CRNP / Amy Paulino, CRNP / Anna Turpin, CRNP / Joanne Desmond, CRNP / Elizabeth Hall, CRNP / Erin Picotte, CRNP / Zoe Ajebon, DO / Sherry Dulling, CRNP / Jessica Kovolenko, CRNP / Samantha Hall, CRNP / Evan Dickstein, CRNP, Psychiatry.

New Patient Registration

Patient's Legal Name: ____

Date of Birth: ___/___/_____ Legal Gender: M/F Pronouns: ______/________

Preferred Name: _______________ Address: ______________________________________

Phone # ______-_______-_________ Email: ______________________________________

Emergency Contact

Name: ____________________________

Phone: _____-_______-__________

Relation: ____________________________

State Insurances require you to choose a Primary Care Physician (PCP). WE VALIDATE INSURANCE COVERAGE FOR EVERY VISIT. <u>IF WE ARE NOT THE PCP ON RECORD, WE WILL NOT BE ABLE TO SEE YOU UNTIL IT IS CHANGED</u>. You will need to call the insurance to change the PCP and provide our office with a reference number – If the PCP is not changed by the 1st visit, we will not be able to see you. Thank you!

PRIMARY INSURANCE:

Name of Insurance Company: ____________________________________

Address for Claim Submissions: ____________________________________

Phone # _____-_____-__________ ____________________________________

Policy Holders Name: ______________________________ Date of Birth___/___/______

Employer: ______________________________ Membership ID #_______________

Group # ___________________ Effective Date: ______________ Copay: _______________

SECONDARY INSURANCE:

Name of Insurance Company: ____________________________________

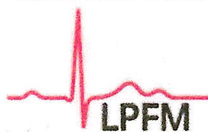
Address for Claim Submissions: ____________________________________

Phone # _____-_____-__________ ____________________________________

Policy Holders Name: ______________________________ Date of Birth___/___/______

Employer: ______________________________ Membership ID #_______________

Group # ___________________ Effective Date: ______________ Copay: _______________



5963 Exchange Drive, Suite 100
Eldersburg, Maryland 21784
Phone 410.549.0900 - Fax 410.549.6121

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MEDICAL RECORDS REQUEST

Thomas Hickey, MD | Manuel Datiles, MD | Lori Kropfelder, CRNP | Amy Paulino, CRNP | Joanne Desmond, CRNP | Anna Turpin, CRNP | Elizabeth Hall, CRNP | Erin Picotte, CRNP | Zoe Ajebon, DO | Sherry Dulling, CRNP | Samantha Hall, CRNP | Jessica Kovolenko, CRNP |

AUTHORIZATION TO RELEASE INFORMATION TO LIBERTY PEDIATRICS AND FAMILY MEDICINE

Patient Name: ______________________________ Date of Birth: ___/___/____

Home Address: ______________________________

Phone Number: ( )______-________ Alternative Number: ( )______-________

Patient, Parent, or Guardian's email address (please circle one): ______________________

I ____________________ (name) hereby authorize________________________ (previous physicians name) to send ALL enclosed and protected information for the following reason ________________________.

LIBERTY PEDIATRICS & FAMILY MEDICINE, LLC
5963 EXCHANGE DRIVE, SUITE 100
ELDERSBURG, MD 21784
(P) 410-549-0900
(F) 410-549-6121

PREVIOUS PHYSICIANS' INFORMATION:

PHYSICIANS NAME: ______________________

PHONE NUMBER: ( )______-________

FAX NUMBER: ( )______-________

Description of information to be disclosed (please check):

____ Complete records to include yours and any medical records that had been sent to you from previous providers including mental health, HIV, and/or substance records. (Cross out any items you do not authorize to be released)

____ Abbreviated Records – Including immunization records, growth charts, summary of visits and most recent physical exam.

_____ Records regarding treatment for the following condition or injury ________________________ on/or around ____________________ (date)

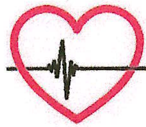
_____ Records covering the period from ____/_____/______ to ____/_____/______

_____ Other (please specify & dates) ______________________________

Please read and sign below. **WE CAN NOT REQUEST RECORDS WITHOUT A SIGNATURE AND DATE.**

1. I may revoke this authorization at any time by providing written notice to the practice.
2. I may not be able to revoke this authorization if the practice has already acted utilizing this authorization.
3. The practice will not condition treatment or payment based on me signing this authorization.
4. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
5. I acknowledge that I have had an opportunity to review the authorization and understand the intent and the use.
6. I am signing this authorization freely and no one has pressured me to sign it.
7. I have received a copy of this authorization.

SIGNATURE: ____________________ **DATE:** ___/___/_____ **RELATION:** ________



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Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information.
I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or that I am a self-pay patient this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification.
In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that to the extent permitted by law, I will reimburse my provider all costs, expenses and attorney fees incurred by my provider to collect those charges.
If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendering according to the plan's provisions. I understand that my failure to do so may result in a reduction or denial of benefit payments and that I will be responsible for the balances due.

Consent to Treatment
I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgement, deem necessary for my health and well-being; however, I may refuse any particular treatment or procedure.
If I request or initiate a telehealth visit (virtual visit), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.
My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infection, and/or HIV, if separate consent is not required by law), cast application/removal and vaccine administration. My consent shall also cover the carrying out of the orders of my treatment provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Treat
I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my "MyPrivia Patient Portal", or my emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA
I understand that my provider's Privacy Notice is available on my provider's website and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE, * and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: ______________________________ **Signature:** ____________________
Email: ____ **Date:** ______/________/________

Name and Relationship or Person signing, if not the patient: ______________________________

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.
***Note: If you DO NOT want to participate in Health Information Exchange (HIE), it is YOUR responsibility to follow the instructions outlined on my provider HIE Opt-Out Request Form and/or contact the HIE directly.**
Privia Financial Policy & Notice of Privacy Practices Effective 02/2022.

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HIPAA COMMUNICATION

Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing.

Patient Name: ______________________________ **Date of Birth:** _____/______/_______

I prefer to be contacted in the following manner (please check all that apply)

☐ **Send ALL communication through my Patient Portal**

☐ Cell Phone: (   ) ______-________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Phone: (   ) ______-________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Home Telephone: (   ) ______-________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication:
- ☐ Please send all my mail to my home address on file
- ☐ Please send all mail different address

Street Address ____

City__________________State______Zip code___________

My Preferred Contacts

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as sharing your test results. **YOU can control access to your patient portal.**

Please indicate the person(s) with whom you prefer to share your information with below. Please update this information in writing promptly if your preferences change.

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about general medical conditions and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 M-F 8AM-6PM EST.

Name: ____________________________ Relationship:__________________________

Contact Number: (   ) ______-_______ Email:______________________________

Name: ____________________________ Relationship:__________________________

Contact Number: (   ) ______-_______ Email:______________________________

Name: ____________________________ Relationship:__________________________

Contact Number: (   ) ______-_______ Email:______________________________

ACKNOWLEDGEMENT: I understand that HIPAA may permit my provider to share my information with other persons **NOT** named on this form as needed for my care, treatment and/or to obtain payment for services provided.

Patient Signature: _________________________________**Date:** ______/______/______

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