The Youth Clinic
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FAMILY CONTACT INFORMATION

----------PLEASE COMPLETE THIS FORM IN BLACK INK ONLY----------

Date_____ Patient #_____

Patient's Name_____ DOB____/____/_____ Gender M / F
First MI Last

School_____ Goes By_____ Patient Cell Phone #_____

Sibling(s)' Names	DOB	Gender	School	Goes By	Cell#
_____	_____	M / F	_____	_____	_____
First MI Last					
_____	_____	M / F	_____	_____	_____
First MI Last					
_____	_____	M / F	_____	_____	_____
First MI Last					
_____	_____	M / F	_____	_____	_____
First MI Last					

Primary Contact?

□ **Parent Name /Legal Guardian**_____ DOB____/____/_____ Gender M / F

Employer_____ Occupation_____

Primary Contact#_____ H / C / W Other Ph#_____ H / C / W

Relationship to Patient_____

□ **Parent Name/Legal Guardian**_____ DOB____/____/_____ Gender M / F

Employer_____ Occupation_____

Contact#_____ H / C / W Other Ph#_____ H / C / W

Relationship to Patient_____

□ **Parent Name/Legal Guardian**_____ DOB____/____/_____ Gender M / F

Employer_____ Occupation_____

Contact#_____ H / C / W Other Ph#_____ H / C / W

Relationship to Patient_____

□ **Parent Name/Legal Guardian**_____ DOB____/____/_____ Gender M / F

Employer_____ Occupation_____

Contact#_____ H / C / W Other Ph#_____ H / C / W

Relationship to Patient_____

Child lives with: □ Both Parents in same home □ Shared Custody □ Mother □ Father □ Other

Parents' relationship to each other: □ Married □ Divorced □ Separated □ Widowed □ Other

Are there any custodial restrictions we need to be aware of? □ No □ Yes – Please specify _____

Do we have a custodial agreement on file? □ Yes □ No – If no, please provide agreement to our office □ N/A

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NOTICE OF HEALTH INFORMATION 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 Youth Clinic is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by The Youth Clinic as well as records we receive from other providers.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Treatment: The Youth Clinic may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, The Youth Clinic will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Health Care Operations: The Youth Clinic may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) accreditation, certification, licensing, or credentialing activities; (3) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (4) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations, The Youth Clinic, may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

USES & DISCLOSURES TO WHICH YOU MAY OBJECT

Family/Friends: The Youth Clinic may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

Research: Under certain circumstances, The Youth Clinic, may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example,

the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: The Youth Clinic may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: The Youth Clinic may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, The Youth Clinic may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers' Compensation: The Youth Clinic may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military: The Youth Clinic may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, The Youth Clinic may disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted By Law: The Youth Clinic will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, The Youth Clinic, will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at The Youth Clinic are the property of The Youth Clinic, you have the following rights concerning your protected health information:

- ***Obtain a copy of this Notice of Privacy Practices upon request***
- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- ***Right to Amend:*** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are

required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.

- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the Compliance Officer at our main line, #(970) 267-9510.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint by calling our main line # (970)267-9510 or with the U.S. Secretary of Health and Human Services. To file a complaint with The Youth Clinic please contact the Compliance Officer at # (970) 267-9510. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: This Notice is effective for all protected health information created on or after September 23, 2013.

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Account Number:

Name of Patient:

Patient Date of Birth:

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the most recent Provider's Notice of Privacy Practices.

_____

Signature of Patient/Patient Representative

_____

Relationship to Patient

_____

Date

Acknowledgement of Receipt of Privacy Notice/Good Faith Efforts
Updated by HHS.gov September 2013
Reviewed 10/2015

Permission Regarding Disclosure of Your/Your Child's Health Care Information

I hereby authorize the following adults to accompany my child to an appointment and allow The Youth Clinic to speak to the individuals named below regarding my/my child's protected health information.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

AUTHORIZATION FOR TREATMENT IN CASE OF EMERGENCY: In case of emergency, if I cannot be reached, The Youth Clinic has my permission to treat the members of my family as necessary.

Signature: _____ Date: _____

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PATIENT INFORMATION FORM

----------PLEASE COMPLETE THIS FORM IN BLACK INK ONLY ----------

Appointment Date: Patient Account #:

Child's Name: Date of Birth:

Ethnicity: ___ Hispanic or Latino

___ Not Hispanic or Latino

Gender:

Religion: _____

Race: ___ White ___ Black or African American

___ American Indian or Alaskan Native ___ Native Hawaiian

___ Asian ___ Other Pacific Islander

Language: Is English your child's primary language? ___ Yes ___ No Please specify language _____

This information is required for Federal Vaccine Program (VFC)

rev. 10/2015

THE YOUTH CLINIC MEDICAL FINANCIAL POLICY

The Providers and Staff of The Youth Clinic want to welcome you and your family to our Clinic. We want to make sure that every encounter you have with our Clinic from Patient Care to Billing is a positive and refreshing experience. In order to ensure this, we have prepared the following financial policies.

Your Visit

Please be prepared to do the following;

- Present your current insurance card at every visit.
- Be prepared to settle any co-pay or deductible. We accept cash, checks, and all major credit cards. A minimum of $75 towards your deductible will be collected at the time of service
- If you do not have insurance, a minimum of $75 towards visit will be collected at the time of service.

Cancelled Appointments

We require 24 hours notice for cancellation of any well care or medication check. We ask for one hour cancellation of any other appointment. If not given appropriate notice or your visit is missed, please reference the information below for charge assessment.

Missed Appointment	Assessed Charged
Nurse Visits	$10.00
1st missed appointment	courtesy notice
2nd missed appointment	½ of estimated visit charge
3rd missed appointment	full estimated visit charge presented to Medical Director for family dismissal

Complete Insurance Information

In order to file your insurance, we must have complete insurance information including:

- Insured's Name, Date of Birth and Employer information
- Group Number & Plan Address

All of the above information is listed on your insurance card which you will be asked to present at every visit. If you are unable to supply us with a valid insurance card, you will be in self-pay status until your information is provided.

Changes In Insurance Coverage

If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Non-Participating Insurance Plans

If The Youth Clinic does not participate with your insurance plan several options are available.

- You may request an itemized statement from our Business Office and file the claim with your insurance company.
- The Youth Clinic can file a claim to your insurance company on your behalf.
- You may contact our Business Office to set up a payment arrangement at (970) 416-6271.

Newborn Insurance Coverage

If your child is a newborn, there may be a delay in the processing of claims. It is your responsibility to make sure your newborn child is added to your insurance. If you do not have your child added to your insurance plan, you will be considered a self-pay patient and payment in full will be expected from you.

Primary Care Physician

Many insurance plans require a Primary Care Physician be assigned to manage your child's healthcare. It is your responsibility to ensure you have chosen a Youth Clinic Provider as your child's Primary Care Physician. You may see any Provider at The Youth Clinic, regardless of your Primary Care assignment.

Insurance Payment Delays

The Youth Clinic is committed to partnering with its patients to resolve insurance payment delays. You may be called on to assist us in resolving issues with your insurance company. If we experience delays in payment beyond 60-days, you will be notified. It is important that you contact us immediately so we can resolve any issues and avoid holding you responsible for unpaid claims. Please call (970) 221-3489.

Coordination Of Benefits

Coordination of benefits will be the responsibility of the parent. The Youth Clinic will mail an insurance claim to your secondary carrier, but will not provide copies of the Explanations Of Benefits.

Responsible Parties

Parents who maintain custodial care of their children will be considered the Guarantor of the patient. Billing statements and other correspondence will only be sent to the address listed under the Guarantor. The Youth Clinic will not provide joint statements due to joint custody arrangements. Insurance information from other responsible parties may be added to the patient's account; however, payment of bills owed to The Youth Clinic will be the responsibility of the Guarantor.

Billing Statements

Statements are sent out by The Youth Clinic on a monthly basis. Any patient responsible balances due on your account may be reflected on your statement.

Returned Checks

A $10.00 service charge will be added to all returned checks.

Service Charges

If your account has a patient balance over 60 days old, there will be a $5 service charge added to your account monthly until the balance is paid in full.

Collection Letters

If you receive a collection letter from us, the most important thing you can do is contact us. We have courteous, helpful staff that can assist you in setting up satisfactory payment arrangements. Payment plans are available by contacting our Business Office at (970) 221-3489.

Collections/Termination

Balances not paid within ninety days will be reviewed for placement with an outside collection agency. Patients whose account is placed with an outside collection agency may be terminated from our practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Bankruptcies

Parents who file for Bankruptcy on behalf of patients attending The Youth Clinic may be subject to termination from the practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Medicaid Patients

Parents of Medicaid patients enrolled in a Primary Care Physician program must ensure that a Provider at The Youth Clinic is selected as the Primary Care Physician. Failure to do so will result in delayed or cancelled appointments until the situation is corrected. If The Youth Clinic is unable to verify eligibility, you may be asked to reschedule.

Phone Charges

As an extension of our total care, our Providers are committed to be available to patients by phone 24 hours a day. After hours phone calls or prescription calls to a pharmacy may result in a charge at the Provider's discretion. Even though the patient care occurred on the telephone, the Provider still takes responsibility for your child's healthcare at that time.

I have read and understand the above policies and agree to the terms outlined above. Failure to sign this Financial Policy will result in dismissal from our practice.

_____ _____ _____

Signature **Date** **Account #**