



the **RIMLAND CENTER**
for INTEGRATIVE MEDICINE
guiding families to good health

New Patient Information Sheet

PATIENT INFORMATION

First Name: _____ **Middle:** _____ **Last:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
SSN: _____ **Sex:** M/F **Date of Birth:** ____/____/____
Preferred Phone: _____ **Race:** _____ **Language Spoken:** _____

Ethnic Group (circle): Hispanic Not Hispanic Unknown

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____
Subscriber's Name: _____ **Relationship to Patient:** _____
Policy Number: _____ **Group Number:** _____
Insurance Company's Address: _____
Insurance Company's Phone Number: _____

Secondary Insurance

Insurance Company: _____
Subscriber's Name: _____ **Relationship to Patient:** _____
Policy Number: _____ **Group Number:** _____
Insurance Company's Address: _____
Insurance Company's Phone Number: _____

SCHOOL & PHARMACY INFORMATION

School Name: _____ **Phone Number:** _____
Pharmacy Name: _____ **Phone Number:** _____
Pharmacy Address: _____ **City:** _____ **State:** _____

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PARENT/GUARDIAN INFORMATION

Parent/Guardian 1 - Primary Guarantor (person responsible for patient's bill):

First Name: _____ Middle: _____ Last: _____

Address: _____

SSN: _____ Sex: M/F Date of Birth: ____/____/____

Marital Status: _____ Relationship to patient: _____

Employer: _____ Job Position: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian 2:

First Name: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ Sex: M/F Date of Birth: ____/____/____

Marital Status: _____ Relationship to patient: _____

Employer: _____ Job Position: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

EMERGENCY CONTACT (OTHER THAN PARENT)

Name: _____ Sex: M/F Relationship to patient: _____

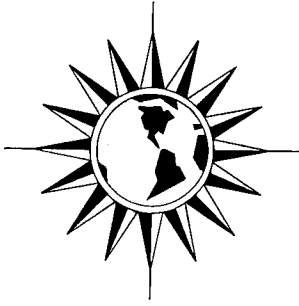
Primary Phone: _____ Secondary Phone: _____

Assignment & Release

I hereby authorize payment directly to *Advocates for Children and its practitioners* of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize *the above doctor and/or any provider or supplier of services in this office* to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____



ADVOCATES FOR CHILDREN
ADVOCATES FOR FAMILIES
INTEGRATIVE MEDICINE
guiding families to good health

2919 Confederate Ave 434.528.9075 ph
Lynchburg, VA 24501 434.528.9078 fx
www.rimlandcenter.com

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including diagnoses, records, examinations, and billing information rendered to my child. This information may be released to:

Name of Parent(s) _____

Name of Grandparents _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: my home _____

my work _____

my cell _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

do not leave any messages

Signed: _____ Relationship to child: _____

Date: _____

Financial Policy
Advocates for Children, Ltd.
2919 Confederate Avenue
Lynchburg, VA 24501

This is an agreement between Advocates for Children, Ltd., a Virginia Professional Corporation, as creditor, and the Patient/Debtor named on this form

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor or Guarantor for minor child. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Advocates for Children, Ltd.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a statement for 4 billing cycles only.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

Payment terms if you have no insurance:

You may pay by cash, check, or credit card on the day that treatment is rendered. We will make every effort to estimate the amount of your charges prior to your visit, and patients making full prompt payment will receive a 10% discount. We cannot guarantee that all charges will be captured at the time of service.

Payment terms if you have insurance:

Insurance is a contract between you and your insurance company. Unless we participate with the insurance company, we are NOT a party to this contract. If we participate, we follow the insurance company's fee schedule. Your cost is limited to your plan deductible, coinsurance, and co-pay amounts. It is the insurance company that makes the final determination of your eligibility and benefits. If you have any questions regarding participation, please ask our front office staff. Our office will bill your primary and one supplemental insurance as a courtesy to you. You agree to pay any portion of the charges not covered by insurance. **If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization OR to do so in a timely manner may result in a lower payment from the insurance company.**

Any co-payments, coinsurance, or deductible required by an insurance company is part of your contractual agreement and MUST be paid at the time of service.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: There is a fee (currently \$35.00) for any checks returned by the bank.

Past Due Accounts: If your accounts become past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur plus all court costs. In case of suit, you agree the venue shall be in Lynchburg, VA. Please note that all accounts sent to collections will result in dismissal from the practice.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of divorce or separation, the **parent/guardian physically present at the time of service is responsible for any co-pays, coinsurance, or deductible owed.**

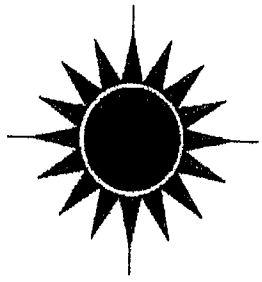
Missed Appointments: Appointments not cancelled 24 hours prior to the appointment time are subject to a \$50.00 charge. We offer reminder calls to help you keep your appointment however you are ultimately responsible for keeping or cancelling your appointments.

*******If your insurance is discontinued and you change to any form of Medicaid, we will be unable to continue to provide care.**

If you have any concerns or questions regarding the signing of this agreement, please see our office manager.

Patient's Name: _____ Date: _____

Responsible Party: _____ Relationship: _____



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Patient Medical History

Patient Name: _____

D.O.B. _____

Past Medical History

Indicate whether your child has been diagnosed, or suffered from, any of the following conditions

- | | | | | | |
|------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|
| Abdominal Pain | <input type="checkbox"/> | Double Vision | <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> |
| Acne | <input type="checkbox"/> | Down Syndrome | <input type="checkbox"/> | Mumps | <input type="checkbox"/> |
| ADHD | <input type="checkbox"/> | Ear Infections | <input type="checkbox"/> | Muscle Weakness | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | Numbness | <input type="checkbox"/> |
| Appetite Decrease | <input type="checkbox"/> | Environmental Allergies | <input type="checkbox"/> | PANDAS | <input type="checkbox"/> |
| Asperger's Syndrome | <input type="checkbox"/> | Facial Tic | <input type="checkbox"/> | PE tubes | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Fatigue/Malaise | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> |
| Autism | <input type="checkbox"/> | Febrile Seizures | <input type="checkbox"/> | Posture Problems | <input type="checkbox"/> |
| Autoimmune problems | <input type="checkbox"/> | Food Allergy | <input type="checkbox"/> | Premature Birth | <input type="checkbox"/> |
| Bloody Stool/Urine | <input type="checkbox"/> | Food Intolerances | <input type="checkbox"/> | Rash | <input type="checkbox"/> |
| Breathing Difficulties | <input type="checkbox"/> | Frequent Colds | <input type="checkbox"/> | Rectal Bleeding | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | GERD | <input type="checkbox"/> | RSV | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Hearing Problems | <input type="checkbox"/> | Rubella | <input type="checkbox"/> |
| Cellulitis | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | Runny Nose | <input type="checkbox"/> |
| Cerebral Palsy | <input type="checkbox"/> | Immunization Reaction | <input type="checkbox"/> | Seasonal Allergies | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Influenza | <input type="checkbox"/> | Seizure d/o | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> |
| Chronic Fatigue | <input type="checkbox"/> | Liver Problems | <input type="checkbox"/> | Sore Throat | <input type="checkbox"/> |
| Conjunctivitis | <input type="checkbox"/> | Low Muscle Tone | <input type="checkbox"/> | Speech Delay | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | Lyme's Disease | <input type="checkbox"/> | Strep Throat | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> | Measles | <input type="checkbox"/> | Vision Problems | <input type="checkbox"/> |
| Croup | <input type="checkbox"/> | Meningitis | <input type="checkbox"/> | Whooping Cough | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Medications

Please list any medications and supplements that your child is currently taking

Medication	Dosage	Start Date

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Allergic Reactions/Sensitivities

Please indicate any allergies or sensitivities your child has to any of the following substances.

- | | | | | | |
|----------------|--------------------------|------------|--------------------------|-------------|--------------------------|
| Aspirin | <input type="checkbox"/> | Latex | <input type="checkbox"/> | Pollen | <input type="checkbox"/> |
| Cephalosporins | <input type="checkbox"/> | Mold | <input type="checkbox"/> | Shellfish | <input type="checkbox"/> |
| Dairy Products | <input type="checkbox"/> | Peanuts | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> |
| Dust mites | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | Wheat | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> | Pet dander | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Surgical History

Please list any surgeries your child has undergone, as well as any complications involved.

Surgery	Year	Complications - if any

Social History

Please check all that apply.

- | | | | |
|----------------------------|--------------------------|------------------------|--------------------------|
| Child in preschool | <input type="checkbox"/> | Child in middle school | <input type="checkbox"/> |
| Child in kindergarten | <input type="checkbox"/> | Child in high school | <input type="checkbox"/> |
| Child in elementary school | <input type="checkbox"/> | Child in college | <input type="checkbox"/> |

Father's occupation: _____

Mother's occupation: _____

Parents Marital Status: single married divorced (recently / past) separated

Household Members: _____

Pets in Home: yes no if yes specify _____

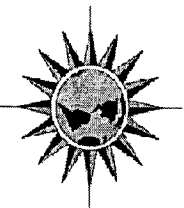
Home environment stressors: _____

Tobacco exposure Yes No

Child Care: None Babysitter Daycare (public / in-home)

Homeschooled: Yes No

Child is adopted: Yes No

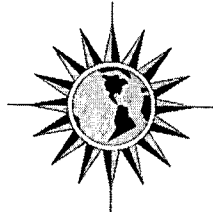


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Patient's Name: _____

Family Medical History	Father	Mother	Sibling(s)	Mother's mother	Mother's father	Father's mother	Father's father	1st cousin	Other
ADD/ADHD									
Alcohol Abuse/Drug Abuse									
Allergy to Milk									
Allergy to Wheat									
Alzheimer's Disease									
Anemia									
Asperger's Syndrome									
Asthma									
Autistic Spectrum Disorder									
Auto-immune problems									
Bipolar Disorder									
Breathing problems									
Bronchitis									
Cancer - please specify type									
Celiac Disease									
Cough									
Crohn's Disease									
Cystic Fibrosis									
Depression									
Diabetes									
Down Syndrome									
Ear Infections									
Eating Disorder									
Eczema									
Fungal Infections									
Glaucoma									
Hay Fever									
Headaches/Migraines									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Hives									
Hypertension									

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Telephone Policy

- *We do not provide medical care over the phone.* If you have a medical need we advise you to make an appointment.
- Urgent medical problems will be addressed by phone *as needed*.
- Changes in *current medication* and prescriptions for *new medication* **require an office visit.**
- Lab results are often given over the phone by our nurses. Our nurses are only informing you of the results, *not* giving an interpretation of those results. If you have any questions regarding this information you must make an appointment to talk with the doctor.
- If you are having a medication side effect or ineffectiveness we will be happy to see you immediately.
- Do not call asking to talk to the doctors, or to have the doctors call you back. They see patients throughout the entire day. If you want to talk to the doctors you must make an appointment. Messages left for the doctors will be dealt with on an urgent basis and will usually result in a request for an office visit.
- Telephone consultations are reserved for Advocates for Families patients. Telephone consult fees will be based on Dr. Mumper's preparation and actual time on the phone.

We want to provide you excellent, personal, medical care, not telephone care!

I have read and understand this telephone policy.

Parent/Guardian's Signature: _____

Patient's Name: _____ Date: _____

Notice of Non-Covered Services

Certain services may be recommended by your physician as a necessary part of your child's care. Please be advised that these procedures may be denied or the charge put toward your deductible by your insurance company. It is impossible for us to know the intricacies of every insurance policy prior to providing care. **Procedures commonly not covered include:**

- *Hearing Screening
- *Vision Screening
- *Wart Freezing
- *Chemical Cauterization
- *Lysis of Penile Adhesions
- *Earwax removal/curettng

Also PLEASE NOTE – well child visits are structured to discuss and provide preventive care only. They cannot be combined with sick visits, medication checks, or consultations. If your child is having any health problems that are addressed at his/her preventive care visits, your insurance company may request that you pay a copay to cover the additional services.

By signing below you acknowledge that all procedures performed in the office are recommended by our practitioners in order to provide quality care and that coverage for these procedures is not guaranteed.

Parent's Name (please print): _____

Parent's Signature: _____

Child's Name (please print): _____

Date: _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you or your child (as a patient of this practice) may be used and disclosed, and how you can get access to this health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

For Treatment:

We may use medical information about you to provide you with medical treatment or service. We may disclose medical information about you to external doctors, nurses, technicians and other health care personnel who are involved in your care.

For Payment:

We may use and disclose medical information about you so that the treatment and service you receive here may be billed to and payment collected from you, an insurance company or a third party.

For Health Care Operations:

We may use and disclose medical information about you for health care operations. To evaluate the care and services we offer, we examine our medical services, treatment plans and options, record-keeping, and communication with other doctors and nurses involved in your care.

For Research and Teaching:

We may use and disclose medical information about you for the purpose of teaching or research. While individually identifiable health information as defined by HITECH will not be disclosed, information regarding your health and/or healthcare may be disclosed to third parties for ongoing research and medical instruction. Additional information may be reviewed in our office handbook.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to your doctor at Advocates for Children, Ltd. or Advocates for Families, PLLC. For further information, call us at (434)528-9075.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your doctor. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact your doctor or the office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your doctor or the office manager at (434)528-9075.

The following special circumstances may require us to use or disclose your health information:

1. To public health authorities and agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

AFTER HOURS CARE

The Rimland Center would like you to know that while we are not open after 5pm, or on the weekends, there are centers we recommend for you to visit if you are in need of immediate care after hours.

There is also a nurse or doctor on call every night that may be able to give you the advice you need about how to care for your child, or to decide whether he or she needs to be seen immediately.

We recommend the following centers for after hours treatment:

CVFP Urgent Care

Airport Immediate Care – 434-239-0132

Amelon Immediate Care – 434-929-1095

Blue Ridge Immediate Care – 434-845-4175

Physicians Treatment Center

Lynchburg – 434-239-3949

Amherst – 434-946-5532

Huddleston – 540-296-0534

***Patients with Medicaid will need to go to Lynchburg General Hospital Emergency Room for after hours care.**