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)

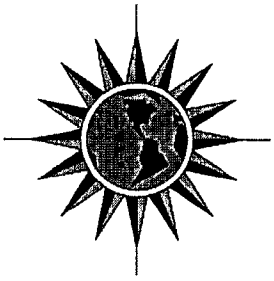
Name: _____ **Sex: M/F** **Relationship to patient:** _____

Primary Phone: _____ **Secondary Phone:** _____

Assignment & Release

I understand that Advocates for Families does not participate with any insurance companies. I agree to pay for services in full at the time of service. Advocates for Families will provide me with the necessary documents to file all visits with my insurance company to attempt reimbursement.

Signature of Responsible Party: _____ **Date:** _____



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Financial Policy

Advocates for Families, PLLC

2919 Confederate Avenue

Lynchburg, VA 24501

I have read the Advocates for Families page on the Advocates for Children website, www.rimlandcenter.com, and understand that I am responsible for all charges at the time of service. Advocates for Families will provide me with information for my insurance company but I am responsible for filing my own claim. Furthermore, I understand that dual appointments on the same day carry separate charges and I am responsible for those charges at the time of service.

I understand that all charges will be based on both the time I am with the physician as well as time spent reviewing records, labs, etc. These charges are based on the fee schedule provided on the website.

I understand that complex phone calls and requests for services addressed to the support staff at Advocates for Families will be billed at $50.00 per hour.

Child's Name: _____

Parent's Signature: _____ Date: _____

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

_____

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	☐	Latex	☐	Pollen	☐
Cephalosporins	☐	Mold	☐	Shellfish	☐
Dairy Products	☐	Peanuts	☐	Sulfa Drugs	☐
Dust mites	☐	Penicillin	☐	Wheat	☐
Eggs	☐	Pet dander	☐	Other	☐

_____

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	☐	Child in middle school	☐
Child in kindergarten	☐	Child in high school	☐
Child in elementary school	☐	Child in college	☐

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_____

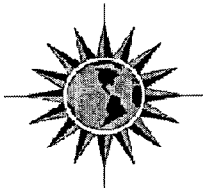
Home environment stressors: _____

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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Family Medical History	Father	Mother	Sibling(s)	Mother's mother	Mother's father	Father's mother	Father's father	1st cousin	Other
Insomnia									
Irritable/Inflammitory Bowels									
Kidney problems									
Learning Disability									
Leukemia									
Light Sensitivity									
Lymphoma									
Manic Depressive									
Mood Swings									
Night Vision Problems									
Obesity									
Obsessive Compulsive Disorder									
Panic Attacks									
Psoriasis									
Reflux/Heart Burn									
Schizophrenia									
Seasonal Allergies									
Seizure disorder									
Sinusitus									
Speech Delay									
Stomach Problems									
Stroke									
Surgeries - please specify									
Thyroid Problems									
Other - please specify									

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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 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.

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.

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 in 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.

Permission to Access Information

Patient Name:_____ DOB:_____/_____/_____

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

[ ] Information is not to be released to anyone.

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

Messages

Form of Contact:
[ ] home #_____
[ ] work #_____
[ ] cell #_____
[ ] email address _____
[ ] text

If unable to reach me:
[ ] you may leave a detailed message by phone
[ ] please leave a message asking me to return your call
[ ] do not leave a message

Please Note: E-mail communications with our office are through an onsite server. While we make every effort to keep our email protected and secure, we cannot guarantee a breach. By choosing email communication as an option, you acknowledge that are email server is not encrypted and could result in unauthorized access.

Signature:_____ Relationship to Patient:_____

Date:_____