PEDIATRIC PATIENT REGISTRATION

(Please Print)

Matthews-Vu
Healthcare for Children and Adults
4190 East Woodmen Road, Suite 100
Colorado Springs, CO 80920
Phone: 719-632-4455
Fax: 719-633-4613

Date: _____

Patient: _____
(Last Name, First Name, Middle Initial)

SSN: _____ Male: _____ Female: _____

Date of Birth: _____

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Information:

Mother: _____ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP: _____

Father: _____ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP: _____

* If mother & father are not living together or if the child does not live with the parents, what is the child's custody status?

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PERSONS AUTHORIZED TO ACCOMPANY AND PROVIDE CONSENT FOR TREATMENT OTHER THAN PARENTS:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PREFERRED PHARMACY NAME: _____

Location: _____ Phone: _____

PLEASE LIST ALL PERSONS LIVING IN THE CHILD'S HOME:

Name	Relationship to Child	Date of Birth

Are there siblings not listed? If so, please list their names and ages and where they live. _____

_____

Does anyone smoke in the home? Yes _____ No _____

Any pets? Yes ____ No _____ If yes, inside the home? Yes _____ No _____

How did you learn about our practice? _____

NAME OF INSURED/RESPONSIBLE PARTY: _____

Relationship to Patient: _____ SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Name of Primary Insurer: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of Secondary Insurer: _____

Contract #: _____ Group #: _____ Subscriber #: _____

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Matthews-Vu Medical Group to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Matthews-Vu Medical Group.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date

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CONSENT NOTICE

PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Richard P. Vu, M.D., Nur P. Matthews, M.D. and Shabnum Matthews-Vu, M.D. and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Richard P. Vu, M.D., Nur P. Matthews, M.D. and Shabnum Matthews-Vu, M.D., are not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Richard P. Vu, M.D., Nur P. Matthews, M.D. and Shabnum Matthews-Vu, M.D. reserve their rights to amend their Notice of Privacy Practices from time to time and that I many at any point request a copy of the current Notice at the address listed above.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent must be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

_____ _____
Signature of Patient/Personal Representative Date (MM/DD/YYYY)

_____
Printed Name

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HIPAA NOTICE OF PRIVACY PRACTICES

Health Information Covered By This Notice
Personal health information or health information is information we create or receive that identifies you and relates your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for health care furnished to you.

Our Pledge Regarding Health Information
We understand that health information about you is personal. We are committed to protecting the privacy of your health information by complying with all applicable federal and state privacy and confidentiality laws. We are required by law to maintain the privacy of your health information and to provide you with this Notice about the ways in which we may use and disclose health information about you, our legal obligations and privacy practices, and your privacy rights.

How We May Use and Disclose Health Information About You
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we explain what we mean and give an example. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information under federal law will fall within one of the categories. Except in certain limited cases such as emergencies, we are required to obtain your written consent prior to releasing your medical records to another party.

Treatment
We may use health information about you to provide you with health treatment or services. We may disclose health information about you to physicians, nurses, technicians, medical students, or other personnel who are involved in taking care of you. This facility may share health information about you for care coordination, such as prescriptions, lab work, and x-rays. We also may disclose health information about you to a specialist who is consulted about your treatment or care. It is also our practice to provide information about the care and treatment we provide to your referring physician of record so that he or she has appropriate information for providing future care to you.

Payment
We may use and disclose health information about you in order to obtain payment for services. For example, we may provide your health plan with information about services you received so your health plan will pay us or reimburse you for the clinic visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

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Authorization For Use or Disclosure of Medical Record Information

Medical Record #

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I authorize to release my medical records to the following:

☐ Mail Copies To *(address below)* ☐ Hold for Patient Pick-up ☐ Discuss Medical Record Information With *(address below)*

Name/Facility: **Matthews-Vu Medical Group** Attention: Medical Records Department

Address: **4190 E Woodmen Rd Ste 100** Phone: 719-632-4455

City: **Colorado Springs,** State **CO** Zip: **80920** Fax: 719-633-4613

Purpose of Request: ◯ * Personal ◯ Continuing Care ◯ * Legal ◯ * Insurance ◯ * Other_____

***COPY FEE** : We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.*
Base fee of 20.00 per chart for personal records. Please make checks payable to Bactes. Charts will be copied once payment is received.

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

_____ Date(s) of Treatment _____

_____ Date(s) of Treatment _____

_____ Date(s) of Treatment _____

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for Matthews Vu Medical Group to properly process your medical record request.

Release Records? Check one

	Yes	or	No	
Mental Health	☐		☐	Initial Here: _____
HIV Tests & Related Information	☐		☐	Initial Here: _____
Alcohol and/or Substance Abuse	☐		☐	Initial Here: _____

STOP Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, MVMG may be unable to fulfill this request.

Sensitive Information

Please check or indicate below any sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARC
☐ Genetic ☐ Domestic Sexual Assault ☐ Other(s) _____

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature/Relationship To Patient** **Date***

Witness **Date**

Know Your Privacy Right
refer to the HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise:_____. You may revoke this Authorization at any time by providing a written statement to the clinic where the Authorization was originally submitted, except to the extent that clinic has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:_____

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Patient does have a right to receive a copy of this form