



Welcome to our office. It is my privilege to be your Primary Care Physician; and I look forward to working with you to resolve any medical issues keeping you healthy and improving the quality of your life.

My office staff and I, are dedicated to providing you within the highest quality and efficient medical care. To do so, we have developed office policies to keep our office functioning efficiently to better serve you. Please take a moment to carefully review the following policies, and please feel free to ask questions for clarification.

Office hours are Monday through Friday and two Saturdays per month. We also have extended schedule two days a week. During this schedule, you can make an appointment or walk-in. If you need to be seen urgently, please call us as early as possible in the day, preferably as soon as the office opens. You may also leave a message on our answering machine after hours and we will call you back within the next business day.

All missed appointments are subject to a **\$25.00 charge**. We require a 24-hour notice for all cancellations. If you have missed 3 or more consequent appointments, you will be asked to find a new Primary Care Physician.

We do not fax, mail or email referrals, Doctor's notes, sick notes, lab requisition forms or lab results. Due to Health Insurance Portability and Accountability Act (HIPPA) regulations, they must be picked up in person during our working hours. Please give us 48 hours to prepare your forms, any forms that are dropped off to be filled by Dr. Pourrat may be subject to a **\$25.00 charge**. For ongoing medication refills, please have your pharmacy fax us a request form or call us during the office hours. Dr. Pourrat does not call in prescriptions during non-work hours. We encourage our patients to use the portal for easier access. Please ask front desk to set up your portal. Additionally, we don't give lab results over the phone- an appointment must be made to be able to discuss lab results.

Every school needs to give you the forms for schools and sports physicals, if you don't have them we provide them with an additional cost for the copies.

ALL COPAYMENTS / PAST DUE BALANCES ARE DUE AT TIME OF YOUR APPOINTMENT

We accept cash, checks and credit cards. If we have to bill you for overdue copayments or balances more than once, there will be a **5% interest** fee for each additional billing cycle. We will gladly file your health insurance claims on your behalf. However, if the claim is denied for reasons not related to our filling procedures, you are responsible for resolving the issue or paying the balance in full.

Thank you,

The Village Pediatric and Wellness Center

I have read and understand all the above policies. I understand that not following these guidelines may be grounds of being dismissed from this practice.

Signature of patient / parent / guardian

Date

**THE VILLAGE PEDIATRIC & WELLNESS CENTER
REGISTRATION FORM**

PATIENT INFORMATION

Date: _____
First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____ Sex: _____ Ethnicity: _____ Country: _____
Street Address: _____
Apt# _____ City: _____ State: _____ Zip Code: _____

Mother Information

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____ Ethnicity: _____ Country: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Marital Status: _____ Occupation: _____ Employer: _____
Email Address: _____

Father Information

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____ Ethnicity: _____ Country: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Marital Status: _____ Occupation: _____ Employer: _____
Email Address: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Chose THE VILLAGE PEDIATRIC & WELLNESS CENTER because:

Family Friend Close to home/work Webpage Insurance Other _____

Insurance Information

Aetna Amerigroup Blue Cross/Blue Shield Cigna Maryland Physician Priority Partners
 Riverside Tricare United Medicaid Self Pay Other.

Policy Holder

Name: _____ Last Name: _____ ID # _____
Date of birth: _____ Sex: _____ Group: _____ Copay: \$ _____

Emergency Contact (other than parent)

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

I authorize my insurance benefits be paid direct to the physician. I understand that I am financially responsible for any balance. I also authorize **THE VILLAGE PEDIATRIC & WELLNESS CENTER** or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____



THE VILLAGE PEDIATRIC & WELLNESS CENTER
50 West Edmonston Drive Suite 502 Rockville, MD 20852
Phone: 240-614-7999 or 301-637-3005 Fax: 866-449-4067

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of birth: _____

Address: _____

City _____ State _____ Zip Code _____

Home phone: _____ Cell phone: _____

I hereby authorize **The Village Pediatric & Wellness Center** to request my protected health information from:

Doctor's Office: _____

Doctor's Name: _____

Address: _____

Phone Number: _____

_____ Mail _____ Fax to The Village Pediatric & Wellness Center

PURPOSE (change physician)

___ Changing Physician ___ Consultation ___ School ___ Other (specify) _____

INFORMATION REQUESTED (Please be specific and enter date of service if known)

___ Medical Record _____ Clinical Notes _____ Pathology reports

___ Consultation Reports _____ MRI reports _____ Medication Records

___ Immunization Record

___ Other (specify) _____

I have carefully read and understand the above, all my questions were answered to my satisfaction, I do herein expressly and voluntarily authorize the request of the above information about medical records, my condition from those persons or agencies listed above.

Signature of parent or guardian _____ Date _____

Signature of patient (18 years older) _____ Date _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: your child's health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating his/her health, diagnosing medical conditions, and providing treatment. For example, results of diagnostic or laboratory tests and producers will be available in your child's medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: your child's health information may be used to seek payment from his/her health plan and other sources of coverage. For example, his/her health plan may request and receive information on dates of service, the service provided, and the medical condition being treated.

Health care operations: your child's health information may be used as necessary to support the day-to- day activities and management of **THE VILLAGE PEDIATRIC AND WELLNESS CENTER**. For example, information on the services he/she received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: your child's health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law- enforcement investigations; and to comply with government mandated reporting.

Public health reporting: your child's health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your child's health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your child's information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your child's protected health information for marketing purposes when financial remuneration is involved. We may not sell your child's protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your child's protected health information.

Additional Uses of information

- Appointment reminders: your child's health information will be used by staff to send you appointment reminders.
- Information about treatments: your child's health information may be used to send you information on the treatment and management of his/her medical condition that you may find interesting.
- We may also send you information describing other health related products and services that we believe may interest you.
- Fundraising: We will not contact you or use your child's medical or personal information for fundraising purposes.
- Marketing: unless you request us to not to, there are some marketing activities for which we may use your name and address, to provide you with information about services available at our practice and changes that may occur in our practice. For example, if we move or add an office location, please check off the following box: please do not use my information for marketing purposes.

Your Patients Rights

You have certain rights under the federal's privacy standards. These include:

The right to reasonable requests that your child's protected health information not to be used or disclosed.

The right to receive confidential communications concerning your child's medical condition and treatment

The right to inspect and copy your child's protected health information.

The right to amend or submit corrections to your child's protected health information.

The right to receive an accounting of how and to whom your child's protected health information has been disclosed.

The right to change your mind and decide not authorize the use or disclosure of your child's protected health information.

The Village Pediatric & Wellness Center Duties

We are required by law to maintain the privacy of your child's protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Once your child turns 18 years old, he/ she will need to complete the disclosure form authorizing **The Village Pediatric & Wellness Center** to maintain communication with you regarding his/her medical and personal information. Disclosure authorizations will be until revoked by the patient in writing. If the patient would like to submit a disclosure form, he/she may obtain one from the desk receptionist on the day of his/her visit. Please note, once the patient is over 18he/she is the only one who can submit request for copies of medical records. Individuals named on the disclosure form cannot a release of records request on the patient's behalf.

The Village Pediatric and Wellness Center will share medical and personal information with both parents of a minor child. We cannot restrict communication with one parent at the request of unless legal court documents outlining the restrictions are presented to us. We may request to see a parent's photo identification and the original copy of the child's birth certificate if a parent requesting information has not been named in the original patient registration form.

Legal guardians may be required to show court documentation as a proof of guardianship.

Right to Revise Privacy Practices

As permitted by law, we reserve to amend or modify policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices win be applied to all health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. If you would like to use our Medical Request Form, you can find it in our web-site. www.thevillagepediatric.com .

Your request will be reviewed and will generally be approved unless they are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment about our practices, or if you believe that your child privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to:

The Village Pediatric & Wellness Center
50 W Edmonston Drive, Suite 502
Rockville, MD 20852

You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after September 18, 2013.

I acknowledge The Village Pediatric & Wellness Center has provided me with a copy of their Noticed of Privacy Practices Policy. I have read and understand my individual rights.

Patient Name _____

Date of birth _____

Parent/Guardian Name (Print) _____

Patient/Parent/Guardian Signature _____

Date _____



PRIVACY WAIVER LETTER

Dear Parent and /or legal guardian

The privacy of our patients and your family is very important for us. If you want to communicate with us for medical reasons, we offer you a secure HIPPA approved, our PORTAL.

(https://mycw104.ecwcloud.com/portal14237/jsp/100mp/login_otp.jsp)

We don't recommend using regular text, or any other regular social media program as WhatsApp, Messenger, Viber, etc. If you prefer not to use the portal, we need to know the best way you want to communicate with us as it is a legal liability for us.

Please sign this waiver letting us know the preferred way to communicate with you. This waiver is to be renewable annually.

Secure ways to communicate with us:

Portal (encrypted e-mail) _____

Phone ___ can we leave a message in your answering machine/ voicemail ___ Yes ___ No

Name of the person who can receive a message if you are not home _____

Unsecure ways to communicate with us:

Text___ Messenger ___ WhatsApp ___ Regular email ___ Other _____

Occasionally, If the medical condition requires it, we may need to take pictures of your child for medical reasons to keep on your' s child medical records. For your privacy we require your permission to take the picture, it will never be copied, resend. It will be taken with a camera without capacity for electronically transmission.

Agree _____ Disagree _____

Parent/Guarantor Name _____

Parent/Guarantor signature _____

Date _____



Appointment Cancellation Policy

Dear Patient/Parent/Legal Guardian

In order to give you the best possible care, a time has been specifically reserved for your appointment. If you can't come at your scheduled time, please call us at least 24 hours before the appointment.

If you fail to show up for your scheduled appointment or you do not notify the office at least 24 hours in advance of your cancellation, we will charge \$25.00 to your account.

Thank you for your understanding and cooperation.

Patient name

Signature of patient or guardian

Date



CONSENT TO TREAT, RELEASE OF INFORMATION, AND FINANCIAL RESPONSIBILITY GUARANTEE

**THE VILLAGE PEDIATRIC & WELLNESS CENTER
Single Consent to Share Medical Information with Children’s IQ
Network Providers Treating Me or My Child**

INTRODUCTION

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, **THE VILLAGE PEDIATRIC & WELLNESS CENTER** has elected to participate in the Children’s National Health System’s IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child’s health care provider and one of the country’s leading children’s hospitals.

This **SINGLE CONSENT** will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child’s healthcare information is encrypted (encoded) and **can be accessed only by health care providers who are caring for you or your child and have a need to know.**

As **THE VILLAGE PEDIATRIC & WELLNESS CENTER** is a part of the Children’s IQ Network, this written **SINGLE CONSENT** will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child’s treatment. You do have the option to opt out of the Children’s IQ Network. If you choose to opt out, you will need to sign a separate consent form each and every time you or your child need to be seen by another member of the Children’s IQ Network other than those at **THE VILLAGE PEDIATRIC & WELLNESS CENTER.**

PATIENT RIGHTS: I have received a copy of the **Children’s IQ Network (CIQN)** Information Sheet. I understand that patient information will still be stored electronically for my provider’s records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN.

PROTECTED DISCLOSURE OF INFORMATION: I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child’s treatment as defined in the Notice of Privacy Practices. I agree to Children’s National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

Patient Name

Date of Birth

Signature of Parent/Legal Guardian/Patient 18 yrs of age or older

Date