PEDIATRICS

New Patients: Are we a good fit for your family?

As a Patient Centered Medical Home, our physicians and staff feel that effective health care is achieved when all parties work together. It is important for our families to agree and abide by our office philosophies and policies, fostering a successful relationship. When all parties have mutual healthcare goals and philosophies, excellent healthcare is achieved.

Please see our key office philosophies and policies below. Our practice may not be a good fit, if you feel the information below cannot be respected and followed. Please feel free to call the office with any questions or concerns. We look forward to meeting you.

Topic	Policy/Philosophy
Vaccines	Our practice follows the CDC guidelines and schedule. We require children to be up to date on vaccines by the age of 2.
Medical Home	As a Patient Centered Medical Home, we ask families to contact our office first unless it is an emergency.
Hours	Our Blacksburg and Radford locations are open from 8:00am-7:00pm, M-F. We are open for same day scheduled appointments on Saturday from 8:00am-12:00pm and Sunday from 12:30pm-3:30pm. We have walk in hours at both locations M-F from 8:00am-10:00am.
Appointments	Except for walk in hours, we ask families call our office to schedule an appointment. We ask all families to schedule yearly well care for their children. We do ask families to call and cancel appointments at least 24 hours in advance. Failure to come to multiple appointments without contacting our office can result in discharge from the practice.
After Hours	We have an on-call physician available 24/7/365.
Insurance	It is your responsibility to know your insurance coverage. Please make sure our office accepts your insurance. We ask you have your up to date insurance card available at every visit.
Billing	We ask for copays to be paid at the time of service. Failure to pay your copay, will result in a $10.00 service charge. You will be responsible for your balance after insurance has paid including but not limited to your deductible or co-insurance. If you do not have insurance coverage, self-pay charges will be due at time of service.

Please sign below indicating you have read and agree to the above policies.
Child(ren)'s Name: _____
Parent or Legal Guardian Signature: _____

New Patient Form

A **parent** or **legal guardian** must complete this packet and return it to New River Valley Pediatrics. For multiple children, please complete the patient information sections for each child only. If you have a newborn that has **NOT** been seen by another provider, please call our office to schedule. **Completion of this packet does not guarantee acceptance in the practice.**

Please circle: I prefer my child to be seen primarily in the **Radford** or **Blacksburg** location.

Please circle: Is your child up to date on immunizations? **Yes** or **No**

Date:

_____

Child's name:

_____

Date of birth:

_____

Address:

_____

Insurance company name:

_____

Policyholder's name and date of birth:

_____

Insurance ID number:

_____

Current medical conditions:

_____

Past medical conditions:

Current Primary Care Physician (PCP):

Current medication prescribed by PCP:

Specialists the child is currently seeing or has seen in the past:

Medication prescribed by specialist:

Parent or legal guardian name:

Address (only if different from child):

Phone number:

Date of birth:

Custody Information- If there are custody arrangements, please indicate below. If you have legal paperwork or paperwork from a Department of Social Services in regard to custody, our office will need that information before proceeding with the new patient process.

Any other pertinent information our office needs to know about your child:

The attached authorization form will need to be completed by a **parent or legal guardian** for each child. A copy of a **photo ID** of the person completing the form will need to be attached. If the paperwork is dropped off in the office, a copy of the photo ID can be made. If the paperwork is faxed, photo ID will need to be included with the faxed paperwork.

The completed authorization form will be sent to the current provider. Receiving the medical records does **NOT** guarantee your child will be a patient of New River Valley Pediatrics.

If New River Valley Pediatrics does not accept your child after receiving medical records, records will be given to a parent or legal guardian upon signing an authorization in our office with photo ID.

Please deliver completed paperwork to the office you would like your child to be seen in (see addresses below) or fax to 540-639-9215 (Radford), 540-552-2305 (Blacksburg). If you have immunizations or medical records, please drop those off with your completed packet.

A NRV Pediatrics new patient coordinator will be your point of contact and will advise you on the next steps in possibly becoming a new patient after receiving this **completed packet** with a **photo ID of parent or legal guardian**.

New River Valley Pediatrics Locations:

Radford Office- 202 Eighth Street, Radford, VA 24141

Blacksburg Office- 805 Davis Street, Blacksburg, VA 24060

CNRVMC Office- 2900 Lamb Circle, Suite 160, Christiansburg, VA 24073

****Incomplete forms will NOT be reviewed by our new patient coordinators.****

Office Use Only:

Date form received:	Accepted in practice: Y or N
Release form signed/ID verified:	Appt scheduled on:

NEW RIVER VALLEY PEDIATRICS

202 Eighth Street
Radford, VA 24141
540-639-5188 (phone)
540-639-9215 (fax)

805 Davis Street
Blacksburg, VA 24060
540-552-7272 (phone)
540-552-2305 (fax)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATON

Patient's Full Name _____ Date of Birth _____

I hereby authorize New River Valley Pediatrics to ☐ disclose ☐ receive the following protected health information below:

____Immunization Records ____Labs/Studies ____Sensitive Information (i.e. HIV testing, STD testing, drug testing, mental health)
____Office Visit ____Radiology Reports
____Other_____

Dates of Service:_____

Release To *or* Receive From:

_____ _____ _____
Name/Agency Phone Number Fax Number

_____ _____ _____ _____
Street Address City State Zip Code

Purpose of Disclosure: _____ Continuity of Care/Changing Providers _____ Legal Representation _____ Insurance
_____ Personal Copy _____ Other_____
_____ Dissatisfield with NRV Pediatrics (please state why)_____

I have read and understand that:

- The information that I am authorizing to be disclosed may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
- My health care and the payment for my health care will not be conditioned on signing this authorization.
- The signing of this authorization is voluntary.
- A copy of this release may be accepted by the health care facility in lieu of the original, and that I am entitled to a copy of this authorization.
- I may revoke this authorization at any time by notifying the Privacy Officer at NRV Pediatrics in writing, but if I do, it will not have an effect on actions already taken prior to receiving the revocation.
- If not previously revoked, this authorization will expire one year from the date of signature or on _____.
- I am responsible for any fees that may be associated with copying records I request including costs of supplies, labor and postage. The charge for this service is $.50 per page up to 50 pages; $.25 per page for 51 pages and up. Fee:_____
- The requested PHI will be released within 15 days of the receipt of this signed authorization.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
Printed Name Relationship to the Patient

Identification (ID) checked? _____Yes _____No Checked by:_____
Copies were: _____Mailed _____Picked Up Date Released_____
New Address for patient if moving_____