5510 UTICA RIDGE ROAD SUITE 200
DAVENPORT, IA 52807
PHONE: (563) 949-4477
FAX: (563) 949-4478

DATE: ________________________

PRIMARY CARE PHYSICIAN(PCP): ____

REASON FOR VISIT:____

PATIENT INFORMATION

LAST NAME:____________________________________FIRST NAME:____ MI: _______

DATE OF BIRTH: _______/_______/________ AGE: _______ CIRCLE: Male OR Female

RACE: □White □Black □Asian □Native Hawaiian/Pacific Islander □American Indian/Alaskan Native □Hispanic □Other

ETHNICITY: □Hispanic/Latino □Non-Hispanic/Latino □Unreported/Refused

LANGUAGE: □English □Spanish □French □Arabic □Chinese □Sign Language

PRIMARY PHONE: (HOME)________________________________ (CELL) _____________________________

MAILING ADDRESS: ____ APT(IF NEEDED):____________

CITY:____ STATE: ________________ ZIP: _________________________

E-MAIL ADDRESS: ____

PHARMACY: ____ADDRESS:____

PARENT OR GUARDIAN

FATHER	MOTHER
NAME:	NAME:
DATE OF BIRTH:	DATE OF BIRTH:
PHONE:	PHONE:
ADDRESS (If different):	ADDRESS (If different):
SSN:	SSN:

INSURANCE INFORMATION

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
POLICY HOLDER'S NAME:	POLICY HOLDER'S NAME:
SSN:	SSN:
DOB:	DOB:
EMPLOYER:	EMPLOYER:
PHONE # (FOR THE POLICY HOLDER IF DIFFERENT FROM ABOVE):	PHONE # (FOR THE POLICY HOLDER IF DIFFERENT FROM ABOVE):

Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information

I, ____ declare that I am the parent or legal guardian of the following child:

-___________________________________born on ________/_______/__________.

I do hereby grant the following person/people below the authority to obtain medical treatment as needed for the above listed child.

Full Name: ____

Full Name: ____

Full Name: ____

Full Name: ____

I grant the person/people listed above permission to do the following in service of seeking medical treatment for my child:

- Obtain medical treatment/procedures for the child as may be appropriate or necessary in routine or emergency situations, including and not limited to treatment by doctors, nurses, hospital and clinic personnel, and any other appropriate and qualified healthcare providers.
- Obtain routine medical treatment/procedures for the child from appropriate and qualified healthcare providers if symptoms of illness occur and the person/people listed above is reasonably certain medical treatment is necessary and in the best interest of the child.
- Obtain medical treatment/immunizations for the child from appropriate and qualified healthcare providers.
- Administer over the counter medications to the child as prudent and necessary.

If necessary, the person/people listed above should contact the following health provider to provide medical information and consultation and set up an appointment if necessary:

- ____

Child's Primary Care Provider

If the child requires hospitalization, , the person/people listed above should make every reasonable effort to use the following:

- ____

Name of Hospital

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period. The authorized person may provide physicians, nurses, and other healthcare providers with the child's health information.

This granting of authority shall begin today and remain in effect until I provide new documentation stating otherwise.

In case of emergency, the person/people listed above should first contact the parent.

____ ______________________________ _______________

Signature of parent /legal guardian Printed Name Date Signed

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy and Informed Consent for telemedicine Services

I acknowledge that I have received the HIPAA Notice of Privacy Practices, Financial Policy, and Informed Consent for telemedicine Services from Just 4 Kids Urgent Care, P.C. I give my consent for the contact via email, phone calls, or voicemail messages. I have read the Informed Consent for telemedicine Services document carefully, and understand the risks and benefits of the telehealth consultation. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. I have also read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

____ ____________________

Signature of parent/ legal guardian Date Signed

____ ____________________

Printed Name of parent/ legal guardian Relationship to Child

Reason Acknowledgement Not Received

The patient, after best effort, did not acknowledge receipt of a HIPAA Notice of Privacy Practices from Just 4 Kids Urgent Care, P.C., because of the following reason(s):

_____________Patient refused to sign acknowledgement form

_____________Patient deceased

_____________Unable to locate patient

Other: (Specify) ____

____ ____________________

Signature of Employee and Title Date Signed

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. Any prior balances must be paid prior to the visit.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Co-payments are due at time of service. The parent or adult accompanying a minor is responsible for payment at the time of service. In the event of a separation or divorce, Just 4 Kids Urgent Care, P.C. will hold both parents responsible for payment.
6. If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Collections Coordinator. Failure to keep these arrangements or resolve any past due accounts will result in immediate referral to a collections agency.
7. If previous arrangements have not been made with our finance office, any account balance outstanding over 60 days will be forwarded to a collection agency. All accounts sent to the collection's agency will also be reported to the Credit Bureaus.
8. The office will file your primary insurance for you as a courtesy and assist you in filling secondary claims. However, you will be responsible for negotiating any unpaid or dispute claims.
9. It is your responsibility to understand your benefit plan. It is your responsibility to know if an authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
10. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this

organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may
not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health
information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an
alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your
request for amendment, you have the right to file a statement of disagreement with us and we may prepare a
rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Office Manager in person or by phone at 563-949-4477.

Associated companies with whom we may do business, such as an answering service or delivery service, are
given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your
privacy. Our goal is always to provide you with the highest quality services.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to provide patient care, share individual patient medical information, remote monitoring and tele-pharmacy. Just 4 Kids Urgent Care, P.C. and/or its consulting physicians (which may include primary care practitioners, specialists, and/or subspecialists, "Providers") may deliver medical care to you via Telemedicine. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) patient medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; and (5) output data from medical devices and sound and video files.

Expected Benefits of Telemedicine:

- Improved access to medical care.
- Lower cost and greater efficiency to receive medical evaluation and management.
- Obtaining expertise of a specialist.

Possible Risks:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
- In very rare events, security protocols could fail, causing a breach of privacy of your personal health information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

You acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Telemedicine services. I understand that Providers offer Telemedicine services, but that these services do not replace the relationship between me and my primary care doctor. I also understand it is up to the provider to determine whether or not my needs are appropriate for a Telemedicine encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of my personal health information. I understand that Providers will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that Telemedicine may involve electronic communication of my personal health information to other medical practitioners who may be located in other areas, including out of state.

3. I understand there is a risk of technical failures during the Telemedicine encounter beyond the control of Providers. I agree to hold Providers harmless for delays in evaluation or for information lost due to such technical failures.

4. I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Providers are not able to connect me directly to any local emergency services.

5. I understand the alternatives to Telemedicine consultation, such as in-person services are available to me, and in choosing to participate in a Telemedicine consultation, I understand that some parts of the services involving physical tests may be conducted by individuals at my location, or at a testing facility, at the

direction of the Provider (e.g. labs or bloodwork).

6. I understand video images and audio recordings of me may be captured and stored electronically. I understand that these recordings may be later viewed and used for purposes of evaluation and training, which may include non-physician personnel of the Provider. I understand and consent to the use of these images and audio recordings for the Telemedicine consultation and, potentially, evaluation, education and training.

7. I understand that I may expect the anticipated benefits from the use of Telemedicine in my care, but that no results can be guaranteed or assured.

8. I understand that my personal health information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Provider in order to operate the Telemedicine technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the Telemedicine examination; and/or (3) terminate the consultation at any time.

9. I understand that I will not be prescribed any Drug Enforcement Agency controlled substances nor is there any guarantee that I will be given a prescription at all.

10. I understand that if I participate in a Telemedicine consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

11. I understand that in the event of any problem with the website or related services, I agree that my sole remedy is to cease using the website or terminate access to the service. Under no circumstances will Provider or any of its subsidiaries, affiliates or vendors be liable in any way for the use of the Telemedicine services, including but not limited to, any errors or omissions in content or infringement by any content on the website of any intellectual property rights or other rights of third parties, or for any losses or damages of any kind arising directly or indirectly out of the use of, inability to use, or the results of use of the website, and any website linked to the website, or the materials or information contained on any or all such websites. I agree that I will not hold Provider, its subsidiaries, affiliates or vendors liable for any punitive, exemplary, consequential, incidental, indirect or special damages (including, without limitation, any personal injury, lost profits, business interruption, loss of programs or other data on my computer or otherwise) arising from or in connection with my use of a Telemedicine consultation whether under a theory of breach of contract, negligence, strict liability, malpractice or otherwise, even if we or they have been advised of the possibility of such damages.

12. I understand that if I access Telemedicine services from a location outside of the United States, that I do so at my own risk and initiative and that I am ultimately responsible for compliance with any laws or regulations associated with my use.

13. Additional State-Specific Consents: The following consents apply to my participation in a Telemedicine consultation, as required by the states listed below:
a. Iowa: I understand that as necessitated by the availability of resources in the community where services are delivered, Telemedicine may be used in delivering and coordinating interventions with appropriate providers for autism support, subject to the licensure of the participating provider. Iowa Code Ann. § 225D.2.