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 devoting 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 **$50.00 charge for commercial insurances**. We require a 24-hour notice for all cancellations. If you have missed 3 or more consequent appointments, you will be receiving a dismissal letter and 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 72 hours to prepare your forms, any forms that are dropped off to be filled by Dr. Pourrat may be subject to a **$15.00** 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**. School forms are a $15.00 charge** and **Sports physicals are $20.00 charge**. As insurance payers do not cover these fees.

ALL COPAYMENTS / PAST DUE BALANCES ARE DUE AT TIME OF YOUR APPOINTMENT
We accept cash, checks and credit cards. If we 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's First Name: ________________________________Last: ___________________Date of Birth: _________ Sex: M/F

Patient's First Name: ________________________________ Last: ___________________ Date of Birth: _________ Sex: M/F

Patient's First Name: ________________________________Last: ___________________Date of Birth: _________ Sex: M/F

Patient's First Name: ________________________________Last: ___________________Date of Birth: _________ Sex: M/F

Patient's 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: _____________

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: ______________

How did you hear about THE VILLAGE PEDIATRIC & WELLNESS CENTER:
___ Family ____ Friend ____Close to home/work ____ Webpage ____ Insurance ____ Other _______________

THE VILLAGE PEDIATRIC & WELLNESS CENTER
121 Congressional Lane, Suite 510 Rockville, MD 20852
Phone: 301-984-0040 or 301-346-9243 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 to 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 website. 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
121 Congressional Lane, Suite 510
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://22881.portal.athenahealth.com/)
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 would 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

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 $50.00 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 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.

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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

Laboratory Policy

Charges for blood collections will be filled with your insurance company and if you do not have insurance coverage then you'll be charged out of pocket. Questions regarding bills received directly from laboratories such as LabCorp, Acutis Diagnostics, and Sunrise Medical Laboratories must be address with those companies specifically. We do not have access to their billing policies or patient accounts. We are not responsible for our third-party laboratory's invoices. By signing below, you have agreed and understand our third-party laboratories charges and fees are addressed directly with those companies

____

Patient name

____

Signature of patient or guardian

____

Date

Thank you for your understanding.