

RIVER PEDIATRIC CLINIC INTAKE FORM

PATIENT & CONTACT INFORMATION			
Name (First and Last):	Birth Date (MM/DD/YY):	Age:	Pronouns: <input type="checkbox"/> She/her <input type="checkbox"/> He/him <input type="checkbox"/> They/them <input type="checkbox"/> _____
Gender: <input type="checkbox"/> Girl <input type="checkbox"/> Boy <input type="checkbox"/> Transgender <input type="checkbox"/> Nonbinary <input type="checkbox"/> Prefer not to answer	Sex assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex	Race <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Prefer not to answer	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer
Email Address & Phone Number:		Home Address:	
Parent/Guardian 1 Information		Parent/Guardian 2 Information	
Name: _____		Name: _____	
DOB: _____		DOB: _____	
Phone: _____		Phone: _____	
Email: _____		Email: _____	
Address: _____ <input type="checkbox"/> Address same as patient		Address: _____ <input type="checkbox"/> Address same as patient	
Occupation: _____		Occupation: _____	
Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
Primary Insurance Provider: <input type="checkbox"/> Kaiser <input type="checkbox"/> Blue Shield <input type="checkbox"/> Aetna <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> MediCare <input type="checkbox"/> MediCal <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Insurance			
All services provided at RIVER Pediatric Clinic are free of charge, however we may use this information to help patients access services unavailable at our clinic.			

Does the patient have a pediatrician or primary care provider? Yes No

Name of Pediatrician: _____

Address: _____

Phone Number: _____

Last Appt: _____ Frequency of Visits: weekly/monthly annually less than annual

Preferred Pharmacy: _____
(Name & Address)

LANGUAGE PREFERENCE

Primary Language(s) Spoken at Home: English Spanish Other: _____

Language Preference: _____

Parent/ Guardian Signature: _____ Date: _____

GENERAL CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Patient: _____ **Birth Date:** _____

I hereby authorize RIVER Pediatric Clinic to provide my child with simple, common, and routine medical services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

Consent must be given for the following services:

1. Diagnosis and treatment of minor and acute illnesses	8. Vision and hearing screening
2. Diagnosis and treatment of mental health issues	9. Laboratory Services
3. First aid for minor injuries	10. Limited x-ray services
4. Physical examinations	11. Over-the-counter items/Prescriptions
5. Assistance with chronic ongoing illnesses, such as: asthma, diabetes, and epilepsy	12. Diet and weight control programs
6. Treatment of acne and other skin problems	13. Referral for health care services that cannot be provided at the Health Center
7. Immunizations	14. Emergency treatment

1. I understand that this consent only applies to services provided at RIVER Pediatric Clinic (RPC) or another Student Run Clinic which is a result of a referral made by the RIVER Pediatric Clinic and does not allow any other private or public facility to provide services to my child.
2. I hereby authorize RPC to give my insurance carrier(s) medical or dental record information needed to complete my child's insurance claims.
3. I understand that my child's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my child's care and treatment. No other release of my child's health information is allowed without written permission by me, except as permitted or required by law. I understand that RPC's privacy policy is published in the RPC Notice of Privacy Practices.
4. I understand that this consent may be revoked, restricted or revised at any time in writing by me, however, this will not affect services and/or treatment previously provided by RPC and other prior reliance by RPC on this consent. This Consent Form remains in effect until my child turns 18, or until revoked in writing.

Signature of Parent/Legal Guardian/: _____ Date: _____

Printed Name: _____

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT**

Name of Patient: _____ **Birth Date:** _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

YES NO

May we leave a message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with any member of your family?

YES NO

If YES, please name the member(s) allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Parent/Guardian Signature: _____

Date: _____