Mary M Varn, MD, LLC - Patient Information Sheet (CHILD)

Patient's Name _____ Sex: M F

Patient's Preferred Name (if different from above) _____

Mailing Address (street) _____

(city) _____ (state) _____ (zip code) _____

Social Security Number _____-____-_____ Date of Birth ____/____/____ Age _____

Phone Number (____) _____-_____ Home or Cell (please circle one)

Race (please circle one): Asian / Black or African-American / Hispanic / White / Other _____

Ethnicity (please circle one): Hispanic or Latino / Not Hispanic or Latino

Primary Care Physician's Name: _____

Who is responsible for payment? _____

Legal guardian (if **not** parent) _____
(We need a copy of the legal document which states you are the legal guardian of this minor.)

Parent(s)/Legal Guardian(s) Information:

Father's Name _____ Father's Date of Birth ____/____/____

Father's Employer_____ Father's cell phone (____) ____-_____

Mother's Name _____ Mother's Date of Birth ____/____/____

Mother's Employer_____ Mother's cell phone (____) ____-_____

Please provide email address for appointment reminders and portal access: _____

Alternate Contact (**not** listed above): _____ Phone Number: (____) ____-_____

	PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insured's Name	_____	_____
Insurance Carrier	_____	_____
Policy Number	_____	_____
Group Number	_____	_____

Appointment Information:

How would you like to receive appointment reminders: Phone Call or Text

I AUTHORIZE that all payments for medical services rendered to me or my dependents be made to MARY M. VARN, MD, LLC. **I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**
If my account becomes delinquent and outside collections are necessary, I am responsible for any and all costs required to collect said debt. I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

SIGNATURE: _____ **DATE:** ____/____/____

PAYMENT FOR OFFICE VISITS IS REQUIRED AT CHECK IN

Today's Date _____/_____/_____ **PATIENT INFORMATION**

Patient's Name: _____ Patient's occupation or grade in school: _____

What is the reason for today's visit? _____

_____

Please answer the following questions about the patient's health – circle all which apply or fill in the blanks

1. **Medical Conditions:** Allergies, Anemia, Arthritis, Asthma, Autism, Diabetes, GERD (reflux), Heart Disease/Murmur, High Blood Pressure (hypertension), Hyperactivity (ADHD), Lung Disease, Seizures, Other: _____

   _____

   Birth History: Birth Weight _____ / Gestational Age _____ weeks (or term) / Birth Complications _____

   _____

   Surgical History (type/date):_____

   _____
2. **Eye Problems:** Cataract, Cornea Problems, Crossed Eyes (strabismus), Double Vision, Glaucoma, Lazy or Wandering Eye (amblyopia), Macular Degeneration, Poor Vision, Ptosis (drooping eyelid), Retinal Detachment, Excessive Tearing, Other: _____

   Surgical History (type/date): _____

   _____
3. **List all medications taken regularly:** _____

   _____

   _____
4. **List all drug or other severe allergies:** _____

   _____
5. **Review of Systems** – circle all which apply for the patient

   General: Chronic Fever, Unexpected weight loss or gain, Fatigue

   ENT: Hearing Loss, Sinus Problems

   Heart: Chest Pain, Irregular Heart Beat, Angina, Arteriosclerosis, Heart Attack

   Respiratory: Shortness of Breath, Wheezing, Asthma, Bronchitis, Emphysema

   Gastrointestinal: Heartburn, Abdominal Pain, Diarrhea, Hepatitis, Colon Problems

   Urinary Tract: Bladder or Kidney Infections, Pain or Discomfort

   Skin: Rashes, Eczema, Dermatitis

   Musculoskeletal: Muscle Aches, Arthritis, Swollen Joints, Gout

   Neurologic: Numbness, Weakness, Paralysis, Headache, Developmental Delays, Reading Problems, Stroke

   Psychiatric: Depression, Anxiety

   Hematologic: Anemia, Sickle Cell Anemia Disease/Sickle Cell Trait, Immunosuppression, Blood Transfusion

   Allergy: Seasonal Allergies, Hayfever, Peanut, Tree Nuts

   Endocrine: Diabetes, Thyroid Problems, High Cholesterol
6. **Does patient smoke?** Yes or No If Yes, how much? _____

   Does patient drink alcohol? Yes or No If Yes, how much? _____
7. **Family History of Medical Disease:** Ansthesia Problems, Cancer, Diabetes, Heart Disease/Heart Attack, High Blood Pressure (hypertension), Stroke, Other: _____
8. **Family History of Eye Problems:** Cataract, Cornea Problems, Crossed Eyes (strabismus), Glaucoma, Lazy or Wandering Eye (amblyopia), Macular Degeneration, Retinal Detachment, Other: _____

FOR OFFICE USE ONLY: Reviewed: _____/ _____/ _____ by _____/ _____ MD

Mary M. Varn, MD, LLC
Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by **Mary M. Varn, MD, LLC** or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
Mary M. Varn, MD, LLC is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Polices and Practices" brochure provided to you. PLEASE REVIEW IT CAREFULLY.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.
Mary M. Varn, MD, LLC may or may not agree to restrict the use or disclosure of your protected health information (see authorization).
If **Mary M. Varn, MD, LLC** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will be affected.

Reservation of Right to Change Privacy Practices
Mary M. Varn, MD, LLC reserves the right to modify the privacy practices outlined in the notice. I understand that **Mary M. Varn, MD, LLC** will notify me of these changes via the method I have authorized or upon my next appointment.

Signature
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Polices and Practices" and give my permission **to Mary M. Varn, MD, LLC** to use and disclose my health information in accordance with this consent and the notice provided.

_____
Name of Patient (Please Print)

_____
Signature of Patient (if applicable)

_____
Date

_____
Signature of Patient Representative

_____
Relationship to Patient

REFRACTION SERVICE AND FEE

A refraction is done to determine whether an adult or pediatric patient is nearsighted, farsighted, or has astigmatism and whether glasses or contact lenses are necessary or need to be changed. This is an **essential** part of your eye examination and is **especially important for children** of all ages to **help us identify problems** such as amblyopia (lazy eye) and strabismus (crossed eyes) as well as to determine why a child may have failed vision screenings at school or a doctor's office. The refraction is critical to **helping us determine precisely how well you can see**. If your vision cannot be corrected with glasses, you may have some form of eye disease, and refraction may be the only way we can effectively determine this.

Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate vision plan that covers routine or annual eye examinations, please let us know. We do not participate with the following vision plans: EyeMed, Opticare, Spectara, VSP, and Blue Choice PEN.

Our office fee for a refraction is $30, and this fee is collected at the time of service in addition to any co-payment your insurance plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Medicaid will pay for one refraction every calendar year. If a refraction is needed prior to a **full year**, you are responsible for the refraction fee at the time of service.

Patient Acknowledgment

I have read the above information and understand a refraction may be a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ _____/_____/_____ _____

Patient Signature (parent or legal guardian if minor) **Date** Chart #

Compound Authorization for Treatment - CHILD

Patient Name: _____ **DOB:** _____

This authorization form permits: Dr. Mary M. Varn, MD, LLC, to use or disclose protected health information (PHI) to the entities or people listed below for the above named patient:

Authorization to leave Voicemail:
Indicate which voicemail boxes we may leave Appointments/Exam Results and Financial information:
Home #:_____ Cell #:_____

Authorization for Text Messaging for Appointments, Financial Information and Medical/Treatment Information:
Cell Phone #: _____

Authorization for School/Work Excuse:
☐ I do give authorization
Authorization for School/Work Clinical Information (fax eye exam, completion of school forms)**:**
☐ I do give authorization

Both Biological parents of minors are entitled to receive all information unless a court order indicates otherwise and is submitted to our office. List others you would allow to bring your child for an appointment and receive Appointment, Financial, and Medical/Treatment information (Must be 18+ years old): (Example: Step-Parents, Siblings, Grandparents, Aunt(s)/Uncle(s), etc.)

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Authorization for any Treating Facility to receive unencrypted email(s) Protected Health Information (PHI) regarding the patient (Example: Email from Dr. Varn to another Doctor regarding patient care)**:**
☐ I do give authorization

Verification Method or Code: This practice will verify the identity of any entity requesting protected health information (PHI). Please provide a password you wish us to use for this purpose (this is what we will use when you call/come in our office regarding the patients account for security purposes to insure who we are speaking with) It does not have to contain a specific amount of letters, numbers, and/or special characters.

Password: _____

Rights of the Patient: I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative (as defined by HIPAA) **Date**

Description of Personal Representative's Authority (attach necessary documentation):
Circle One: Parent of child / Legal Guardian / Foster Parent / Other – specify _____

Purpose: The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforced until revoked by the patient's parent or legal guardian in writing or the patient leaves the practice.

PERMISSION TO TREAT IN ABSENCE OF PARENT OR LEGAL GUARDIAN

Patient Name: _____ **DOB**: _____

If you have listed others (on the Compound Authorization Form) besides Biological Parent(s) or Legal Guardian to bring the minor please read and sign below:

I **give** my permission for Mary M. Varn, MD, LLC, to treat this child / minor **in my absence**. This means we will see patient if he or she is brought by someone other than the Parent or Legal Guardian (such as grandparent, aunt, uncle, friend, relative, etc.). **Please list anyone other than biological parents that would bring the minor on the Compound Authorization form.**

Signature: _____ **Date:** _____
(Parent/Legal Guardian)

(If being signed by Legal Guardian, we need a copy of the legal document which states you are the Legal Guardian of this minor)

OR

If no one besides Biological Parent(s) or Legal Guardian will bring the minor please read and sign below:

I **do NOT** give my permission for Mary M. Varn, MD, LLC, to treat this child / minor in my absence. This means we **WILL NOT** see your child if he or she is not accompanied by a Parent or Legal Guardian.

Signature: _____ **Date:** _____
(Parent/Legal Guardian)

(If being signed by Legal Guardian, we need a copy of the legal document which states you are the Legal Guardian of this minor)