



SOUTHWEST VIRGINIA  
COMMUNITY HEALTH SYSTEMS

Meadowview Community Health Center  
13168 Meadowview Square  
Meadowview, VA 24361  
Phone: (276) 944-3999  
Fax: (276) 944-3882

## Welcome!

We would like to take this opportunity to welcome you to our organization. We want to thank you for trusting us to be your primary medical care provider. Our mission is to provide care for all of your health needs. We provide care using a holistic approach for prevention and treatment. All of our services are integrated to provide you with the best possible outcomes.

Southwest Virginia Community Health Systems, Inc. provides services in Saltville, Tazewell, Meadowview and Bristol VA/TN areas. The services offered are primary medical, dental, vision and behavioral health. Please visit our website, [svchs.com](http://svchs.com), for more detailed information about our services and locations.

Enclosed with this communication are the forms that you need to bring to your first visit. It is very important that you bring your Insurance information and a picture identification card, as well. (A driver's license is preferred).

If you have questions relating to your visit, please feel free to contact our staff at 276-496-4492.

Respectfully yours,  
Bryan Haynes, Executive Director

Thank you for choosing Southwest Virginia Community Health Systems, Inc. to handle your healthcare needs.

Please take a few minutes to review and complete the Patient Demographics form as well as the General Consent form.

If you need a slide fee application or would like to review our Privacy policy, they are available on our website [www.svchs.com](http://www.svchs.com).

Please remember to bring these forms with you to your first visit. We look forward to serving you in the future.

### **Patient Rights**

This health center was created to serve the needs of your community. We want you to be an active part of your treatment here.

- We want you to know what you can expect from us. We want you to be informed about our policies regarding confidentiality, treatment of minors, and other ethical issues. There are some situations, however, when the law itself determines what we must do.
- We want you to know your rights as a patient of this center and to exercise them. A patient who participates in his or her care helps to create a successful outcome.
- You have a right to a reasonable response to your requests for treatment within the scope of the health center's mission, capacity, and regulations.
- You have a right to considerate and respectful care.
- You have a right to confidential treatment. You also have the right to approve or disapprove the release of any disclosures or records, except when release is required by law.
- You have a right to information about your diagnosis, treatments, and prognosis. This information will help you to make informed decisions regarding your care.
- You have the right to prompt and effective pain management and to be informed by staff about available measures.
- You have the right to access any information contained in your medical record.
- You have the right and responsibility to participate in decisions about the intensity and scope of your treatment, within the limits of the health center's mission and applicable laws.
- You have the right to care which takes into consideration your psychosocial, spiritual, and cultural values.
- You have the right to accept medical care, or to refuse treatment, to the extent permitted by law. You also have the right to be informed of the medical consequences of refusing treatment.
- You have the right to participate in the consideration of ethical issues that arise in your care.
- You guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you have been medically or legally determined to be unable to participate yourself.
- You have the right to be informed of any research or experimentation which could affect your care. You may then decide whether or not you want to participate in it.
- You have the right to be made aware of advanced directives and to know how this organization will respond to such advance directives.

This Information about patient rights can be found in: The Joint Commission's Comprehensive Accreditation Manual for Ambulatory Care, 2000.

## PATIENT “NO SHOW” POLICY SUMMARY

Our patients are strongly urged to keep their appointments. If you cannot make your appointment, please be sure to call as soon as possible when you know you will not be able to come for your visit. **“No show” patients (those who don’t call & cancel/reschedule, without at least an 2 hour notice or simply do not show up for a scheduled appointment)**, cause us to hold appointments that would otherwise be used by someone who is ill and may need to be seen by a provider.

**SVCHS, Inc.’s** policy regarding “no shows” is as follows:

1. **First “no show” occurrence** – Our staff will call to find out the reason for missing your visit and offer to make another appointment for you.
2. **Second “no show” occurrence** – You will receive a letter from our staff warning you of the consequences of not presenting for your visit.
3. **Third “no show” occurrence** – will constitute a “non-compliance issue” which will be discussed with your Care Team. The Care Team determines the severity of the action and determines the outcome. The third “no show” could result in a patient dismissal or necessitate a “Cancellation Status” for the patient. “Cancellation Status” means that if a patient needs to be seen by our providers, they must contact the office after 10:00 a.m. to check for the next available appointment.
4. If you are more than 10 minutes late for your appointment, you will be considered a “no show” and will have to reschedule your appointment for another day.

As partners in your care, we respect and acknowledge the confidence you show in our organization by allowing us to participate in your care. By the same token we ask that you respect us and accept responsibility for keeping your appointments as scheduled.

**We look forward to a long and rewarding provider/patient relationship and welcome you to our facility.**

**Thank you & Welcome!**

## *General Consent*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

1. **CONSENT TO FILE INSURANCE/CORRECT INFORMATION**

I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize SVCHS to file my insurance for services rendered. I request that payment be made directly to SVCHS. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for all charges incurred regardless of my insurance status or lack thereof. I also understand that I am, as a patient, required to abide by the policies of SVCHS, Inc.

2. **HIPPA NOTICE OF PRIVACY POLICY**

I acknowledge that I have received and or have read SVCHS's HIPPA Notice of Privacy Policy.

3. **CONSENT FOR TREATMENT**

I give my consent to the medical staff of SVCHS to perform emergency medical treatment, acute or chronic medical treatment, preventive health care, behavioral/mental health care, and health maintenance care as deemed medically necessary. (If the above named individual is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment.) A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.

4. **SVCHS is serious about the responsibility of keeping your medical and account information private and confidential. In order for us to share any of your information with someone else, you must designate who you want to have access to this information and give us your signed permission to share the information.**

- a. If we are unable to get in touch with you or someone calls the office about you, please list family members or others we may notify concerning your general medical condition, lab results, test results, other treatment results, or appointment information. If you do not list anyone, then we will not share your private information with anyone else.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Date \_\_\_\_\_

- b. If you wish to designate someone else to receive information concerning your account and balance information, please list below.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Date \_\_\_\_\_

- c. If we are unable to contact you and you have an answering machine, do we have your permission to leave a message?

Yes \_\_\_\_\_ No \_\_\_\_\_

5. **DATA PARTICIPANT** may make your medical information available electronically, or may electronically transmit your medical information to a third party, in order to fulfill Data Participant's obligations to release your medical information to others in the future.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE ANY OF THE ABOVE CONSENTS AT ANYTIME.)

Interpreter (if necessary) \_\_\_\_\_

Date: \_\_\_\_\_

**2021 Consent Revised**

**PEDIATRIC PATIENT DEMOGRAPHIC FORM**

**PERSONAL INFORMATION:**

NAME: \_\_\_\_\_  
                        First    Middle    Last

PREFERRED NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
                        PO BOX    PHYSICAL ADDRESS/STREET ADDRESS  
\_\_\_\_\_  
                        CITY    STATE    ZIP

TELEPHONE: HOME \_\_\_\_\_

                        CELL \_\_\_\_\_ OTHER \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX AT BIRTH: Male \_\_\_\_\_ Female \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

STUDENT: Full -Time \_\_\_ Part -Time \_\_\_ No \_\_\_ GRADE LEVEL: \_\_\_\_\_

SCHOOL/DAYCARE NAME: \_\_\_\_\_

RACE: American Indian or Alaskan Native \_\_\_\_\_ Asian \_\_\_\_\_ Black or African American \_\_\_\_\_  
                        Native Hawaiian or other Pacific Islander \_\_\_\_\_ White \_\_\_\_\_ Refused to respond \_\_\_\_\_

ETHNICITY: Hispanic \_\_\_\_\_ Non-Hispanic \_\_\_\_\_ Refused to respond \_\_\_\_\_

**RESPONSIBLE PERSON FOR PAYMENT:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOMELESS? YES \_\_\_ NO \_\_\_ IN TRANSITION? YES \_\_\_ NO \_\_\_

**FINANCIAL INFORMATION - RANGE OF INCOME PER YEAR: \_\_\_\_\_ # in household (including yourself)**

- |                           |                           |                           |
|---------------------------|---------------------------|---------------------------|
| _____ \$0 - \$5,000       | _____ \$5,001 - \$10,000  | _____ \$10,001 - \$15,000 |
| _____ \$15,001 - \$20,000 | _____ \$20,001 - \$25,000 | _____ \$25,001 - \$30,000 |
| _____ \$30,001 - \$35,000 | _____ \$35,001 - \$40,000 | _____ \$40,001 - \$45,000 |
| _____ \$45,001 - \$50,000 | _____ \$50,001 - \$55,000 | _____ \$55,001 - \$60,000 |
| _____ \$65,001 - \$70,000 | _____ \$70,001 - \$75,000 | _____ \$75,001 or higher  |

Do you feel financially strained? YES \_\_\_ NO \_\_\_

**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

**INSURANCE INFORMATION:**

INSURANCE NAME: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

SUBSCRIBER ID# \_\_\_\_\_

GROUP # \_\_\_\_\_ EFF. DATE \_\_\_\_\_

INSURANCE PROVIDED BY EMPLOYER? Yes \_\_\_\_\_ No \_\_\_\_\_

IS PATIENT COVERED BY INSURANCE? Yes \_\_\_\_\_ No \_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

SECONDARY INSURANCE (if applicable) \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ ID# \_\_\_\_\_

GROUP # \_\_\_\_\_ EFF. DATE \_\_\_\_\_

**PHARMACY** \_\_\_\_\_ **PHONE** \_\_\_\_\_

ADDRESS \_\_\_\_\_

Translator or interpreter required? Yes \_\_\_\_\_ No \_\_\_\_\_

**Patient (or) Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## MEDICAL HISTORY

### NEW PATIENT INFORMATION *(PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)*

Last Name		First		M.I.		DOB	
Previous or Current Primary Care Physician:							
Primary Care Physician Phone:							
Date of last physical exam/Well Child visit:							
Are your child's immunizations up to date? <i>(circle one)</i> Yes No Office where immunizations were given:							

### PLEASE LIST ANY OTHER PHYSICIANS THAT CONTRIBUTE TO YOUR CHILD'S CARE

NAME	CONTACT NUMBER	SPECIALTY	DATE OF LAST VISIT

### CURRENT MEDICAL PROBLEMS

*Please list any concerns or problems you would like to address with your child's physician:*


### MEDICATIONS *(PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)*

Provide Your Local Pharmacy Name and Phone:

List your child's prescribed and over-the-counter medications (i.e., vitamins, aspirin, inhalers)

Medication	Strength	Frequency Taken

**MEDICAL HISTORY** (PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)

Current and past medical diagnosis for your child (check all that apply)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Prematurity	<input type="checkbox"/> Hypogonadism
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Depression	<input type="checkbox"/> Allergies (specify)
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> ADHD	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Behavioral problems	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> GERD/reflux	<input type="checkbox"/> Bone Fractures	<input type="checkbox"/> Cancer (specify)
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> UTI	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Exposure to sexually transmitted diseases	<input type="checkbox"/> In utero drug, alcohol, or tobacco exposure (specify):	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> Currently pregnant? Estimated delivery date: _____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Exposure to Lead		

**ALLERGIES TO MEDICATIONS** (PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)

Check here if your child has no known allergies

Medication	Reaction Your Child Had

**SURGICAL HISTORY** (PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)

Operation	Year	Surgeon




<b>PAST HOSPITALIZATIONS</b> <i>(PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)</i>		
Reason	Year	Hospital

<b>FAMILY HISTORY</b> <i>(PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)</i>					
Relative	Current Age or Age at Time of Death	Heart Attack	Stroke	Cancer	Other Health Problems
Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased		<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____	
Father <input type="checkbox"/> Living <input type="checkbox"/> Deceased		<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____	
Sibling <input type="checkbox"/> Living <input type="checkbox"/> Deceased		<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____	
Sibling <input type="checkbox"/> Living <input type="checkbox"/> Deceased		<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____	

Sibling <input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Grandmother: Maternal <input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Grandfather: Maternal <input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Grandmother: Paternal <input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Grandfather: Paternal <input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes At age: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____

**SOCIAL HISTORY** (PLEASE FILL OUT THIS SECTION FROM YOUR CHILD'S PERSPECTIVE)

Birth Hospital:

Birth Complications:

Travel outside of USA:  No  Yes

Pre-term or Full term pregnancy: (circle one)

Birth weight/height:

**Alcohol**

Do you drink alcohol?  No  Yes

If yes, what kind?

How many drinks per week?

Are you concerned about the amount you drink?  No  Yes

**Tobacco**

Do you use tobacco?  No  Yes

Cigarettes \_\_\_\_\_pks/day  Chew \_\_\_\_\_#/day  Pipe \_\_\_\_\_#/day  Cigars \_\_\_\_\_#/day  E-cigarettes/vaping \_\_\_\_\_#/day

Number of years used:

Year quit:

Does anyone in the home use tobacco?

Cigarettes \_\_\_\_\_pks/day  Chew \_\_\_\_\_#/day  Pipe \_\_\_\_\_#/day  Cigars \_\_\_\_\_#/day  E-cigarettes/vaping \_\_\_\_\_#/day

Number of years used:

Year quit:

<b>Sex</b>	How many sexual partners have you had in the past six months?	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness or other sexual transmitted diseases?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Personal Safety</b>	Who lives in the home with the child?	
	Are there any firearms in the home? If so, are they secured properly?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Are there smoke alarms in the home?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Are there any medications kept in the home? If so, are they secured properly?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Depression</b>	In the past two weeks have you felt down, depressed or hopeless?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	In the past two weeks have you felt little interest or pleasure in doing things?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Anxiety</b>	In the past two weeks have you been feeling nervous, anxious, or on edge?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes the how frequently: <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day	
	In the past two weeks have you not been able to stop or control worrying?	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes the how frequently: <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day	
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)	
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)	
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes)	
<b>Domestic</b>	Over the last 12 months, has anyone close to you hurt, hit or threatened you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Drugs</b>	Do you or someone in the home currently use recreational or illicit drugs (including marijuana)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**RESPONSIBLE PARTY:**  
**Are you the Parent or Guardian? (Circle one)**

**PARENT 1:** \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
PHYSICAL ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ OK TO CONTACT VIA EMAIL? YES \_\_\_\_\_ NO \_\_\_\_\_  
PERMISSION TO: CALL WORK? YES \_\_\_\_\_ NO \_\_\_\_\_  
LEAVE A MESSAGE AT WORK? YES \_\_\_\_\_ NO \_\_\_\_\_  
LEAVE MESSAGE AT HOME? YES \_\_\_\_\_ NO \_\_\_\_\_

**PARENT 2:** \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
PHYSICAL ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ OK TO CONTACT VIA EMAIL? YES \_\_\_\_\_ NO \_\_\_\_\_  
PERMISSION TO: CALL WORK? YES \_\_\_\_\_ NO \_\_\_\_\_  
LEAVE A MESSAGE AT WORK? YES \_\_\_\_\_ NO \_\_\_\_\_  
LEAVE MESSAGE AT HOME? YES \_\_\_\_\_ NO \_\_\_\_\_

**PERMISSION LIST:**

This permission allows the individuals listed below to bring the patient to our office(s) for healthcare services (when you cannot be present). Please list Mother, Father, Step-parents or any other individual who may need access to the patient’s medical information and/or may need to bring the patient to our providers for treatment. **(PLEASE BE ADVISED THAT THE INDIVIDUALS LISTED BELOW MUST BE 18 YEARS OF AGE OR OLDER). This consent can be revised or altered at any time upon request.**

1. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
2. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
3. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
4. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
5. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
6. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Are there any custody issues regarding this child of which our provider’s need to be aware?

Explain: \_\_\_\_\_  
\_\_\_\_\_

PERMISSION TO COMMUNICATE WITH THE SCHOOL NURSE ABOUT YOUR CHILD'S HEALTH CARE NEEDS? YES \_\_\_\_\_ NO \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**IN INSTANCES OF DIVORCE OR SEPARATION, PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE ARE NOT PART OR PARTY TO ANY DIVORCE DECREE, SUPPORT AGREEMENT OR CHILD CUSTODY AGREEMENT. CO-PAYS ARE DUE AT THE TIME OF SERVICE FROM THE PARTY WHO BRINGS THE CHILD INTO OUR OFFICE.**

2022 PEDIATRIC CONSENT FORM - Rev. 05-18-22

## Permission for Telehealth Visits

### What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor, nurse practitioner, or dentist.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

### How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

### How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

### Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

### Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.

- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

**What if I try telehealth and don't like it?**

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
  - call 276-496-4433 chose your clinic site and say you want to stop
  - It will be as if you never signed this form.

**How much does a telehealth visit cost?**

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit for a medical visit. A teledentistry visit could cost more than an in person visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

**Do I have to sign this document?**

No. Only sign this document if you want to use telehealth.

**What does it mean if I sign this document?**

If you sign this document, you agree that:

- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

---

Your name (please print)

Date

---

Your signature

Date

8-13-2021 – Telehealth Form Added

### **Social Determinants of Health Questionnaire**

SVCHS cares about your safety and well-being. Please take a moment to answer the following three questions.

Thank you!

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- Food
- Clothing
- Utilities
- Child care
- Medicine or any health care (medical, dental, mental health, or vision)
- Phone
- Other (please write in notes)
- I do not have problems meeting my needs
- I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- Yes, it has kept me from medical appointments or from getting my medications
- Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- No
- I choose not to answer this question



Do you feel physically and emotionally safe where you currently live?

- Yes
- No
- Unsure
- I choose not to answer this question