❒ New Patient
❒ Existing/Update

CHILDREN'S HEART INSTITUTE -

Member of Johns Hopkins Regional Physicians

JOHNS HOPKINS MEDICINE

PEDIATRIC PATIENT REGISTRATION

Patient Information

Child's Name: First Name – M I – Last Name	Nick Name	Birth Date	Sex	Soc. Sec #
			[] M [] F	

Mother (❒ Birth ❒Stepmother / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Mother?* **Yes / No**

Mother's Full Name (First M. Last)		Social Security Number		Date of Birth
Home Address		City	State	Zip
Mother's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Mother's **Home E-mail**	

Father (❒ Birth ❒Stepfather / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Father?* **Yes / No**

Father's Full Name (First M. Last)		Social Security Number		Date of Birth
Home Address		City	State	Zip
Father's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Father's Home E-mail	

Referring Physician – (Primary Care Physician)

Physician Name:

Reason for Today's Visit:

Pharmacy

Primary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

Secondary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

I certify that the information I have reported above is correct and that as the Parent/Guardian/Guarantor I have read, understand and fully accept the Patient's Financial Payment Policy conditions of Registration.

Signature of Parent/Guardian/Guarantor _____ Print Name _____ Date _____

Please read and sign the *Practice Payment and Financial Policy* on the back of this form. *Thank You*

PATIENT HISTORY INTAKE – CARDIOLOGY / CARDIOVASCULAR

(CHILD)

FEEDING HISTORY - (For Babies / Infants Only)

1) If on formula, how many ounces at each feeding?
2) How long does it take the baby to finish one feeding?
3) If breast feeding, how many minutes on each breast?
4) Does the baby suck strongly during a feeding? ◯Yes ◯No
5) Does the baby get tired easily during feeding? ◯Yes ◯No
6) Does the baby sweat or have labored breathing during feeding? ◯Yes ◯No

SOCIAL HISTORY

Does the child live with both parents? ☐ Yes ☐ No – If No, Lives with:			
Mother Age?	Father Age?	Mother Job?	Father Job?
How many siblings does the child have?		Age/Sex of Sibling Each?	
Do any siblings also have Congenital or other heart disease? [] Yes [] No – If Yes, please detail:			
At what grade in school?		Any problems at school?	
What hobbies/activities does the child enjoy/play?		What kind of sport does the child participate in?	
Any major stress at home, or school?			

GROWTH AND DEVELOPMENT

Does child appear to be growing similar to family pattern? ☐ Yes ☐ No
Does child have any difficulty keeping up with age group? [] Yes [] No; If yes, please describe below
Is the child up to expectations at school? Any learning or attention problems? [] Yes [] No; If yes, please describe.

PAST MEDICAL AND SURGICAL HISTORY

Prescription & OTC Drugs - Name / Dosage / Frequency		***Any Drug or Food Allergies?*** ☐ Yes ☐ No ☐ Not Known	
		List Drug or Food:	
Operations / Hospitalizations – Reason	***Date***	***Operations / Hospitalizations – Reason***	***Date***

PATIENT'S PAST MEDICAL AND FAMILY HISTORY

PLEASE INDICATE IF YOU OR A RELATIVE - (M) =MOTHER / (F) =FATHER / (S) =SIBLING / (GP) =GRAND PARENT – WAS AFFECTED BY CONDITION

Condition	***You***	***Relatives***	***Condition***	***You***	***Relatives***
Anemia			High Cholesterol or Triglycerides		
Blood Clot or Bleeding Disorder			Kawasaki Disease		
Congenital Heart Disease (Born With)			Mitral Valve Prolapse		
Deaf from Birth (Neuronal)			Rheumatic Fever		
Diabetes - [] Type I [] Type II			Stroke or Mini-strokes (TIA)		
Heart Murmur			Unexplained death in young		
Heart Attack / MI			Thyroid Problems		
High Blood Pressure			Other Cardio-Vascular Disease		

REVIEW OF SYSTEMS HISTORY - **DOES YOUR CHILD HAVE ANY OF THE FOLLOWING SIGNS AND/OR SYMPTOMS? (CHILD)**

PLEASE MARK (X) IF ANY OF THE FOLLOWING APPLY TO YOU **CURRENTLY**, IN THE **PAST** OR **NEVER**

	CURRENTLY	PAST	NEVER	List Other Signs or Related-Symptoms
GENERAL HEALTH				
Healthy Appetite	☐	☐	☐	
Weight loss or Weight gain	☐	☐	☐	
Fever	☐	☐	☐	
Fever last over 5 days	☐	☐	☐	
Lethargy	☐	☐	☐	
Excessive Fatigue	☐	☐	☐	
EYES				
Vision changes	☐	☐	☐	
EARS, NOSE, THROAT & MOUTH				
Ringing in ears	☐	☐	☐	
Sinus problems or Sore throat	☐	☐	☐	
CARDIO / PERIPHERAL VASCULAR				
Chest Pain or discomfort	☐	☐	☐	
Irregular heart rhythms	☐	☐	☐	
Palpitations	☐	☐	☐	
Color changes in Lips or Tongue	☐	☐	☐	
Swelling around eyes, hands or Feet	☐	☐	☐	
RESPIRATORY				
Coughing or Wheezing	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Difficult breathing on exertion	☐	☐	☐	
Painful breathing	☐	☐	☐	
Rapid breathing	☐	☐	☐	
GASTROINTESTINAL				
Abdominal Pains	☐	☐	☐	
Nausea or Vomiting	☐	☐	☐	
Black or Bloody stool	☐	☐	☐	
Heartburn or Acid reflux	☐	☐	☐	
URINARY				
Blood in urine	☐	☐	☐	
Painful urination	☐	☐	☐	
MUSCULOSKELETAL				
Muscle aches / pains / weakness	☐	☐	☐	
Bone aches / pains / weakness	☐	☐	☐	
Swelling of legs	☐	☐	☐	
Pain in extremities	☐	☐	☐	
SKIN / BREAST				
Masses / Lumps or Rash / Ulcers	☐	☐	☐	
NEUROLOGICAL				
Dizziness	☐	☐	☐	
Fainting	☐	☐	☐	
Forgetfulness or Confusion	☐	☐	☐	
Headaches	☐	☐	☐	
Numbness	☐	☐	☐	
Seizures	☐	☐	☐	
PSYCHIATRIC				
Depression	☐	☐	☐	
Anxiety / Stress	☐	☐	☐	
ENDOCRINE				
Excessive Sweating	☐	☐	☐	
Thyroid problems	☐	☐	☐	
Abnormal thirst	☐	☐	☐	
HEMATOLOGIC / LYMPHATIC				
Bruises, frequent	☐	☐	☐	
Enlarged lymph nodes	☐	☐	☐	
Thyroid problems	☐	☐	☐	

Nurse Note:

Children's Heart Institute - Member of Johns Hopkins Regional Physicians

P: 703.481.5801 • F: 703.481.5804
www.childrensheartinstitute.org

"NOTICES OF PRIVACY ACT"

Effective August 1, 2022

1. The Children's Heart Institute - Johns Hopkins Regional Physicians may use and disclose protected health information for treatment, payment, health care operations and voluntary research operations. Examples of these include, but are not limited to, referrals to home health agencies and other providers for treatment. Payment examples include but are not limited to collection agencies, insurance companies for claims and pre-authorization, including coordination of benefits with other insurers. Health care operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. The Children's Heart Institute - Johns Hopkins Regional Physicians is permitted or required to disclose protected health information without the individual's written consent in certain circumstances. Two examples of such are for public health requirements or court orders.
3. The Children's Heart Institute - Johns Hopkins Regional Physicians will not make any other use or disclosure of a patient's protected health information without the individual's written authorization, which may be revoked at any time in writing.
4. The Children's Heart Institute - Johns Hopkins Regional Physicians will abide by the terms of this notice currently in effect at the time of the disclosure.
5. The Children's Heart Institute - Johns Hopkins Regional Physicians reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Any revisions will be posted and copies may be obtained at any time at our office.
6. Any patient, guardian, or personal representative has the right to inspect and obtain copies of their medical records. A fee will be assessed for copies.
7. Any patient, guardian, or personal representative has the right to request amendments to be made to their medical record.
8. Any patient, guardian, or personal representative has the right to request a six-year accounting of all disclosures of their medical records from April 2003 henceforth. The history will be provided within 60 days of the request and a reasonable charge will be assessed for any copies after the first requested in a 12 month period.
9. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to the restriction requested in a 12 month period.
10. Any person or patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy has been violated. To file a complaint with the practice, please contact the privacy officer at The Children's Heart Institute - Johns Hopkins Regional Physicians at 540-310-0117. It is the policy of this practice that no retaliatory action will be made against any individual that submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
11. A detailed copy of this Notice of Privacy Act is available upon request.

NAME OF PATIENT:_____ DATE:_____

SIGNATURE OF PATIENT OR GUARDIAN:_____

Children's Heart Institute - Johns Hopkins Regional Physicians
Practice Financial Policies

1. **Patient Information/Proof of Insurance:**
   At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for payment of services rendered.
2. **Insurance**: We participate in most insurance plans. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.
3. **Referrals:** Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full.
4. **Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Deductibles are due at the time of notification by your insurance company.
5. **Non-covered services**: Not all services provided by our practice are covered by every plan. Any service determined to not be covered by your plan will be your responsibility, Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid. The charges for these non-covered services be your responsibility and must be paid before being scheduled for another appointment.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.
7. **Claims submission:** Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim
8. **Nonpayment/delinquent accounts:** If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full to halt collection activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and processing costs.
9. **Missed appointments:** Our policy is to charge for missed appointments not canceled within 48 hours of your scheduled appointment. These charges will be your responsibility and must be paid before being scheduled for another appointment. The charge for missed appointments for patients with POTS or Stress Test is $100, for all other conditions it is $50.
10. **Forms Fees:** Any forms such as school, camp, sports, family and medical forms are subject to a fee that is due when the forms are dropped off. Completing these forms is time consuming to our staff, and requires time away from patient care from our providers. The charge for the form is determined by the complexity of

the required written or verbal communication. Fee amount may periodically change without prior notice. Payment for these forms is nonrefundable. It is our duty that these forms are accurate and consistent with the patient care plan needs. We require 15-days turnaround time.

11. **Release of medical information**: You will be provided a copy of our policies at the time of your visit and required to sign a release that authorizes us to provide a copy of your medical records if requested by your insurance carrier to process a claim. This release will expire one year from the date of your signature unless cancelled in writing prior to that date.
12. **Contacting us concerning your Bill**: You may call our Billing director at 571-612-2600 with any billing questions or concerns. Our goal is to provide and maintain a good Physician v. patient relationship focused on your clinical needs while letting the experts in our billing department handle their work directly. Please address all billing concerns with those experts rather than your physician so that your clinical team can focus on your medical care

13. **Termination of Services:** If you do not respond to 3 notices to the address we have on file, you agree that Children's Heart Institute - Johns Hopkins Regional Physicians may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual our provider.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

OUTPATIENT AGREEMENT FORM

OUTPATIENT AGREEMENT FORM

Patient Identification Information

This form applies to the following Johns Hopkins Medicine ("Johns Hopkins") entities: Johns Hopkins Bayview Medical Center, Clinical Practices of the Johns Hopkins University School of Medicine, Howard County General Hospital, Johns Hopkins Community Physicians, Johns Hopkins Home Care Group, Suburban Hospital, Sibley Memorial Hospital, Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. and The Johns Hopkins Hospital, Johns Hopkins Imaging, and Ambulatory Surgery Centers.

General Policy: All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.

Consent for Treatment: I, or my representative, agree to have Johns Hopkins providers evaluate and treat my condition. Absent an emergency, if the proposed treatment has significant risks, then an additional informed consent will be obtained. I understand that the practice of medicine is not an exact science, and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

Disclosure & Authorization to Release Information: I hereby authorize Johns Hopkins to release my final diagnosis and other medical information to third parties to determine benefits payable and process claims. I authorize Johns Hopkins to release medical information to my insurance carrier for payment purposes. I authorize Johns Hopkins and/or any physicians who render services to me to release all or part of my medical and billing records for treatment, payment, and operations and for those purposes outlined in the Johns Hopkins Notice of Privacy Practices.

Consent to be Contacted: I agree that by providing my landline, cell phone number(s) or email address, I am giving express consent for Johns Hopkins, its staff, employees, independent contractors, assignees, successors, and agents, to contact me through email or at these numbers, or any number or email address that is later acquired for me and to leave live or pre-recorded messages, text messages or emails regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto- dialer. Additionally, for my convenience, emails and text messages may be sent unencrypted, which may present certain risks, including the risk of being intercepted during transmission or viewed by someone other than me. I agree to accept these risks. If I do not wish to receive text messages, I can call 1-800-318-4246 to opt-out. Providing an email address or telephone or cell phone number is not a condition of receiving services.

Physicians Not Employees of the Hospital: I understand that physicians may not be employees of the health system. I understand that my physician may ask other physicians to participate in my care including but not limited to attending physicians, radiologists, surgeons, obstetricians/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and physician assistants. I also agree that physicians in training, students or other qualified health care personnel, under supervision of my physician, may participate in and/or observe my care unless I specifically state otherwise, either verbally or in writing.

Electronic Prescribing: I authorize Surescripts, an electronic prescribing network, to release my medication refill history to my providers for the purpose of continued treatment.

Payment for Services: I understand that Johns Hopkins may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Johns Hopkins. If I should receive the payments, I understand that I will be responsible for paying Johns Hopkins. I assign the benefits payable for health care services to the physicians and/or organizations furnishing the services. I authorize direct payment to Johns Hopkins and all other providers of service to me, of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source for the care and services rendered to me or the patient. I assign my right to appeal a denial of payment to Johns Hopkins for services rendered to me.

I understand that Johns Hopkins may be treated as an out of network provider by my health plan for services rendered at Johns Hopkins. In such case, my copay or deductible may be greater than if services were rendered at an in network facility or lab. This means that your insurance may cover less than expected depending upon your health plan. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefits. I know that I may need to pay this before I am treated.

Patients seen in a clinic or outpatient setting may receive multiple bills. The hospital is permitted to bill a fee for outpatient visits, commonly referred to as a "facility fee", for the use of hospital facilities or space, clinics, supplies, tests, procedures, equipment, and non-physician services, including but not limited to the services of non-physician clinicians. I understand that all professional services of physicians are billed separately from the hospital bill. I understand that I am responsible for the charges of all physicians and ancillary services involved in my treatment.

I understand that hospital rates for hospitals located in the State of Maryland are subject to change without notice during the course of my outpatient treatment. *This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia. This does not apply to Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.*

I understand that at Maryland hospitals I am entitled to a Prompt Payment hospital discount as follows: 2% if payment is made on or before the date of service, or 1% if payment is made within 30 days of the date of the first bill or date of discharge, whichever is earlier. *This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia, or Johns Hopkins All Children's Hospital and Pediatric Physician Services, Inc. and West Coast Neonatology Inc. located in Florida.*

I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. If my account is sent to a collection agency, I agree to pay all reasonable fees that are required to collect what is due. These fees may include court costs, attorney's fees of 15% of the billed charges and interest at the judicial rate if judgment is entered.

ERISA: If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Johns Hopkins act on my behalf to obtain my benefits when Johns Hopkins asks to do so. I also agree that Johns Hopkins can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

Private Contract: I understand that Johns Hopkins will hold me responsible in any one of the following situations. I may be asked to review and sign the Private Contract form in addition to this form:

(1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.

JOHNS HOPKINS MEDICINE
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(2) When I choose not to use my health plan and agree to pay for services myself.
(3) When my health plan does not participate with Johns Hopkins for the services I want or need and I agree to pay for my care myself.
(4) When I receive services that are not covered under my health plan.

Assignment of Benefits: I assign to Johns Hopkins the right to submit a pre-service appeal to my health plan on my behalf.

Mediation Agreement (applicable to Maryland only): I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at any Johns Hopkins entity located in the state of Maryland are governed by the laws of the State of Maryland. I agree that before I file any lawsuit, I will try to resolve my claim through mediation. Mediation is a process through which a neutral third person assists the parties to help settle the claim. I do not give up my right to file a lawsuit if the mediation process fails to resolve my claim. I agree that any mediation or action in court must take place in Maryland. This agreement is binding on me and anyone who makes a claim for me.

The Johns Hopkins Notice of Privacy Practices: I received a copy of the Johns Hopkins Notice of Privacy Practices.

Consent for the Creation and Use of Photographs, Audio and Video Recordings (PAVR):): I acknowledge that I have received the Johns Hopkins Photographs, Audio and Video Recording Patient Information Guide. I agree to allow for the creation and use of photographs, audio and video, recordings (PAVR), and other images and recordings of me, or the patient I represent, for the purposes of internal education and quality improvement.
Initial one: _____I authorize _____I do not authorize

Other Tests: In the event that a member of the hospital's work force sustains a bodily fluid exposure during the course of my treatment, I consent to HIV testing and authorize the hospital to release the result of this said test to me, the exposed healthcare employee, and my physician. I understand that I have the right to refuse testing without penalty. _____**I authorize** _____**I do not authorize**

Interpreter: If interpreter used, please complete the following: ☐ **Remote** ☐ **In-person**

Interpreter ID Number (if phone/video interpreter used): _____ Date:_____ Time:_____

Printed Name of Interpreter: _____

I AGREE TO THE ITEMS STATED ABOVE AND CERTIFY THAT ALL INFORMATION PROVIDED INCLUDING INSURANCE IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. NO CHANGES TO THIS FORM WILL BE ACCEPTED.

Date:_____ Time:_____ Patient Signature:_____

For health care agent / guardian / surrogate / parent / spouse (circle one), I, _____(print name), am the representative for the patient.

Date:_____ Time:_____ Representative's signature: _____

Relationship to Patient:_____Date:_____ Time:_____

JOHNS HOPKINS NOTICES

Pathology: Johns Hopkins may dispose of any tissue or parts that are removed during a procedure; may retain, preserve, use, and share these tissues, parts or related information for internal educational and quality improvement purposes without my permission (even when these tissues, parts or related information identify me); and may use or share tissues, parts or related information that identifies me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If tissues, parts or related information do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

Pathology (Florida): *I authorize Johns Hopkins to dispose of any tissue or parts that are removed during a procedure; to retain, preserve, use, and share these tissues, parts or related information, including any related DNA analysis, for internal education, research, quality improvement and other healthcare operations purposes, and as otherwise permitted by federal and state privacy laws, even when these tissues, parts or related information identify me.*

Personal Belongings: Patients are responsible for their personal belongings and are encouraged to leave all money and valuables at home. Johns Hopkins shall not be responsible or liable for the loss of or damage to any personal property the patient brought into the facility including but not limited to money, dentures, glasses, hearing aids, personal electronic devices and documents.

Financial Assistance: II understand that Johns Hopkins has Financial Assistance Policies which provide financial assistance and payment plans to patients under certain circumstances. I understand that I can request information concerning Johns Hopkins Financial Assistance by contacting the Customer Service Department for Johns Hopkins at 443-997-3370 or 1-855-662-3017. I hereby authorize Johns Hopkins to run a credit report on me for use in determining whether I qualify for financial assistance or a payment plan. I also understand that I can obtain information by going online at:
www.hopkinsmedicine.org/patient_care/pay_bill/payment_assistance.html
Physicians have their own financial assistance policies and the patient should contact the physician's office to inquire.

Advance Directives: An Advance Directive can mean any written or spoken statement of wishes regarding healthcare that is listed in the medical record. Advance Directives tell your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself. Examples include an appointment of a healthcare agent, healthcare instructions/treatment preferences (e.g., "Living will"), oral Advance Directive, and/or Advance Directive for Mental Health Services. If you have a written Advance Directive, please give a copy to the Registrar, your Nurse or Physician. If you would like to complete an Oral Advance Directive or revoke or revise an existing Advance Directive, please inform the Registrar, your Nurse or Physician.

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

OUTPATIENT AGREEMENT FORM

Patient Identification Information

The Johns Hopkins Photographs, Audio and Video Recordings (PAVR) Patient Information Guide:

Internal Education and Quality Improvement

Please review this Information Guide before signing the **Photographs, Audio and Video Recordings (PAVR)** consent portion of The Johns Hopkins Inpatient or Outpatient Agreement form. **Photographs, video, and audio recordings (PAVR)** created and used at Johns Hopkins for the purposes of internal quality improvement and education are designed to improve patient care. Examples of how PAVR may be used include:

- **Quality Improvement Use- Video monitoring preparation the patient for surgery to prevent infection and ensure compliance with standards of care.**
- **Internal Education- The proper way to treat a wound, insert an IV or perform a procedure.**

Protecting your privacy: Johns Hopkins is grateful to patients who are willing to allow us to create and use **PAVR** so that we can improve the care we provide. At the same time, the privacy of patients, as well as the confidentiality of medical and related information, are among our highest priorities

- During the creation of PAVR, your privacy is protected as much as possible, and whenever possible the PAVR will be modified so that you are not recognizable.
- The Johns Hopkins staff will explain any intended use of the PAVR and answer any questions you may have.
- Use of your PAVR for purposes other than internal education and quality improvement shall require your additional consent and/or authorization.
- PAVR may include, but is not limited to photographs, drawings, video or audio recordings, digital or electronic images, motion pictures or other images

It is important that you **understand your rights** when PAVR is created or used. Your rights include:

- Consent for the creation and use of PAVR is voluntary. Your treatment will not be impacted, based on whether you sign the consent or not.
- Your consent will end only when the use of your information is no longer needed for the purposes of internal education and/or quality improvement.
- You may verbally request cessation of the creation of PAVR at any time while it is being made.
- You hereby release and waive all claims for compensation and rights to the images and recordings for which you consent.
- Following the creation of images and recordings you may revoke or withdraw your consent by mailing or faxing your written request to the care provider, clinic or department where your consent was made or given or to the Health Information Department. This withdrawal would affect only any new use of your PAVR by Johns Hopkins. If all identifiers have been removed from the PAVR this may not be feasible.

Please be sure to ask a Johns Hopkins staff member to clarify any questions you may have. We appreciate your assistance, and value your participation.

AUTH TO DISCUSS HEALTH INFO

JOHNS HOPKINS INSTITUTIONS

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

For this Authorization, "**My Health Care Provider**" means _____
(Name of Facility, Specific Physician or Provider, or etc.)

For this Authorization, "**My Health Information**" means any and all information relating to my course of examination and treatment.

If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.

If I have initialed here (_____), "My Health Information" includes Behavioral Health Records/Information.

I authorize My Health Care Provider to discuss **My Health Information** with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- If I do not sign this Authorization, My Health Care Provider will not disclose My Health Information as requested.
- This Authorization is valid until _____ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department or office where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, behavioral health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date**: ____/____/____
(Required)

If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, _____, **am the (check which applies)**
(print your name)

- ☐ **Parent with Parental Rights** *(applies only to minors) (not sufficient for substance abuse records)*
- ☐ **Informal Kinship Care Relative** *(applies only to minors) (Maryland only) (not sufficient for substance abuse records)*
- ☐ **Legal Guardian**
- ☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
- ☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy) (not sufficient for behavioral health/substance abuse records)*
- ☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

Representative's Signature: _____ **Date**: ____/____/____
(Required)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

Signature of Patient Only: _____ **Date**: _____/_____/_____
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____, confirm that I am the representative for the patient based
(insert your name)
on the following relationship to the patient:

_____
(state relationship, for example – parent, spouse, guardian)

Representative's Signature: _____ **Date**: _____/_____/_____
(Required)

Address: _____ **Phone #:** _____
(street address)

_____
(city) (state) (zip code)