Welcome to Windhaven Adolescent & Sports Medicine!

We are different kind of primary care practice, focusing on the unique health and wellness issues of teens and young adults. We care for patients during their teens and twenties and offer primary and specialty/consult care.

Dr.Scalfano is passionate about providing excellent care to Teens and Twenties. Her visits allow for more than 3x the average physician visit in order to thoroughly assess the patient's needs and develop a treatment or health-maintenance plan that is effective and practical.

If you/your son/daughter has been referred to us by their primary care physician or healthcare provider, you should still receive primary care from that person but we may see you in conjunction with them for a specific issue.
If you/your son/daughter is coming to our practice to establish as primary care patient of Dr.Scalfano, please let us know that when making your initial appointment.

The following forms should be completed prior to your first appointment. **Please complete these word documents and return to the secure email through which you received them OR fax them back to (731) 201-5756.**

Please see our website for maps/directions to our several office locations. Contact instructions can be found there or you can contact us through your chart portal as soon as you have an established chart.

We look forward to meeting you!

Windhaven Adolescent & Sports Medicine

SPECIALIZED HEALTHCARE FOR TEENS & TWENTIES

Patient Information

Full given name____________ Preferred name____________
DOB____________ Gender at Birth____________
Address of residence____________
Billing address if other than above____________
Where should we send your invoices?____________email____________phone

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If **patient is married**,name of spouse____________phone____________ If **patient is a MINOR,** name and relationship of parents/guardian(s):
name____________DOB______relation____________phone____________
name____________DOB______relation____________phone____________
name____________DOB______relation____________phone____________
name____________DOB______relation____________phone____________

Patient's email____________Parents' emails____________
Patient's phone____________(even if pt is a minor)

School name if patient is a full-time student____________
Employer if patient is employed____________
Patient's siblings ____________age(s)____________

Primary Insurance Information:
Name of insurance company____________ Member ID____________
Group #____________ Policyholder's name____________DOB____________
policyholder's relation to patient____________

Emergency Contacts:
Name____________phone____________

Name and specialty of other physicians that care for the patient:
____
____

Preferred Pharmacy Name/
Address____________

PATIENT'S NAME:________________________ PATIENT'S DOB:____________________

CONSENTS :

1. ASSIGNMENT OF BENEFITS: I Hereby assign all medical and surgical benefits to the attending Physician. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid for by the said insurance company. I hereby authorize said assigned to release all information that may be needed to secure payment.

_X____
Signature of patient (or guardian if under 18 yrs old) DATE

2. AUTHORIZATION FOR TREATMENT: I hereby authorize Laura H. Scalfano, MD and any such assistant or physician as she designates, to render any necessary or advisable treatment.

__X____
Signature of patient (or guardian if under 18 yrs old). DATE

3. *Please read first!* AUTHORIZATION FOR PATIENT TO CONSENT TO TREATMENT WITHOUT PARENT PRESENT: I ____________________ (name of parent or legal guardian) hereby authorize my child/ward, ____________________ (name of child/ patient) to consent to treatment in my absence.

_X____
Signature of parent or guardian DATE

4. AUTHORIZATION TO CONTACT: I hereby authorize Laura H. Scalfano, MD and any of her representatives or staff to contact me by the methods listed here. Our practice may use or disclose the patients PHI to contact you by phone, voice mail, email, text.
___________________________email
___________________________phone (text)
___________________________phone (voice mail)

_X____
Signature of patient (or guardian if under 18 yrs old) DATE

5. RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT:
I acknowledge that I have received, or have been offered a copy, of the Windhaven Adolescent and Sports Medicine Notice of Privacy Practices.__________(initial)
OR I have DECLINED to receive the Notice of Privacy Practices offered by Windhaven Adolescent and Sports Medicine. I understand that I do not have to sign the acknowledgment in order for me/the patient to receive treatment by Windhaven Adolescent and Sports Medicine._________(initial)

_X____
Signature of patient (or guardian if under 18 yrs old) DATE

6. AUTHORIZATION OF THE RELEASE OF VACCINE RECORDS OR SCHOOL/WORK EXCUSES BY VERBAL REQUEST: I hereby authorize Laura H. Scalfano, MD or her representatives to release my vaccine records or a school/work release on my verbal request to the facility of my choosing.

_X____
Signature of patient (or guardian if under 18 yrs old). DATE

7. Where should we send the invoices for bills/charges for services? ________________________(Name of person)
____email ________________________phone
Does this person have your permission to receive a detailed statement with diagnostic codes/ test codes? _____ Yes _____No

__X____ signature of patient (or of parent/guardian if patient is under 18)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Health Insurance portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually. Identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information , and how we may use and disclose it. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

*Treatment means providing, coordination, or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
*Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
*Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which can be exercised by presenting a written request to the privacy officer:
*The right to request restrictions on certain uses and disclosures of PHI, including those related to family members, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
*The right to amend your PHI.
*The right to inspect and copy your PHI.
*The right to receive an accounting of disclosure of PHI.
*The right to obtain a paper copy of this notice from us upon request.

We are required, by law, to maintain the privacy of your PHI, and to provide you with notice of our legal duties and privacy practices with respect to PHI.
You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office, or with the Department of Health and Human Services, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The US Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington DC 20201