PEDIATRICS *at* Oyster Point

895 City Center Blvd., Suite 200
Newport News, VA 23606
(757) 599-4090

Brian K. Butcher, M.D. , F.A.A.P.
Nakeshia Brown Hunter, M.D., F.A.A.P.
Danielle Calabrese, FNP-BC

Morgan Bennett, MSN, FNP-BC
Franciene Golding FNP-CCRN
Erin Smith FNP-BC, MSN
Jaena Scholten MSPAS, PA-C

Patient Name: _____ Date of Birth: _____

◯ I authorize Pediatrics at Oyster Point, 895 City Center Blvd, Suite 200, Newport News, VA 23606 to release records to:

_____

Phone # _____ Fax # _____

☒ I authorize _____

Phone # _____ Fax # _____

To release records to: ***Pediatrics at Oyster Point, 895 City Center Blvd, Suite 200, Newport News, VA 23606***

This information is being released at the request of the individual signed below.

_____ Please release all records in order for Pediatrics at Oyster Point to assume medical care.

_____ Please only release patient records for specific dates: _____

Entire record is requested unless specific dates indicated above. Please include vaccine records, lab reports, well exams, growth charts, etc.

I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency (HIV). **If I don't want those to be released, I will initial here**: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

_____ Parent/Guardian Signature

_____ Printed Parent/Guardian Name

_____ Address

_____ Phone Number

_____ City, State, Zipcode

_____ Relationship to Patient

_____ Date of Request

PLEASE MAIL RECORDS

2/14/2024

PEDIATRICS AT OYSTER POINT

895 City Center Blvd, Suite 200 -- Newport News, VA 23606
Phone: 757-599-4090 -- Fax: 757-599-4093

TODAY'S DATE: _____

PROVIDER REQUESTED: __Brian K. Butcher, MD, FAAP __Nakeshia Brown Hunter MD, FAAP__Erin Smith FNP-BC, MSN __Morgan Bennett MSN FNP-BC__Danielle Calabrese FNP-BC__Franciene Golding FNP-CCRN__Jaena Scholten MSPAS, PA-C

PATIENT: _____ **DOB:** _____

CONTACT INFORMATION: We will call/text reminder for appointments, please provide a cell phone number, if possible.

	Name/Relationship (parent, stepparent, legal guardian, etc) & Date of Birth	Cell/Land (Type of phone)	Phone Number
#1 Contact/ Relationship & DOB:			
#2 Contact/ Relationship & DOB:			
EMERGENCY/ Relationship:			

Reason for leaving previous practice: _____

Are there any legal documents in place for custody/guardianship? Y N (*Please provide a copy for our files*)

INSURANCE PLAN: _____ ***Complete attached Insurance Sheet, please provide staff with your insurance card so that we can obtain a copy for the patient profile.***

(We will bill your insurance first; however, in the event there is a remaining balance, whom can we contact for responsibility in paying the patient's bill. Patients 18 and over are considered the guarantor on the account.

GUARANTOR (responsible for statements):_____ **DOB** _____
Relationship to patient: (self, parent, step parent, legal guardian, other:_____)
TYPE OF APPOINTMENT NEEDED: _____SICK ____WELL EXAM/PHYSICAL

SIBLINGS NAME(s)/DOB: _____

OUR PHYSICIANS REQUIRE OUR PATIENTS TO RECEIVE ALL VACCINATIONS THAT ARE RECOMMENDED BY THE ACADEMY OF PEDIATRICS. DO YOU PLAN TO GET ALL VACCINATIONS? (initial choice) ____YES _____NO

PARENT COMMENTS/CONCERNS ABOUT HEALTH _____

_____

_____

MD Approval:_____

DATE RECORDS RECEIVED IN OFFICE: _____

RECORDS RECEIVED BY: ____MAIL _____PATIENT DROPOFF _____FAX

Date called for appt: _____ Chart created/scanned into EMR by_____

Pediatrics at Oyster Point
New Patient Insurance Information

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Address: _____

***** Please note that patient's insurance MUST be ACTIVE to schedule an appointment. All insurance information will be checked/ verified upon receiving your child's records*****

Primary Insurance Name: _____

Policy Number: _____ (Ie. Benefits #, Member ID, Etc.)

Plan Type: HFA ☐ PPO ☐ HMO ☐ POS ☐ Other: _____

Group #: _____ Copay Amount: _____

Policy Owner Name: _____ Date of Birth: _____

Policy Owner Address: _____

(If address of policy owner is different from patient, please indicate above)

Policy Owner Relationship to Patient: MOM ☐ DAD ☐ SELF ☐ OTHER: _____

- If you would like to sign up for our **patient portal** please provide your email below:

Email: _____

(You will receive an email from IQHEALTH to set up your patient portal account)

Important Disclosure Information:

We will request patient records upon receiving this completed new patient packet. Before scheduling an appointment, we must first receive patient records and verify insurance information. Be aware this process may take on average 2-3 weeks (possibly longer) and can be expedited by contacting your previous pediatrician to let them know we have sent a release of records request. During this process, we may need to contact you to confirm patient information before we can proceed further. Note we will do our best to complete this process quickly and we thank you for your patience and understanding.

By signing below, you confirm that you understand the above disclosure information:

Print Name: _____ Signature: _____ Date: _____

Pediatrics at Oyster Point

Appointment Cancellation & No Show Policy

Please note that we require a 24-hour notice to cancel, change, or reschedule your appointment(s). Last-minute cancellations and no shows may be subject to a $45.00 fee.

If your child/ family misses a collective three appointments, your child/ family will be dismissed from the practice.

It is your responsibility to remember your appointment(s). Reminders are sent as a courtesy, and you are always welcome to call and confirm your appointment time.

Here at Pediatrics at Oyster Point, we understand that we all have busy lives and things may come up last minute from time to time. Your time is valuable, therefore, in an effort to respect the time of all our patients and providers, we ask that you sign the below acknowledging you and your family understand and follow this policy.

Patient Name: _____ Date of Birth: _____

Guarantor Printed Name: _____

Guarantor Signature: _____ Date: _____

Policy Effective Date: 1-1-2025 (Updated 4-9-2025)