PEDIATRIC ASSOCIATES OF WATERTOWN THRIVE

PATIENT INFORMATION SHEET

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

PATIENT NAME:_____ DOB:_____ Sex: _____ SS#:_____

ADDRESS:_____
STREET CITY ZIP

RACE: American Indian/Alaskan Native Asian Black/African-American Hawaiian/Pacific Islander White Other Decline/Refuse to Answer/Unknown

GENDER IDENTITY: Woman Man Transgender Woman Transgender Man Non-Binary Agender/I don't identify with any gender Prefer not to state
Gender not listed. My gender is _____

ETHNICITY: Hispanic or Latino Not Hispanic or Latino Decline PATIENT PREFERRED LANGUAGE: _____

MOTHER'S MAIDEN NAME:_____ PREFERRED PHARMACY:_____
NAME STREET/TOWN

PRIMARY PARENT/GUARDIAN:_____ DOB:_____ SS#:_____

RELATIONSHIP TO PATIENT: _____ Address same as patient? Y / N

If no:_____Email address:_____
STREET CITY ZIP

Primary Phone# (_____)-_____-_____ Secondary Phone#: (_____)-_____-_____ WORK PHONE: (____)-_____-_____

ALTERNATE PARENT/GUARDIAN:_____ _____ DOB:_____ SS#:_____

RELATIONSHIP TO PATIENT: _____ Address same as patient? Y / N Yes

If no:_____Email address:_____
STREET CITY ZIP

Primary Phone# (_____)-_____-_____ Secondary Phone#: (_____)-_____-_____ WORK PHONE: (____)-_____-_____

EMERGENCY CONTACTS

Name:_____Relationship to Patient:_____Ph #: (_____)-_____-_____

Name:_____Relationship to Patient:_____Ph #: (_____)-_____-_____

BILLING INFORMATION

Primary Insurance Company: _____Policy ID#:_____Group #:_____

Policy Holder's Name:_____ DOB:_____ SS#:_____

Employer:_____ Address same as patient? Y / N

If no:_____
STREET CITY ZIP

Secondary Insurance Company:_____Policy ID#:_____Group #:_____

Policy Holder's Name:_____DOB:_____ SS#:_____-_____-_____

Employer:_____ Address same as patient? Y / N

If no:_____
STREET CITY ZIP

Form filled out by:_____ Relationship to patient:_____ Date:_____

Please designate who you would prefer as your Primary Care Provider:_____

Pediatric Associates of Watertown, P.C.
20011 Summit View Blvd. Watertown, NY 13601
www.pediatricassociatesofwatertown.com
Phone: (315)782-4391 Fax: (315)782-4387

Patient Name: _____ DOB: _____

Vaccine Policy Statement

● We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
● We firmly believe in the safety of vaccines. The recommended vaccine schedule is the results of years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.
● We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
● We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
● We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as doctors, and that you can perform as parents.

The vaccine campaign is a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether they should be given. Because of vaccines, many people have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. Though it used to be tragically commonplace, most people no longer know a friend or family member whose child died of one of these diseases. Such success can make us complacent about vaccination. But such an attitude, if it becomes widespread, can only lead to tragic results.
We recognize that the choice may be a very emotional one for some parents. Social media and internet sensationalism have created a great deal of anxiety in many people. However, vaccinating according to the schedule is the right thing to do. The doctors here all vaccinate their own babies according to the CDC recommendations. In some cases, we may alter the schedule to accommodate parental anxiety. **Please be advised, however, that delaying or breaking up vaccines goes against the recommendation of the doctors at Pediatric Associates, expert recommendations, and scientific evidence, and can put your child at risk for serious illness and death. Parents will be required to sign a Refusal to Vaccinate acknowledgement in the event of lengthy delays. All patients in our practice are required to receive a minimum of DTaP, Hib, Polio, and Pneumococcal by 3 months of age, the second dose of each of these by 6 months of age, and the third dose of each by 10 months of age. They must have ALL AAP-recommended doses of DTaP, Hib, Polio, and Pneumococcal, MMR, Varicella, Hepatitis B, and Hepatitis A by two years of age. The MMR, Varicella, Polio, and DTaP boosters must be completed by 6 years of age. The meningococcal vaccine and the TDap booster must be received by age 12.**
Out of commitment to the safety of your child and all of the other children in the waiting room, we cannot continue provide medical care to families who will not follow the above guidelines. There are currently no pediatric offices in the immediate area that are accepting unvaccinated children into their practice. Additionally, please be aware that if a vaccine is refused after it is discussed, ordered, and prepared you may be Out of commitment to the safety of your child and all of the other children in the waiting room, we cannot continue to provide medical care to families who will not follow the above guidelines. There are currently no pediatric offices in the immediate area that are accepting unvaccinated children into their practice. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us. responsible for the cost of the vaccine. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Parent/Guardian/Patient Signature: _____ Date: _____

Printed Parent/Guardian/Patient Name: _____

Updated 3/25

Financial Policy & Education

As you may know, there are very specific regulations about billing for health care services. As your health care provider, we are obligated to follow those regulations in how we report services provided to you. Additionally, every insurance plan may have different rules that vary from insurer to insurer and may even vary between plans of the same insurer. It is your responsibility to know what your insurance plan covers and does not cover.

- All physicians/providers must report services using a variety of codes to tell the insurance company what was done and why.
- It is not uncommon for patients during a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventive services at the same time.
- Both services must be reported to the insurance company and may result in an additional co-payment or charge as per the insurer's plan rules, which we are obligated to follow.
- There are many different insurance companies and plans: addressing a problem may trigger a co-payment or additional charges to your account.
- Your financial responsibility is determined by the rules of your insurance company, which we are obligated to follow.
- If you have questions, please check with your insurance plan.

You hereby authorize the treatment and assignment of your insurance benefits for claims to be paid to Pediatric Associates of Watertown, P.C. for medical services rendered. If we do not participate with your insurance, we will Courtesy Bill that insurance for you. However, you will be responsible for any payment due. Payment is required at the time of the visit, by the accompanying parent or adult. This includes co-pays, coinsurance, deductibles, and charges not covered by your insurance. Knowing your insurance coverage is your responsibility. We accept cash, check or most major credit cards. Should you choose to pay with a traditional credit card, you are foregoing all of the protections afforded by both federal and state medical debt laws.

There is a service charge of $20.00 for returned checks. Accounts that are overdue by 30 days from the date payment was due will be charged 1.5% interest on the total amount. Failure to pay your bill in a timely manner may result in turning your account over to a Collection Agency and dismissal from the practice. We require your insurance card and ID for every visit

We provide the best possible care for you and your family and to being respectful of your time.

Patient's Name: _____

Signature of Patient/Parent: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

PEDIATRIC ASSOCIATES OF WATERTOWN, P.C.

20011 Summit View Boulevard Watertown, NY 13601www.pediatricassociatesofwatertown.com(315)782-4391

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 6/1/17

This Notice of Privacy Practices applies to the following organizations.

Pediatric Associates of Watertown, P.C.

Patient Name

Parent/Patient Signature Date

Privacy Officer: Caressa Flowers, BSN RN (315)782-4391

Pediatric Associates of Watertown, P.C.
20011 Summitview Blvd
Watertown, NY 13601
Phone: (315)782-4391 Fax: (315)782-4387

Initial History Questionnaire

Name: _____ ID Number: _____

Birth Date: _____ Age:_____ ☐ M ☐ F

Form Completed By: _____ Date Completed: _____

Illness/Injuries

Do you consider your child to be in good health? ☐ Yes ☐ No Explain: _____

Does your child have a serious illness or medical condition? ☐ Yes ☐ No Explain: _____

Does your child have, or has he/she ever had:
Any chronic or recurrent skin problem (acne, eczema, etc.) ☐ Yes ☐ No Explain: _____

Use of alcohol or drugs ☐ Yes ☐ No Explain: _____

Nasal allergies ☐ Yes ☐ No Explain: _____

Anemia or bleeding problem ☐ Yes ☐ No Explain: _____

Asthma, bronchitis, bronchiolitis, or pneumonia ☐ Yes ☐ No Explain: _____

Bed-wetting (after 5 years old) ☐ Yes ☐ No Explain: _____

Bladder or kidney infection ☐ Yes ☐ No Explain: _____

Blood transfusion ☐ Yes ☐ No Explain: _____

Chickenpox ☐ Yes ☐ No Explain: _____

Constipation requiring doctor visits ☐ Yes ☐ No Explain: _____

Convulsions or other neurologic problem ☐ Yes ☐ No Explain: _____

Diabetes ☐ Yes ☐ No Explain: _____

Frequent ear infections ☐ Yes ☐ No Explain: _____

Problems with ears or hearing ☐ Yes ☐ No Explain: _____

Problems with eyes or vision ☐ Yes ☐ No Explain: _____

Frequent abdominal pain ☐ Yes ☐ No Explain: _____

Frequent headaches ☐ Yes ☐ No Explain: _____

Any heart problem or heart murmur ☐ Yes ☐ No Explain: _____

Thyroid or other endocrine problem ☐ Yes ☐ No Explain: _____

Any other significant problem ☐ Yes ☐ No Explain: _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain: _____

Surgery/Hospitalization/Past Medical History

Has your child had any surgery? ☐ Yes ☐ No Explain: _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain: _____
Please list any medications or vitamins your child takes:_____ _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain: _____

Is your child followed by any specialist? ☐ Yes ☐ No Explain: _____

(For girls) OB-GYN

Has she started her menstrual periods? ☐ Yes ☐ No Explain: _____

Are there problems with her periods? ☐ Yes ☐ No Explain: _____

Birth History

Was the baby born at term? ☐ Yes ☐ No ☐ Early? ☐ Late?

If early, how many weeks gestation? _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Birth Weight: _____

Did mother have any illness or problem with her pregnancy? ☐ Yes ☐ No Explain:_____

During pregnancy, did mother? Smoke: ☐ Yes ☐ No Drink Alcohol: ☐ Yes ☐ No

Use drugs or medications? ☐ Yes ☐ No What? _____ When? _____

Family History

List all blood relatives of your child who have had the following-use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (Father's Mother), (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Immune problems, HIV, or AIDS	☐ Yes ☐ No	Who:_____	Comments: _____
Alcohol abuse	☐ Yes ☐ No	Who:_____	Comments: _____
Nasal Allergies	☐ Yes ☐ No	Who:_____	Comments: _____
Anemia	☐ Yes ☐ No	Who:_____	Comments: _____
Asthma	☐ Yes ☐ No	Who:_____	Comments: _____
Bed-wetting (after 10 years old)	☐ Yes ☐ No	Who:_____	Comments: _____
Birth defects	☐ Yes ☐ No	Who:_____	Comments: _____
Bleeding disorder	☐ Yes ☐ No	Who:_____	Comments: _____
Cancer	☐ Yes ☐ No	Who:_____	Comments: _____
Diabetes Before Age 20	☐ Yes ☐ No	Who:_____	Comments: _____
Diabetes After Age 20	☐ Yes ☐ No	Who:_____	Comments: _____
Drug abuse	☐ Yes ☐ No	Who:_____	Comments: _____
Epilepsy or convulsions	☐ Yes ☐ No	Who:_____	Comments: _____
Deafness	☐ Yes ☐ No	Who:_____	Comments: _____
Heart disease (before 50 years old)	☐ Yes ☐ No	Who:_____	Comments: _____
High cholesterol	☐ Yes ☐ No	Who:_____	Comments: _____
High blood pressure (before 50yrs old)	☐ Yes ☐ No	Who:_____	Comments: _____
Kidney disease	☐ Yes ☐ No	Who:_____	Comments: _____
Liver disease	☐ Yes ☐ No	Who:_____	Comments: _____
Mental illness	☐ Yes ☐ No	Who:_____	Comments: _____
Mental retardation	☐ Yes ☐ No	Who:_____	Comments: _____

Migraines ☐ Yes ☐ No Who:_____ Comments: _____

Scoliosis ☐ Yes ☐ No Who:_____ Comments: _____

Thyroid disorder ☐ Yes ☐ No Who:_____ Comments: _____

Tuberculosis ☐ Yes ☐ No Who:_____ Comments: _____

Additional family history ☐ Yes ☐ No Who:_____ Comments: _____

Social History/Home Environment

Mother's occupation:_____

Father's occupation:_____

Please list all those living in the child's home.

Name	Relationship to Child	Birthdate	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is the water source in the home? _____

Does your child attend daycare? ☐ Yes ☐ No
If Yes, how many days/hours per week? _____

Are there siblings not listed? If so, please list their names and ages and where they live. _____

_____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?_____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?_____

_____

Does your child always wear a seat belt? ☐ Yes ☐ No Explain:_____

Does your child wear a bike helmet? ☐ Yes ☐ No Explain:_____

Are there smoke alarms in the home? ☐ Yes ☐ No Explain:_____

Are there carbon monoxide detectors in the home? ☐ Yes ☐ No Explain: _____

Are there guns in the home? ☐ Yes ☐ No Explain:_____

If yes, are they locked? ☐ Yes ☐ No Explain:_____

Is your child exposed to smoke in the home? ☐ Yes ☐ No Explain:_____

Are there pets in the home? ☐ Yes ☐ No Explain:_____

Does your child participate in any extracurricular activities? ☐ Yes ☐ No Explain: _____

PEDIATRIC ASSOCIATES
OF WATERTOWN
THRIVE

MINOR'S AUTHORIZATION TO SHARE MEDICAL INFORMATION WITH PARENT/GUARDIAN AGE 12-17 yrs

PLEASE READ ALL INFORMATION AND INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM

PATIENT NAME:_____ **DOB:**_____/_____/_____

MINORS AGE 12-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 12 and older), (2) alcohol and/or drug abuse (age 12 and older), and mental health conditions (age 12 and older).

I hereby consent to the release of the specified information, verbally or electronically, relating to diagnosis, testing or treatment to the person or entity named below. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the person(s) named below. I am aware I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

(Printed below are the name(s) and relationship of those who may receive above said information)

Name:_____ Relationship:_____
Name:_____ Relationship:_____

_____ I do not grant any permission for my above mentioned medical health information to be released to anyone other than myself.

This authorization expires on _____(Date or Event). Authorization will expire in one year if not otherwise specified.

Patient Signature:_____ **Date:**_____

Printed Name:_____

Parent or Legal Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient:**_____

NYS Health Related Social Needs Screening Questionnaire

Housing/ Utilities	
1. What is your living situation today?	I have a steady place to live I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Pests such as bugs, ants, or mice Mold Lead paint or pipes Lack of heat Oven or stove not working Smoke detectors missing or not working Water leaks None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes No Already shut off
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true Sometimes true Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true Sometimes true Never true
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes No
Employment	
7. Do you want help finding or keeping work or a job?	Yes, help finding work Yes, help keeping work I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	Yes No
Interpersonal Safety Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.	A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe
9. How often does anyone, including family and friends, physically hurt you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

PLEASE NOTE: If the records are over 40 pages, we ask that you send them via direct message or encrypted portable media (CD or flash drive). Any records under 40 pages can be sent via mail, fax, direct message, or encrypted portable media. All records released from our office that are over 40 pages will mailed via encrypted portable media.

PEDIATRIC ASSOCIATES
OF WATERTOWN
THRIVE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PARENTS/MINORS AGE 12-17 yrs

PLEASE READ ALL INFORMATION AND INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM

PATIENT NAME:_____ **DOB:**____/____/____

INFORMATION TO BE RELEASED **BY:**

ORGANIZATION/PERSON NAME

ADDRESS

PHONE FAX

INFORMATION TO BE RELEASED **TO:**

ORGANIZATION/PERSON NAME

ADDRESS

PHONE FAX

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ Complete Medical Record, including Growth Chart & Immunizations
- ☐ Health Information related to following treatment or condition:_____
- ☐ Health Information only for the following dates:_____
- ☐ Other:_____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of Care ☐ Continuing Care ☐ Legal Review

☐ Other (please explain)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below:

_____

MINORS AGE 12-17: A minor patient's signature is required in order to release the following information: (1)conditions relating to the minor's reproductive care including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 12 and older), (2) alcohol and/or drug abuse (age 12 and older), and mental health conditions (age 12 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD

This authorization expires on _____(Date or Event). Authorization will expire in one year if not otherwise specified.

Patient Signature:_____ **Date:**_____

Printed Name:_____

Parent or Legal Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient:**_____

Ages: Birth through 11 years and 18 years and older.

PEDIATRIC ASSOCIATES
OF WATERTOWN
THRIVE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PLEASE READ ALL INFORMATION AND INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM

PATIENT NAME:_____ **DOB:**____/____/____

INFORMATION TO BE RELEASED **BY:**

ORGANIZATION/PERSON NAME

ADDRESS

PHONE FAX

INFORMATION TO BE RELEASED **TO:**

ORGANIZATION/PERSON NAME

ADDRESS

PHONE FAX

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ Complete Medical Record, including Growth Chart & Immunizations
- ☐ Health Information related to following treatment or condition:_____
- ☐ Health Information only for the following dates:_____
- ☐ Other:_____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of Care ☐ Continuing Care ☐ Legal Review

☐ Other (please explain)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below:

_____

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD

This authorization expires on _____(Date or Event). Authorization will expire in one year if not otherwise specified.

Patient/Parent or Legal Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient:**_____

PLEASE NOTE: If the records are over 40 pages, we ask that you send them via direct message or encrypted portable media (CD or flash drive). Any records under 40 pages can be sent via mail, fax, direct message, or encrypted portable media. All records released from our office that are over 40 pages will mailed via encrypted portable media.

Pediatric Associates of Watertown, P.C.
20011 Summit View Blvd.
Watertown, NY 13601
Phone: (315)782-4391 Fax: (315)782-4387

I, hereby grant permission to Pediatric Associates of Watertown to take photographs of my child for the following purposes:

To document medical condition and progress.
To use for educational purposes, such as teaching medical students or other healthcare professionals.
To use for marketing purposes, such as on the medical office's website or in social media posts.

Ownership, Storage, and Retention of the Images
Pediatric Associates of Watertown owns all photographs taken of patients. Photographs must be stored in a secure location and retained for a period of time that is consistent with the organization's policies and practices.

Patient Authorization for the Release and/or Use of Images Outside the Organization
If Pediatric Associates of Watertown plans to release or use patient photographs outside of the organization, written authorization must be obtained from the patient or their legal guardian.

I understand that the photographs will not be used without my consent and that I can withdraw my consent at any time by contacting the office manager. I understand that this is my consent.

I also understand that the photographs may be used in a way that may identify the patient, but that the medical office will take all reasonable steps to protect my privacy.

I have read and understand this consent form and I agree to its terms.

Patient's Name: _____

Parent/Guardian Name: _____

Relationship to Patient: _____

Signature of Parent/Guardian: _____

Date: _____

Patient Name:_____ Date of Birth:___/ ___/____

PEDIATRIC ASSOCIATES OF WATERTOWN, PC
CLINIC POLICIES AND PROCEDURES AGREEMENT

Below are important policies you need to review and be aware of to maintain our trusting professional relationship with you and/or your child. PLEASE INITIAL EACH POLICY, indicating you are aware of them and agree to abide by them. Inability to follow these policies may result in dismissal from the practice.

_____ **APPOINTMENTS REQUIRED FOR ALL VISITS**
To schedule an appointment, please call us in advance. For same-day sick visits, call as soon as possible. We reserve a limited number of same-day appointments, which can fill up quickly. All same-day appointments are prioritized. If there is a life-threatening emergency, call 911. Pediatric Associates of Watertown does not discriminate based on age (except for being beyond the scope of practice of Pediatrics), gender, race, sexual orientation, creed, religion, disability, or national origin.

_____ **REFILLS AND REFERRALS**
Please allow up to 2 weeks for referrals to be processed. Repeated calls may delay the process. We ask that you wait 2-3 weeks before calling to check on routine referrals. Prescription refills require at least 3 business days' notice. Some medications, like ADD/ADHD, anxiety, and asthma meds, may require regular office visits for refills. We cannot refill routine medications without a yearly physical.

_____ **BILLING EDUCATION**
We follow insurance rules for reporting services. These rules vary by plan, so it's important to understand your coverage. It is your responsibility to know what your insurance plan covers and does not cover. During a visit, we may address both a specific issue and routine care. Both get reported to your insurance, which may result in additional charges based on your plan.

_____ **APPOINTMENT CANCELLATIONS AND RESCHEDULING**
Please call us ASAP to cancel or reschedule appointments. We charge a $25 fee for missed appointments without 24-hour notice. Arrive 10 minutes early. If you are more than 10 minutes past your appointment time, we will reschedule you to the next available time. We may dismiss families after 3 missed appointments without notice.

_____ **NO CELL PHONES OR DISRUPTIVE BEHAVIOR**
Please no cell phone use in the office. Inform anyone accompanying your child of our policy. No video recording or images of staff without consent. No cursing or rude behavior allowed. There is also a zero-tolerance policy for cursing and rude/disruptive behavior, which will result in dismissal from the practice.

_____ **PERMISSION RELEASE FORMS** (ONLY APPLIES TO PATIENTS UNDER 18 YEARS OF AGE)
If you authorize someone other than yourself to bring your child for treatment, we require that the necessary release forms be completed by the legal guardian prior to the child's visit. It is your responsibility to ensure that the individual accompanying your child has the insurance card, their photo ID, and the required copay or co-insurance payment.

_____ **FORM/PAPERWORK REQUESTS**
If you are requesting any type of paperwork such as school forms, shot records, etc, this could take up to 5 business days to process them for you in time. Some forms may require an appointment to be completed or reviewed. Currently, we do not charge for forms to be filled out.

_____ **YEARLY PHYSICALS**
PLEASE NOTE: IT IS IMPORTANT FOR CONTINUITY OF CARE THAT WE, AS THE MEDICAL HOME, PERFORM A YEARLY PHYSICAL. School physicals are not accepted as proof of yearly physicals. Refusal to schedule yearly physicals may result in discharge from our practice.

_____ **PATIENT PORTAL BILLING STATEMENTS**
Our office utilizes the patient portal to notify you of any outstanding balances on the patient's account. Patients with an active patient portal account on file will receive billing statements via the patient portal.

_____ _____
Signature of Patient/ Parent/Legal Guardian Printed Name of Patient/ Parent/Legal Guardian

Date signed:___/ ___/____ Relationship: _____

Updated 9/24/24

Authorization to Disclose Protected Health Information & Consent for Treatment

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY AND ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AND TO PROVIDE THE OFFICE WITH INFORMATION IF THERE ARE ANY CUSTODY RESTRICTIONS INVOLVING MY CHILD.

PATIENT NAME:_____ DOB:_____ Sex: _____ SS#:___-_____-_____

ADDRESS:_____
STREET CITY ZIP

_____
FATHER'S NAME PREFERRED PHONE # MOTHER'S NAME PREFERRED PHONE #

_____
CHILD LIVES WITH ADDRESS RELATIONSHIP TO CHILD

I hereby consent to medical care and treatment for my child at Pediatric Associates of Watertown. If I am unable to bring my child for an appointment or if emergency treatment is necessary, I authorize one of the listed below, who must be over the age of 18, to obtain medical care and treatment on my child's behalf. I understand that a valid photo ID will be required at each visit, and a copy will be kept on file. I acknowledge that the disclosure of my child's protected health information is authorized for the purpose of providing medical care and treatment. I am solely responsible for notifying Pediatric Associates of Watertown of any changes to the information provided on this form, as well as for all financial obligations and custody restrictions pertaining to my child.

The following information should not be disclosed to anyone else besides the parent or legal guardian:_____

_____
NAME PREFERRED PHONE # RELATIONSHIP TO CHILD

_____
NAME PREFERRED PHONE # RELATIONSHIP TO CHILD

_____
NAME PREFERRED PHONE # RELATIONSHIP TO CHILD

_____
NAME PREFERRED PHONE # RELATIONSHIP TO CHILD

This authorization expires on _____(Date or Event). Authorization will expire in one year if not otherwise specified.

Parent or Legal Guardian Signature:_____ Date:_____

Printed Name:_____ Relationship to Patient:_____