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:**_____

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:**_____

PARENT/GUARDIAN CONSENT

PARENT/GUARDIAN CONSENT

Please READ CAREFULLY
and sign and Date Below

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.

LAST NAME OF PATIENT _____ FIRST _____ MIDDLE _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ COURT ORDER ON FILE _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

THE PERSONS LISTED ARE THE ONLY ONES WHO MAY BE ALLOWED TO SEEK MEDICAL CARE AND/OR TREATMENT FOR MY CHILD AT PEDIATRIC ASSOCIATES OF WATERTOWN. I ALSO UNDERSTAND A PHOTO ID OF THE INDIVIDUALS WILL BE REQUIRED AT EACH VISIT AND A COPY WILL BE MADE AND PLACED IN MY CHILD'S CHART. PLEASE NOTE: ANYONE YOU ARE GRANTING PERMISSION TO MUST BE OVER THE AGE OF 18.

FATHER'S NAME _____ PREFERRED PHONE (CELL/HOME) _____ MOTHER'S NAME _____ PREFERRED PHONE (CELL/HOME) _____

CHILD LIVES WITH _____ ADDRESS _____ RELATIONSHIP TO CHILD _____

OTHER PERSONS THAT YOU CONSENT TO BRING YOUR CHILD/CHILDREN IN (MUST BE 18 YEARS OF AGE OR OLDER):

OTHER (NAME) _____ PREFERRED PHONE (CELL/HOME) _____ RELATIONSHIP TO CHILD _____

OTHER (NAME) _____ PREFERRED PHONE (CELL/HOME) _____ RELATIONSHIP TO CHILD _____

OTHER (NAME) _____ PREFERRED PHONE (CELL/HOME) _____ RELATIONSHIP TO CHILD _____

OTHER (NAME) _____ PREFERRED PHONE (CELL/HOME) _____ RELATIONSHIP TO CHILD _____

IN CASE OF AN INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD FOR HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE PERSONS LISTED ABOVE ON THIS FORM WILL BE ALLOWED TO ARRANGE AND SEEK TREATMENT FOR MY CHILD.

BY SIGNING BELOW, I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY/ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AS WELL AS ALL FINANCIAL RESPONSIBILITIES AND TO PROVIDE THE OFFICE WITH ANY AND ALL CUSTODY RESTRICTIONS INVOLVING MY CHILD.

PRINT PARENT/GUARDIAN NAME _____ RELATIONSHIP TO PATIENT _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PEDIATRIC ASSOCIATES
OF WATERTOWN
THRIVE

PATIENT INFORMATION SHEET

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

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

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

ADDRESS:_____
STREET CITY ZIP

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

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:_____

OFFICE USE ONLY

Date rec'd_____
Date entered_____
Initials:_____

Patient Waiver for Non-Covered Services

Your health insurance may not cover all of your health care costs. Some items and services are not considered "covered benefits" under your health insurance plan and therefore will not pay for these services. It is your responsibility to know your individual plan coverage and if these services are covered.

Pediatric Associates of Watertown, P.C. follows the American Academy of Pediatrics guidelines in the care provided for our patients and believe that the following service(s) are an important part of evaluating your child's health and growth and development. Since the services listed here may not be covered by your health insurance, should you choose for your child to receive these services, you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want your child to receive these service(s).

The services have been arranged by age/diagnosis below. Please check next to the service you **DO NOT WISH** your child to receive:

AGE 6 MONTHS/AGE 9 MONTHS

_____ Lead level (fingerprick) $18.43

_____ Fluoride Varnish (prevention of dental cavities) $30.00

AGES 1 YEAR, 2 YEAR, AND 3 YEARS OF AGE

_____ Hemoglobin test (fingerprick) $3.62

_____ Fluoride Varnish (prevention of dental cavities) $30.00
(prevention of dental cavities)

_____Lead Level (fingerprick) $18.43

_____Hearing Evaluation (EOE) $75.00

AGES 4, 5 AND 6 YEARS OF AGE

_____ Hemoglobin test (fingerprick) $3.62

_____ Fluoride Varnish (prevention of dental cavities) $30.00
(prevention of dental cavities)

_____Vision Screening (eye chart Snellen test) $11.00

_____Lead Level (fingerprick) $18.43

_____Hearing Evaluation (EOE/Puretone) $75.00/$26.00

AGES 7 YEARS THROUGH 11 YEARS

_____Hearing Evaluation (EOE/Puretone) $75.00/$26.00

_____Vision Screening (eye chart Snellen test) $11.00

AGES 12 YEARS THROUGH 14 YEARS

_____Hearing Evaluation (EOE/Puretone) $75.00/$26.00

_____CRAFFT (Screening for smoking, alcohol or substance abuse) $15.00

_____Vision Screening (eye chart Snellen test) $11.00

_____PHQ9 (Screening for depression) $10.00

AGES 15 AND UP

_____Hearing Evaluation (EOE/Puretone) $75.00/$26.00

_____CRAFFT (Screening for smoking, alcohol or substance abuse) $15.00

_____GAD (Screening for anxiety)$10.00

_____Vision Screening (eye chart Snellen test) $11.00

_____PHQ9 (Screening for depression) $10.00

Initial visits and recheck visits for following diagnoses: ADD/ADHD; BEHAVIORAL ISSUES; DEPRESSION; ANXIETY; DEVELOPMENTAL CONCERNS/DELAYS

_____CRAFFT (Screening for smoking, alcohol or substance abuse)$15.00

_____GAD (Screening for anxiety) $10.00

_____VANDERBILT (Screening for ADD/ADHD) $10.00

_____PHQ9 (Screening for depression) $10.00

_____SCARED (Screening for anxiety)$10.00

I acknowledge that I have been informed in advance of receiving these services that these services are not or may not be covered by my health insurance plan. I have chosen for my child NOT to receive these services that are checked and understand that I will be financially responsible for the charges not checked as indicated above.

PRINT PATIENT NAME:_____ DOB:_____

Patient Signature:_____ Date:_____

Print Name of Parent/Legal Guardian/Entrusted Adult:_____ Date:_____
if applicable

Signature of Parent/Legal Guardian/Entrusted Adult_____ Date:_____
if applicable

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: _____

Development

Are you concerned about your child's:
Attention span? ☐ Yes ☐ No Explain:_____

Mental or emotional development? ☐ Yes ☐ No Explain:_____

Physical development? ☐ Yes ☐ No Explain:_____

What grade and school is your child currently in? _____

If your child is in school:
How is his/her behavior in school?_____

_____

How is he/she doing in academic subjects?_____

_____

Is he/she in special or resource classes?_____

_____

Has he/she failed or repeated a grade in school?_____

_____

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 of 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 or not 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 has 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 MMR, varicella, Hepatitis B, Hepatitis A, DTAP, and polio vaccines 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. 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 Signature: _____

Parent/Guardian Printed Name: _____

Date: _____

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 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:**_____

PATIENT INFORMATION SHEET FOR PATIENTS OVER THE AGE OF 18 YEARS

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

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

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

ADDRESS:_____Email:_____
STREET CITY ZIP

PHONE NUMBER:_____ ALT. PHONE NUMBER:_____

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

EMERGENCY CONTACT:_____
NAME PHONE NUMBER RELATIONSHIP TO PATIENT

EMERGENCY CONTACT:_____
NAME PHONE NUMBER RELATIONSHIP TO PATIENT

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will not be permitted to have access to my medical records or information about my care without my specific written permission.

I wish to grant my parent(s)/guardian(s) access to my healthcare providers, appointment and/or medical information as follows:

(Printed below are the name(s) and relationship of those who may act on my behalf)

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

Please select and initial one of the following options:

_____ I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or staff member at Pediatric Associates of Watertown to schedule appointments, discuss my healthcare and access my medical records. THEY HAVE NO RESTRICTIONS

_____ I do not grant any access to my parent(s)/guardian(s). No medical record or information may be accessed or discussed. No appointment information may be released.

This consent will be valid for one year from the date signed. I understand that I may withdraw or change my consent at any time by submitting a new written consent form indicating the changes in access.

Patient Name:_____

Patient Signature:_____ Date:_____

Witness:_____

Witness Signature:_____ Date:_____

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

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

OFFICE USE ONLY
Date rec'd_____
Date entered_____
Initials:_____

Patient Name:_____ Patient Date of Birth:_____

PEDIATRIC ASSOCIATES OF WATERTOWN, PC
CLINIC POLICIES AND PROCEDURES AGREEMENT

Below are our important policies you need to review and be aware of to maintain our trusting professional relationship with you and 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

When your child needs to see their provider, please call in advance to schedule an appointment. If your child needs a sick visit for the same day, call us ASAP so that we can accommodate your needs. We keep a percentage of appt times open for Same Day Call Ins and these may fill in quickly. All same day appts. are scheduled on a priority basis. We will do everything we can to see your sick child on the day you call, as we believe your child should be seen by us, their Medical Home. If your child has a life-threatening emergency, CALL 911.

Pediatric Associates of Watertown, PC does not discriminate on the basis of age (with the exception of being beyond the scope of practice of Pediatrics), gender, race, sexual orientation, creed, religion, disability or national origin.

_____ Authorized person initials indicating agreement

APPOINTMENT CANCELLATIONS AND RESCHEDULING

If you are unable to keep your appointment, please call us ASAP to cancel or reschedule. This will allow us to care for another family that day. It is our policy to charge $25.00 to families that don't give 24 hour notice to cancel an appt or miss their appt. Please arrive 10 minutes prior to your scheduled appointment. If you are more than 10 minutes past your appointment time, we will reschedule you to the next available time.

We reserve the right to dismiss all family members after 3 missed appts without a 24 hour notice.

_____ Authorized person initials indicating agreement

FINANCIAL AND INSURANCE

You hereby authorize 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, co-insurance, deductibles and charges not covered by your insurance. Knowing your insurance coverage is your responsibility. We accept cash, check or most major credit cards. 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

_____ Authorized person initials indicating agreement

REFILLS AND REFERRALS

Please be advised that referrals may take up to 2 weeks and although some may take less time, we ask that you wait 2-3 weeks before calling us to check on the status. Repeated phone calls only delay the process further.

Please note that any and all prescription refills must be called in a minimum of 3 business days prior to needing a refill.

Filling prescriptions may take up to 3 business days to fill.

For certain medications such as ADD/ADHD meds, anxiety meds, asthma meds, your child will be required to maintain regular office visits for monitoring in order to get these meds refilled.

We cannot refill routine medications (asthma, ADD, acne etc) unless your child has a yearly physical with Pediatric Associates of Watertown.

_____ Authorized person initials indicating agreement

NO CELL PHONES OR DISRUPTIVE BEHAVIOR

Please turn off all cell phones while in the office. It is your responsibility to let anyone you have consented to bring in your child/children made aware of our 'no cell phone' policy. There is also a zero-tolerance policy for cursing and rude/disruptive behavior, which will result in dismissal from the practice

i

PERMISSION RELEASE FORMS

If you would like for someone other than yourself to bring your child for treatment, we MUST have the necessary release forms completed by the legal guardian before the child can be seen. It is your responsibility to ensure that if someone else brings your child in to be seen they must have the insurance card and their photo ID, as well as the 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 in order 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.

_____ Authorized person initials indicating agreement

PLEASE NOTE: IT IS IMPORTANT FOR YOUR CHILD'S CONTINUITY OF CARE THAT WE, AS YOUR CHILD'S 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.

_____ Authorized person initials indicating agreement

_____ _____ _____

Signature of Parent/Legal Guardian | Printed Name of Parent/Legal Guardian and relationship | Date signed

PEDIATRIC ASSOCIATES OF WATERTOWN, P.C.

20011 Summit View Boulevard
Watertown, NY 13601
www.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.

Privacy Officer: Alicia Bacsik (315)782-4391