Boston Children's Health Physicians

Until every child is well™

BCHP REGISTRATION

DATE: _____

PATIENT NAME: _____ MED. REC. #: _____

PATIENT ADDRESS: _____ DATE OF BIRTH: ____/____/____

_____ AGE: _____ GENDER: _____

RESPONSIBLE PARTY/GUARDIAN: _____ RELATIONSHIP: _____

MAILING ADDRESS: _____ HOME PHONE: _____

_____ CELL PHONE: _____

WORK PHONE: _____

PARENT/GUARANTOR #1: _____ PHONE: _____

ADDRESS: _____ EMAIL: _____

_____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

PARENT/GUARANTOR #2: _____ PHONE: _____

ADDRESS: _____ EMAIL: _____

_____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

PRIMARY INSURANCE: _____ ID #: _____

INS. ADDRESS: _____ CARDHOLDER: _____

_____ CARDHOLDER DOB: _____ SEX: _____

INS. TELEPHONE #: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____ ID #: _____

INS. ADDRESS: _____ CARDHOLDER: _____

_____ CARDHOLDER DOB: _____ SEX: _____

INS. TELEPHONE #: _____ EFFECTIVE DATE: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

Signature of Patient: _____ Date: _____

Created by Ellen Nolan 12/30/10; edited by Lauren Coluccio 5/6/2016

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I hereby acknowledge that a copy of ***Boston Children's Health Physicians, LLP's*** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *BCHP's* privacy practices or my rights with regard to my personal health information, I may contact *BCHP's* Privacy Officer for further information as set forth in the Notice.

_____	_____
Name of Patient – Please Print Name	Name of Parent or Guardian
_____	_____
Signature of Patient	Signature of Parent or Guardian
_____	_____
Date	Relationship to Patient

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Identification #: _____

I hereby certify that on ____/____/____ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of BCHP's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name) _____

Signature of Staff Person Date

_____ _____

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

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PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments
We are required to collect your co-payment at the time of visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. BCHP accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

No Show/Late Cancel Policy
A $40 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to the late cancel period. Please consult with your physician's office for specific information about the late cancel period.

Insurance
We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

Participating Plans
BCHP participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans
If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

Referrals
If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

_____
Name of Patient

_____
Date of Birth

_____
Signature of Parent or Authorized Person

_____
Print name of Parent or Authorized Person

_____
Date

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RACE & ETHNICITY PATIENT FORM

The U.S. government now requires that we ask patients for their race and ethnicity. You have the option to provide this information or to decline by checking the box. All responses will be kept confidential.

Patient Name: _____ Date of Birth: _____

1. Which category best describes the patient's ethnicity?
   - ☐ Hispanic or Latino or Spanish origin
   - ☐ American Indian/Alaskan native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Black or African-American
   - ☐ White/Caucasian
   - ☐ Other

2. What is the patient's preferred language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other _____
   - ☐ I do not wish to provide this information.

Thank you for your time.

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Authorization for the Release of Medical Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Date of Birth: Mm dd yr	
Other identifier (social security number):	

I hereby authorize _____ [health care provider] to disclose or transfer my protected health information as indicated below.

This information is to be disclosed to:

Name:

Attention of:

Street Address:

City, State, Zip

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:

[ ] Transfer of health coverage [ ] Personal use [ ] Form completion [ ] Referral

[ ] Change in health care provider [ ] Other

This authorization expires in one year from the date signed or earlier _____
date

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
c. The disclosing provider will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure form any individual to do so.
e. The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
f. I acknowledge that I have had an opportunity to review this authorization and understand its intent and use.
g. I will receive a copy of this completed and signed authorization form.

There will be a charge of 75 cents per page for copying medical records plus cost of mailing.

Patient Signature:	Date:

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MINOR CONSENT

For Children Under Age 18

I authorize my child _____, Date of Birth _____

to be seen on _____ (date) by Boston Children's Health Physicians, LLP.

1. **Alone or Accompanied to Appointment:**

___ My child may be seen without being accompanied by anyone.

___ My child may be seen only accompanied by _____ and BCHP personnel.

2. **Alone or Accompanied in Examination Room:**

___ My child may be seen and treated in the examination room without being accompanied by anyone.

___ My child may be seen and treated in the examination room only accompanied by _____ and BCHP personnel.

___ I authorize any test, procedure, and/or vaccination to be done on my child in the course of treatment.

3. **This authorization is valid for the following date or period of time** _____.

Parent/Guardian Signature _____

Print Name _____

Date _____

FOR VERBAL CONSENT OBTAIN ANSWERS TO #1, 2 AND 3 ABOVE

Date _____

Verbal consent obtained by phone call at: _____

Phone number received from/called and time of call

_____

Name of person giving verbal consent and relationship to patient

Witnessed by: _____

_____

Boston Children's Health Physicians

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Dear _____:

E-mail offers an easy and convenient way to communicate but is not the same as calling your physician's office. You can't tell when your message will be read or responded to, or even if your doctor is readily available or on vacation. Children's and Women's Physicians of Westchester LLP ("BCHP") will communicate with our patients (or their parents or guardians) by email only if we receive your agreement to the terms set forth in this Consent. Your consent to these terms will apply to all BCHP clinical providers as well as non-clinical personnel of BCHP who are involved in your care, scheduling, billing and other activities.

- **Use of e-mail is never appropriate for urgent or emergency health problems!** You must call your physician's office or go to a hospital Emergency Department.
- **BCHP WILL NOT ENGAGE IN OR RESPOND TO TEXT MESSAGING BY USE OF A CELL PHONE OR SIMILAR MOBILE DEVICE.**
- E-mail is not to be used as a substitute for face-to-face medical consultation with your physician and is at your physician's sole discretion.
- E-mail is appropriate for communicating regarding routine matters that don't require a lot of discussion, such as prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. BCHP may utilize e-mail at its discretion to send you information about our practice and services, including appointment reminders, our patient programs and new services.
- Your use of e-mail is not confidential and it may not be encrypted. It is like sending a postcard through the mail. Our staff (clinical and non-clinical) may read your e-mails in the course of their work duties. If you send e-mails through a work email account, your employer may have the legal right to read your email.
- E-mail should never be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail may become a part of the medical record when it contains clinical information, and we believe it is appropriate to include it in the medical record. In such case, the message may be retained in the patient health record.
- By signing below, you represent to BCHP that (a) you are the patient or parent or guardian of **the minor child or person lacking capacity to consent to their treatment** listed below; (b) you are an authorized user of the listed email account, (c) you have authority to consent to our use of the account for communications concerning the patient; and (d) you accept full responsibility for monitoring the security of use of the email account on your end. You agree that BCHP will have no responsibility to use any measure to verify that the recipient or sender utilizing your email address is you.
- Either party can revoke permission to use the e-mail system at any time in writing.
- This email agreement ONLY covers the individual signing below. Each authorized representative of the patient must sign his own email Consent.

I wish to communicate by e-mail with BCHP concerning the patient listed below upon the terms of this Consent.

Patient Name: _____

Patient Signature: _____ Date: _____

Your E-mail Address: _____ Your state of residence: _____

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Dear Patient/Responsible Party,

Please be advised that a referral is required from your primary care physician in order for services to be billed to your insurance company. It is your responsibility to obtain a referral prior to your visit and have it at the time of the visit.

Please contact your primary care physician now to obtain the referral for today's visit and ask their office to fax the referral to us.

If we do not receive the appropriate referral, you will be responsible for payment of services rendered by Boston Children's Health Physicians, LLP.

BCHP Physician's Name: _____

Date of Doctor's Visit: _____/_____/_____

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

_____

Print Name of Parent/Responsible Party

_____

Signature of Parent/Responsible Party

Phone: (914) 593-8800 | Fax: (914) 593-8801

www.bchphysicians.org

Boston Children's Health Physicians

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Division of Pediatric Neurology

Patient's Name: _____

Date of Birth: _____

Prescription Insurance Plan: _____

Local Pharmacy: _____

Address: _____

Telephone: _____

Are you eligible for a 90 day supply? Yes | No

Mail Order Pharmacy: _____

Address: _____

Telephone: _____

Do we have your consent to check your medication history? Yes | No

Print Name/Guardian:_____

Signature: _____ Date:_____

Email Address: _____

Boston Children's Health Physicians

Until every child is well™

Division of Pediatric Neurology

Patient History Form
(PFSH/ROS)

Today's Date:_____

Please print the requested information or place a check mark "√ " where appropriate:

Patient's Name: _____ Date of Birth: _____

Form completed by: _____ Relationship: _____

Reason for Referral: _____

_____

_____

Who may we thank for referring you? _____

Birth History

What was the baby's birth weight: _____

Was the baby full term? _____ Premature? _____

Was delivery vaginal? _____ Complicated? _____

What were the baby's Apgar scores? (if known) _____

Mother's age at delivery? _____

Baby's birth order: 1st _____ 2nd _____ 3rd _____ 4th _____

Was baby in regular newborn nursery? _____ Neonatal intensive care unit? _____

Was baby discharged from hospital with mother? _____

Developmental History

Did child walk by 14 months? _____

Did child speak short phrases by 24 months? _____

What age (in months) did the child speak first word? _____ Short phrases? _____

Roll over? _____ Crawl? _____ Sit? _____ Walk? _____ Ride tricycle? _____

Has your child had any delayed milestones? _____

Was the child enrolled in an infant program (Early Intervention)? _____

If yes, what was the reason: _____

Boston Children's Health Physicians

Until every child is well™

Division of Pediatric Neurology

Patient Name: _____ Date of Birth: _____

Educational History

Present grade: _____

Did your child attend preschool? _____

Were any problems noted by teacher? _____

Were there problems with attention? _____ Activity? _____ Behavior? ____ Scissors? _____

Was it therapeutic? (special education) _____

Name of school: _____

Is your child in regular class? _____

Past Medical History (circle answer)

Has your child ever been hospitalized? Yes | No Describe: _____

Has your child had any serious injuries/ broken bones? Yes | No Describe: _____

Has your child ever received a blood transfusion? Yes | No Describe: _____

Has your child ever had surgery? Yes | No Describe: _____

Are your child's immunizations up to date?	Unknown	Yes	No	Year: _____
Pneumococcal (pneumonia)	Unknown	Yes	No	Year: _____
Hepatitis B	Unknown	Yes	No	Year: _____
Influenza (flu)	Unknown	Yes	No	Year: _____
Tetanus/Diphtheria (past 10 yrs)	Unknown	Yes	No	Year: _____
Measles	Unknown	Yes	No	Year: _____
Mumps	Unknown	Yes	No	Year: _____
Rubella	Unknown	Yes	No	Year: _____
Polio	Unknown	Yes	No	Year: _____

Does your child have allergies (including medication) Yes____ No_____

If yes, please list with reaction: _____

Please list any medications your child is currently taking: _____

_____

_____

Has your child recently stopped any medications? Yes ____ No_____

If yes, please describe: _____

_____

Boston Children's Health Physicians

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Division of Pediatric Neurology

Patient Name: _____ DOB: _____

Has your child had any of the following? Please mark response with "√"

	No	Yes	Describe when appropriate
Strep Throat			
Asthma			
Heart Problems			
Lung Problems			
Kidney Problems			
Stomach Problems			
Colon Problems			
Depression			
Psychiatric Illness			
Alcohol/Drug problems			
Poisoning (describe)			
Endocrine Disorder			
Infectious Disease			
Lyme Disease			
Attention Deficit Disorder			
Stroke/ TIA			
Seizure			
Migraine			
Learning Disability			
Other (describe)			

Social History

Where was your child born? _____ Raised? _____

Does the child live with: mother? _____ Father? _____ other: _____

Mother's age: _____ Education: _____ Occupation: _____

Father's age: _____ Education: _____ Occupation: _____

Has the child ever used any of the following substances? Circle one

Substance	Current Use		Previous Use		Type/amountt/Frequency	# of years	Year stopped
Tobacco	YES	NO	YES	NO			
Alcohol (beer, wine, liquor)	YES	NO	YES	NO			
Illicit Substances (street drugs)	YES	NO	YES	NO			
Caffeine (coffee/soda/tea)	YES	NO	YES	NO			
Other (toxin/exposure)	YES	NO	YES	NO			

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Division of Pediatric Neurology

Patient Name: _____ DOB: _____

Family History

Is your child adopted? (circle) Yes | No (if medical history of blood relatives known, describe below)

Father: Alive? _____ Age? _____ Deceased? _____ Cause of Death: _____

Mother: Alive? _____ Age? _____ Deceased? _____ Cause of Death: _____

Please list any illness and age diagnosed in the following family members:

Father: _____

Mother: _____

Grandparents: _____

Sisters: _____

Brothers: _____

Other: _____

Please circle:

Does anyone in the family have neurologic problems? Yes | No

Does anyone in the family have psychiatric problems? Yes | No

Does anyone in the family have problems similar to your child's problems? Yes | No

If yes to any above, please describe: _____

_____

_____

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Division of Pediatric Neurology

Patient Name: _____ DOB: _____

Review of Systems

Has the child had a problem related to any of the following areas? Please "√" your response:

	YES	NO	Describe:
Constitutional (fever, weight loss)			
Unconsciousness			
Eyes			
Ears/Nose/Mouth/Throat			
Cardiovascular			
Respiratory (trouble breathing)			
GI (nausea, vomiting, reflux, constipation)			
GU (trouble with urination)			
Musculoskeletal (muscle or joint pain)			
Skin (rash, lumps, bumps)			
Psychiatric/ Behavioral			
Endocrine (diabetes, thyroid, growth problem)			
Hematological/Lymphatic(bruising, enlarged lymph nodes)			
Immunological disorder			
Neurological:			
Staring episodes/ daydreaming			
Hyperactivity			
Attention problems			
Double vision			
Tics			
Repetitive habits			
Loss of vision			
Dizziness/ Spinning			
Ringing in the ears			
Hearing Loss			
Slurred speech/stuttering after age 4 yrs old			
Weakness			
Numbness/ tingling			
Incoordination/ clumsiness			
Gross motor (walking, climbing)			
Fine motor (hand use)			
Memory Loss			
Headache			
Sleep disturbances			