PEDIATRIC CARE OF THE HUDSON VALLEY affiliated with

Boston Children's Health Physicians
Until every child is well™
formerly CWPW

BCHP REGISTRATION

DATE: _____

PATIENT NAME: _____ MED REC NUMBER: _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

RESPONSIBLE PARTY/GUARDIAN:

NAME: _____ RELATIONSHIP: _____ PHONE NUMBERS:

MAILING ADDRESS: _____ HOME #: _____

_____ CELL #: _____

WORK #: _____

PARENT/GUARANTOR: FATHER'S NAME: _____

GUARANTOR PHONE #: _____

MOTHER'S NAME: _____

GUARANTOR ADDRESS: _____ EMPLOYER NAME _____

_____ ADDRESS: _____

EMERGENCY CONTACT INFO:

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

PRIMARY PHARMACY: _____ PHONE: _____

INSURANCE INFORMATION:

PRIMARY INS NAME & ADDRESS: ID #_____GROUP #_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

PRIM INS TEL #: _____

SECONDARY INS NAME & ADDRESS: ID #_____GROUP #_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

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: _____

PEDIATRIC CARE OF THE HUDSON VALLEY
AFFILIATED WITH
BOSTON CHILDREN'S HEALTH PHYSICIANS

AUTHORIZATION TO BRING CHILD FOR TREATMENT

Date: _____

I, _____ parent/guardian of

_____
Child's Name

Authorize the following individuals to bring my child to Pediatric Care of the Hudson Valley for treatment.

_____
Name Relationship to Child

_____
Address

_____
Name

_____
Address

_____
Name

_____
Address

_____
Name

_____
Address

_____
Signature of Parent/Guardian

This authorization will be in effect for one year from the date above. It can be revoked by the parent/guardian at any time.

Boston Children's Health Physicians

Until every child is well℠ formerly CWPW

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. Boston Children's Health Physicians ("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: _____

Boston Children's Health Physicians

Until every child is well™

formerly CWPW

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

PEDIATRIC CARE OF THE HUDSON VALLEY
266 NORTH ST, SUITE A
NEWBURGH, NY 12550
(845) 565-5437

NAME _____
DOB: _____

PEDIATRIC HISTORY RECORD

BIRTH HISTORY:

Prenatal care: Month initiated _____ Source of care _____ Problems? _____
Was baby born at term? __Yes __No If not, how many weeks early? _____
Was delivery Vaginal ___ Cesarean ___ or other? Explain _____
Any problems with delivery? _____
Birth Weight _____lbs _____ozs Discharge weight _____lbs _____ozs
Did baby have any problems in the nursery? _____
Was Newborn screening normal? __Yes __ No Hearing Screen? __Yes __ No

GROWTH AND DEVELOPMENT:

At what age did child: Sat alone? _____ Stood? _____ Walk? _____
Talk? _____ How many words? _____ Say short sentences? _____
Is child toilet trained? __ Yes __ No
How is child's school behavior or performance? Explain: _____
Do you have any concerns about your child's growth and development?
Explain: _____

Nutrition:

What is your child's present diet? ___Regular ___Restricted ___ Other: _____
Is child currently breastfeeding? ___ Yes ___ No Frequency? _____ Weaned? _____
Formula? ___ Yes ___ No Amount? _____ Weaned? _____
How is child's appetite? Explain: _____
Does the child have any problems with stools? Explain: _____
Does the child have any problems with urine output? Explain: _____
Is the child drinking fluoridated water? ___ Yes ___ No
Do you have any concerns about your child's nutrition? Explain: _____

PEDIATRIC CARE OF THE HUDSON VALLEY
266 NORTH ST, SUITE A
NEWBURGH, NY 12550
(845) 565-5437

NAME _____
DOB: _____

PEDIATRIC HISTORY RECORD CONTINUED:

PAST MEDICAL HISTORY:

Illnesses: _____

_____

Hospitalizations: _____

_____

Surgery: _____

_____

Medications: _____

_____

Allergies: _____

_____

FAMILY HISTORY:

Indicate conditions which close relatives (parents, grandparents, siblings, aunts and uncles) have:

__ Alcoholism	__ Anemia	__ Asthma	__ Blood disorders
__ Cancer	__ Diabetes	__ Heart Disease	__ High Cholesterol
__ Hypertension	__ Kidney Disease	__ Mental Illness	__ Migraines
__ Seizures	__ S.I.D.S.	__ Thyroid Disease	__ Tuberculosis

__ Other: _____

SOCIAL HISTORY:

Household members: _____

_____

Primary Child Caretaker: _____

Smoking in the house _____ Drug use in house _____ Need for Social Services _____

Comments: _____

_____

Signature: _____ Date: _____

Reviewed by provider: _____

Boston Children's Health Physicians

Until every child is well℠ formerly CWPW

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

PEDIATRIC CARE OF THE HUDSON VALLEY
Affiliated with Boston Children's Health Physicians
266 North Street
Suite A
Newburgh, NY 12550
(845) 565-KIDS
Fax (845) 565-7021

VACCINE POLICY :

- We believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We believe in the safety of vaccines.
- We 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. Delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at the Pediatric Care of the Hudson Valley.
- We believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.
- Should you absolutely refuse to vaccinate your child despite all our efforts, we ask you to find another health care provider who shares your views.
- Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death. As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.
- 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.

PEDIATRIC CARE OF THE HUDSON VALLEY
845-565-KIDS

We are committed to provide your child/children with the best quality medical care and we need your help to accomplish this goal. The professional relationship between our office and you is very important. Our responsibility is to keep your child healthy and your responsibility is to make sure that appointments are kept and physician's orders are followed. Together we can achieve the goal of keeping your child in good health. The front desk staff or the office manager is happy to discuss with you our professional fees, financial policy, appointment policy and your responsibility.

APPOINTMENT POLICY

Our office operates by **appointment only** which will cut down waiting room time. We can never predict how complicated an office visit will be until the provider evaluates the situation. Therefore, some delays may occur. But this situation can be alleviated by following our policy.

- Be on time for your appointment.
- Late arrivals greater than fifteen (15) minutes may result in cancellation
- Give twenty-four (24) hours notice for cancellations.
- Give 24-48 hours' notice for referrals.

PRESCRIPTION POLICY

- We will no longer be able to write prescriptions as per the NYS law requiring all prescriptions be eprescribe. This mandate, effective 3/27/16, disallows practitioners from prescribing medications by phone, fax or on a handwritten NYS prescription.
- Plan ahead and request your refill at the time of your visit. If you had a recent visit and forgot to request the refill, call the office during business hours and allow at 48-72 hours for the office to respond. Please **DO NOT LET YOUR PRESCRIPTION RUN OUT OR EXPIRE.**

OTHER OFFICE POLICY

- No person shall be discriminated against because of individual's race, religion, color, sex, age, national origin, sexual orientation or disabilities.
- Medical record fee – 75 cents per page with a signed HIPPA release.
- Inform staff of any change in address, phone #, permission to accompany child letter or child custody status.
- Children under 18 years of age must be accompanied by a parent/guardian.

I understand and agree to vaccinate my child according to the AAP recommendations. I understand and agree to comply with the above named policies.

Signature of Parent or Guardian: _____ Date: _____

Boston Children's Health Physicians
Until every child is well™
formerly CWPW

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.

Boston Children's Health Physicians

Until every child is well®

formerly CWPW

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 CWPW 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 CWPW 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 or called and time of call

_____

Name of person giving verbal consent and relationship to patient

Witnessed by: _____

_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Parent

_____ Signature

_____ Date

_____
Patient

_____ Name

_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Pediatric Care of Hudson Valley
Boston Children's Health Physicians
Until every child is well™

CREDIT CARD ON FILE

We ask that all patients maintain a valid credit card on file with us. **Any patient balances that are present 30 days after you have received a statement will be billed on your credit card.** Please be assured, if there are financial circumstances that preclude you from settling your account, we are more than willing to work with you, but you must communicate this with our billing staff so arrangements can be made.

Your credit card information will be stored in an encrypted merchant service account. Pediatric Care of the Hudson Valley (and BCHP) only has access to the last 4 digits of your account number. Nothing is stored on site.

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of receipt of your bill. For your convenience, we accept debit cards and credit cards.

Patient Name: _____ Date of birth: _____

Patient Name: _____ Date of birth: _____

Patient Name: _____ Date of birth: _____

Patient Name: _____ Date of birth: _____

Patient Name: _____ Date of birth: _____

(Please print name) _____ authorizes Pediatric Care of the Hudson Valley/BCHP to charge my credit/debit card for the following reasons: Office visits, deductibles, Coinsurance, co-payments, non-covered services, cancellations and no show fees.

_____ Date: ___/___/___

Parent/Guardian Signature