BATAVIA PEDIATRICS PC

47 BATAVIA CITY CENTRE
BATAVIA, NY 14020
P: (585) 343-2611
F: (585) 343-3826

CONSENT

TO OUR PATIENTS:

COPIES OF BATAVIA PEDIATRIC'S PRIVACY PRACTICES ARE AVAILABLE FOR YOU TO READ IN OUR WAITING ROOM AND PAPER COPIES ARE AVAILABLE FROM THE RECEPTIONIST IF YOU WISH TO KEEP ONE.

I consent to have Batavia Pediatrics, PC use and disclose my protected health information for payment, treatment and health care operations and for such purposes allow under federal and state law.

I have been given a copy of the HIPPA Privacy Notice describing how I may use it and my rights under it.

Patient's Name: _____ **DOB** _____

Parent's Signature or Legal Guardian: _____

Today's Date: _____

***Person(s) other than parents and relationship to patient** with permission to authorize child's medical treatment and to receive medical record information:

_____

_____

BATAVIA PEDIATRICS PC

PATIENT INFORMATION

Date_____

Last Name First Name Middle Name DOB

PRIMARY LANGUAGE English Spanish Other_____

RACE African American Asian Filipino Hispanic Native American White Other_____

PARENTAL INFORMATION

MOTHER/LEGAL GUARDIAN

Name _____

DOB:_____

Mailing Address_____

_____County_____

Home Phone_____

Cell Phone_____

Work Phone_____

Employer_____

Marital Status

☐Single ☐Married ☐Divorced ☐Widowed

FATHER/LEGAL GUARDIAN

Name_____

DOB_____

Mailing Address_____

_____County_____

Home Phone_____

Cell Phone_____

Work Phone_____

Employer_____

Marital Status

☐Single ☐Married ☐Divorced ☐Widowed

Who does the child reside with? ☐Father ☐Mother ☐Other_____

Who has legal custody of the child? ☐Joint ☐Mother ☐Father ☐Other _____

(PLEASE PROVIDE ANY APPLICABLE LEGAL DOCUMENTS)

Who is responsible for the medical bills? ☐Both ☐Mother ☐Father ☐Other_____

Which Phone # should we list as child's Primary contact?_____ **Can we leave message at this #?**_____

Phone #_____ ☐Email _____

PLEASE CHECK EMAIL BOX IF YOU WOULD LIKE US TO WEB ENABLE YOU TO BE ABLE TO VIEW SOME OF YOUR CHILD'S RECORDS.

INSURNACE INFORMATION

****PLEASE NOTE: YOU WILL BE ASKED TO RPESENT YOUR INSURANCE CARD *AT EVERY VISIT*****

PRIMARY INSURANCE

Insurance Company_____

Date_____

Card Holder's Name_____

Card Holder's DOB_____

SECONDARY INSURANCE

Insurance Company_____

Date _____

Card Holder's Name_____

Card Holder's DOB_____

EMERGENCY CONTACT (OTHER THAN PARENT)

Name_____Relationship_____

Home Phone_____Cell Phone_____Work Phone_____

Signature of Parent/Guardian:_____**DATE**_____

How did you hear about our practice? ☐Yellow Pages ☐Friend/Family/Neighbor ☐Other Physician

☐Online (name of website)_____ ☐Other _____

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Patient Medical History

NAME _____ BIRTHDATE _____

PATIENT HISTORY

Where was the child born? _____ Obstetrician _____

Is child adopted? _____ Race _____ At what age? _____ Is child aware? _____

Full term pregnancy? _____ Premature? _____ Type of delivery? _____

Mother: Have you had breast surgery? _____

Did you take hormones or medicines during pregnancy? _____

Do you or the father have any history of S.T.D. (herpes, HIV, group B strep, etc.)? _____

Problems at birth or in first few weeks? _____

Birth wt. _____ Length _____ Head Circ. _____ Apgar _____

Breast/bottle fed _____ Sat alone _____ mos. Walked _____ mos. Words _____ mos.

Sentence _____ mos. First teeth _____ mos. Bladder _____ mos. Bowel _____ mos.

Is your child taking medication now? _____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY

Rubella (German measles) _____

Chicken pox Disease _____ Vaccine _____

Strep Throats _____ Ear infections _____

Pneumonia _____

Convulsions/Seizures _____

Urinary infections _____ Bedwetting/soiling problem? _____

Asthma _____

Allergic to any medication? _____

Allergic to any food or insects? _____

Any smokers at home? _____ Any pets? _____

Is he/she receiving desensitization shots? _____

Heart disease? _____ A heart murmur? _____

Meningitis? _____

Has child received blood transfusion or blood products? _____

Any orthopedic (bone, joint, muscle) problems? _____

School Problems/Performance:

Scholastic _____

Conduct _____

Has child had a learning problem? _____

Has child ever been in a special class? _____

Handicaps? _____

Any other past illness? _____

OPERATIONS (Enter Dates)

Circumcision _____

Tonsils and Adenoids _____

Appendectomy _____

Ear Tubes _____

Other operation or hospitalizations _____

FAMILY HISTORY

	Birth Date	Ht.	Wt.	Medical Problems	Education Level
Mother					
Father					

Any history in close relative (grandparent, sibling, aunt, uncle) of: *(please check appropriate items)*

__ Interrupted Pregnancies
__ Tuberculosis
__ Allergies
__ Convulsions or Epilepsy
__ Other Heart Disease
__ HIV/AIDS
__ Diabetes
__ High Cholesterol
__ High Blood Pressure
__ Early Heart Attacks
__ Birth Defects
__ Chemotherapy
__ Bleeding Tendencies
__ Sudden Unexpected Death or fatality from illness
__ Kidney Disease
__ Thyroid Disease
__ Liver Disease
__ Mental or Emotional Problems
__ Cancer
__ Substance Abuse
__ Other

Has there been a separation, divorce or death? _____ When? _____

Who is legal guardian? _____ With whom does child live? _____

Has there been a remarriage? _____ What has been the attitude of your child to the situation? _____

Batavia Pediatrics PC

Office Policy

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____**Relationship**_____

Responsible Party Member's Signature _____ **Date** _____

Revised 2017

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There may be a charge of $25.00 for missed appointments.**
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, hearing and vision screenings, strep tests and urine tests.
    b. If these are not covered, you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service. A **$10.00 service fee** may be charged in addition to your co-payment if the co-payment is not paid by the end of next business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$10.00 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A $20.00 fee will be charged for any checks returned for insufficient funds.

Forms

1) There is no charge for annual physical form given at the time of your child's visit. This is considered part of the visit. **However,** should you lose your forms, there will be a $5.00 charge ($5.00 for one form) to replace them.
2) Family and Medical Leave Act forms are $10.00. Payment is due when the forms are dropped off. We require 4-day turnaround time.

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) A copy of your complete record is available for a $.75-per-page fee.
3) We provide records of your child for visits (including consultations from specialists) rendered here at Batavia Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Prescription Refills

1) For monthly medication refills, we require 72 hours' notice, during regular business hours. Please plan accordingly.

Night Calls

1) We engage an after-hours, night call service, thru Night Nurse Inc.
   Night Nurse Inc., records all of its calls (incoming and outgoing) so as to have an actual record of the information provided. Your signature on this form serves as consent for you and your minor children.

Initial: _____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: BATAVIA PEDIATRICS P.C.
47 BATAVIA CITY CENTRE
BATAVIA, NY 14020

Patient Name	Date of Birth	
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.