Pediatric Associates OF PLYMOUTH

PATIENT REGISTRATION FORMS TODAY'S DATE: ________________________

Last Name of Child **First Name of Child** **Date of Birth**

________________________________ ____________________________ ___________________

Race: (Circle) White Black Asian American Indian/Alaskan Native Other: ___________________
Ethnicity: (Circle) Non-Hispanic or Latino Hispanic-Latino
Gender Identity: Male ____ Female ____ Preferred Language: ____________________________

Last Name of Child **First Name of Child** **Date of Birth**

________________________________ ____________________________ ___________________

Race: (Circle) White Black Asian American Indian/Alaskan Native Other: ___________________
Ethnicity: (Circle) Non-Hispanic or Latino Hispanic-Latino
Gender Identity: Male ____ Female ____ Preferred Language: ____________________________

Last Name of Child **First Name of Child** **Date of Birth**

________________________________ ____________________________ ___________________

Race: (Circle) White Black Asian American Indian/Alaskan Native Other: ___________________
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Gender Identity: Male ____ Female ____ Preferred Language: ____________________________

Last Name of Child **First Name of Child** **Date of Birth**

________________________________ ____________________________ ___________________

Race: (Circle) White Black Asian American Indian/Alaskan Native Other: ___________________
Ethnicity: (Circle) Non-Hispanic or Latino Hispanic-Latino
Gender Identity: Male ____ Female ____ Preferred Language: ____________________________

Parent/Guardian Information:

Full Name: #1 _____ DOB: _____

Address: _____

Please Circle: Male / Female Cell Phone # _____

Home Phone #: _____Email Address: _____

Please Circle: I DO I DO NOT give permission to PAP to use the above information to send an invite to join the patient portal.

Relationship to child: _____

Full Name: #2 _____ DOB: _____

Address: _____

Please circle: Male / Female Cell # _____

Home Phone #: _____Email Address: _____

Please Circle: I DO I DO NOT give permission to PAP to use the above information to send an invite to join the patient portal.

Relationship to child: _____

PREFERRED CELL PHONE FOR APPOINTMENT REMINDER TEXT MESSAGES: _____

Pharmacy Information

Preferred Pharmacy Name: _____

Address: _____

Phone Number: _____

Prescription Benefits/Pharmacy Plan: _____

Secondary Pharmacy Information

Preferred Pharmacy Name: _____

Address: _____

Phone Number: _____

Prescription Benefits/Pharmacy Plan: _____

Insurance Information

Name of Primary Insurance: _____

Identification Number: _____ Group Number #: _____

Subscriber Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Relationship to child: _____

Cell # _____

Does your child have secondary insurance/please circle: YES NO

Insurance Company Name: _____

ID # _____ Group # _____

Subscriber Name: _____ Date of Birth: _____

Release and Assignment:

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO Plans and Commercial Insurance to Pediatric Associates of Plymouth. I understand that I am financially responsible for all charges whether or not covered by insurance. I hereby authorize and designee to release any information to secure payment.

Signature: _____ Date: _____

Patient/Patient Representative/Parent

Financial Responsibility:

I understand that payment of all medical care is due and payable at the time of service. With dependents of divorced parents, responsibility and payments shall be that of the guardian bringing the child for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's accounts in case of default, including reasonable attorney fees and court costs. I hereby grant permission to Pediatric Associates of Plymouth to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Associates of Plymouth. A photocopy of this authorization shall be considered as affective and as valid as the original.

_____ _____

Signature Print Name

HIPAA Privacy Practices Acknowledgement Form/attached

I have read The Notice of Privacy Practices for Pediatric Associates of Plymouth and by my signature below acknowledge that I have reviewed it. Parent/Guardian/Patient over 18 reviewing HIPAA:

_____ _____

Signature Print Name

Protected Health Information / Messages

Your child's care at Pediatric Associates of Plymouth may require phone contact with our staff. If you are not available to receive a call and would like your child's results/medical instructions/medication information containing protected health information (PHI) left on voicemail please set up your voicemail. For us to leave a message, your voicemail must be set up with your identity (First and Last Name), otherwise we will not leave a message with PHI information. You have already designated preferred contact number in the above paperwork.

_____ _____

Signature Print Name

Vaccine/Immunization Policy/attached

I have read The Pediatric Associates of Plymouth Vaccine Policy and acknowledge this by signing below.

_____ _____

Signature Print Name

Medical History – This page may have to be duplicated depending on number of children being registered into the practice.

Child's Name (First) _____ Last Name: _____

Gender Identity: Male _____ Female _____

Pregnancy
What number pregnancy was this child? _____ Was the pregnancy normal? Yes No
In no, please explain: _____

Did the mother have any illness during pregnancy: Yes No
If yes, please explain: _____

Was the baby born on time? Yes No If not, early or late? _____ How many weeks? _____

What hospital was the baby born? _____ Doctor who delivered baby? _____

Vaginal or cesarean delivery (circle). Any complications? Yes No
If yes, please explain _____

Baby's birth weight _____ Length _____ Discharge weight _____

Child's blood type _____ Mother's Blood Type _____ Father's Blood Type _____

Post Natal Course

Did the baby come home with the mother? Yes No If not, why?: _____

Did the baby have any problems in the nursery? Yes No If yes, what? _____

Is the baby breast fed? Yes No If formula is used, which one? _____

Has your child ever had:

Significant illnesses/infections: _____

Hospitalizations: _____

Operations: _____

Allergies: _____

List all current medications: _____

_____

Family History

If any family members listed below are deceased, please indicate so with a "D", and age at which they passed.

Child's Mother's Age: _____ Child's Father's Age: _____
Maternal grandmother _____ Maternal grandfather _____ Paternal grandmother _____ Paternal grandfather _____

Ages, sex and health status of child's siblings:

_____

_____

_____

Are the child's parents Single Married Divorced Separated

Circle any of the following diseases which any member of either side of the family has had:

Tuberculosis Cancer Diabetes Seizures Heart Disease
High Blood Pressure Mental Illness Anemia Asthma Color Blindness
Migraine Headaches
Inherited Diseases: (specify) _____

Family Habits

Smoking Yes No Alcohol Use Yes No Drug Use Yes No

Guns in the house Yes No Pets Yes No

Do you have any special concerns about your child? _____

_____

Is there anything else that you want us to know about your child? _____

_____

_____
Person supplying the medical history

_____
Relationship to child

Pediatric Associates OF PLYMOUTH

AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

It is the policy of our office that any NEW patient under the age of 18 must be seen in the presence of their parent or legal guardian for their first visit. An established patient may be brought in by an adult if written permission is given by the parent or legal guardian and that person shows a valid ID.

I _____ for _____ DOB: _____
Parent/Guardian/PRINT

_____ DOB: _____

_____ DOB: _____
Child/Children's First/Last Name/PRINT

By completing the information below you are giving permission to the following people to accompany your child to their appointments.

_____ _____
Name/PRINT Relationship to child/children

_____ _____
Name/PRINT Relationship to child/children

_____ _____
Name/PRINT Relationship to child/children

This authorization includes necessary labwork as well as the administration of any recommended immunizations.

This authorization: ____ is effective only on _____
____ is effective from _____ to _____
____ is effective until revoked by me in writing.

_____
Signature of Parent/Guardian

Date: _____

Forms/Protocols/lgs August 2018

Pediatric Associates of Plymouth

RECORD RELEASE REQUEST

(INCOMING PATIENT RECORDS)

Please print.

Date: _____

TO: _____

FAX #: _____

I hereby authorize the release of ALL my child's medical records to:

Pediatric Associates of Plymouth

(please choose office)

___3031 Walton Road, Suite C101

Plymouth Meeting, Pa. 19462

610.825.3500

610.825.8502 (FAX)

___50 W. Third Avenue, Suite 400

Collegeville, Pa. 19426

610. 489.2229

610.489.4788 (FAX)

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____

Parent/Guardian's Signature

Forms/Protocols/lgs August 2018

VACCINE POLICY

Pediatric Associates of Plymouth firmly believe in the effectiveness of vaccines to prevent serious illness. We want to ensure that all of our patients are as healthy as possible.

One of the most important public health advances has been the development of vaccines. Because of vaccines, many diseases have been eliminated or have become uncommon, including polio, smallpox, diphtheria and tetanus. Scientific research has consistently shown that vaccines are safe and effective. Choosing not to vaccinate your child puts your child as well as others at risk, including family members, classmates, and other children in our waiting room.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the **schedule*** is the right thing to do. However, should you have doubts, please discuss these with your health care provider but be advised, that delaying or "breaking up the vaccines" goes against expert recommendations. This can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Pediatric Associates of Plymouth. We expect you to complete the vaccines in a timely manner. Please realize that you will be required to sign a "Refusal to Vaccinate" for any vaccine delays.

Finally, if you should absolutely refuse to vaccinate or complete vaccinations for your child despite all of our efforts, we will ask you to consider finding another health care provider who shares your views. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for preventable life threatening illnesses, disability and even death.

Our medical relationship is built on trust: trust that we have been trained well, that we follow the most up to date scientific evidence, that we are concerned about your child's well-being, and that we will recommend the best care for each child. When a family does not trust our judgement or recommendations on something that is so well established, it creates a poor relationship. If you do not wish to immunize your child, our practice many not be a good fit for your family.

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 our providers.

Vaccine **Schedule*** – by age 7 months, all primary series (DTap, Hib, Polio, Pneumococcal, Rotavirus) vaccines and Hepatitis B by 10 months of age. All other American Academy of Pediatric recommended immunizations such as Hepatitis A, MMR and Varivax must be received by 2 years of age and boosters of these vaccines by age 6. Tdap and meningococcal vaccines must be received by 12 years of age. The booster meningitis shot must be received by 17 years of age. Please visit https://www.cdc.gov/vaccines/parents/childhood-vaccines for standard schedule information.

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d, et seq., and regulations adopted under that Act ("HIPAA").

****THIS NOTICE DESCRIBES HOW YOUR (CHILD'S) HEALTH INFORMATION (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED. IT INFORMS YOU HOW TO OBTAIN ACCESS TO YOUR (CHILD'S) PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

Effective Date: This notice takes effect on August 1, 2016 and stays in effect until replaced by another notice.

OUR COMMITMENT TO YOUR PRIVACY - Our practice is dedicated to maintaining the privacy of our patients' protected health information ("PHI"). In conducting our business, we create records regarding our patients and the treatment and services we provide to them. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: (a) how we may use and disclose your PHI, (b) your privacy rights in your PHI, and (c) our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current notice in our office in a visible location at all times and a copy on any website that we may create or maintain. You may also request a copy of our most current notice at any time.

IF YOU HAVE QUESTIONS ABOUT THE NOTICE, PLEASE CONTACT:

Linda Simon, HIPAA Compliance Officer at: Address: 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462 or Phone number: (610) 825-3500.

WE MAY USE AND DISCLOSE PHI IN THE FOLLOWING WAYS:

1. **Treatment:** Our practice may use your PHI to treat you. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Employees of our practice (including, but not limited to, our doctors, nurses and medical assistants) may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your parents or other family members (when appropriate or with consent).

2. **Payment:** Our practice may use and disclose your PHI in order to bill and collect for the services and items you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs (such as family members). We may use your PHI to bill you directly for services and items.

3. **Health Care Operations:** Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to: evaluate the quality of care you receive from us; conduct cost-management and business planning activities for our practice; conduct trainings for our employees; and/or other business management or administrative activities.

4. **Other possible uses:**
    a. **Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
    b. **Health Related Benefits and Services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
    c. **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you by consent.
    d. **Disclosures Required By Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. **Public Health Risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    a. Reporting child abuse or neglect;
    b. Preventing or controlling disease, injury or disability;
    c. Notifying a person regarding a potential risk for spreading or contacting a disease or condition;
    d. Reporting reactions to drugs or problems with products or devices;
    e. Notifying individuals if a product or device they may be using has been recalled;
    f. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only

disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or

g. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings:** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute; provided that we have received adequate assurances from the party making the request that such party has made an effort to inform you of the request or has obtained a protective order for the information the party has requested.

4. **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official:
   a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
   b. Concerning a death we believe has resulted from criminal conduct;
   c. Regarding criminal conduct at our office;
   d. In response to a warrant, summons, court order, subpoena or similar legal process;
   e. To identify/locate a suspect, material witness, fugitive or missing person; or
   f. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

6. **Organ and Tissue Donation:** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research:** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when:
   a. Our use or disclosure was approved by an Institutional Review Board or a Privacy Board; and
   b. We obtain the oral or written agreement of a researcher that:
      i. The information being sought is necessary for the research study and the researcher is subject to an appropriate agreement;
      ii. The use or disclosure of your PHI is being used only for the research;

iii. The researcher will not remove any of your PHI from our practice; or, iv. The PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if requested, will provide us with proof of death prior to access to the PHI of the decedents.

8. **Serious Threats to Health or Safety:** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military:** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your PHI to authorized federal officials in order to provide protective services to the President, other officials or foreign heads of state and to conduct investigations.

11. **Inmates:** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation:** Our practice may disclose your PHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR PHI

1. **Confidential Communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Pediatric Associates of Plymouth, Attention: HIPAA Compliance Officer, 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request.** However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request

in writing to Pediatric Associates of Plymouth, Attention: HIPAA Compliance Officer, 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462. Your request must describe in a clear and concise fashion:

a. The information you wish restricted;
b. Whether you are requesting to limit our practice's use, disclosure or both; and,
c. To whom you want the limits to apply.

3. **Inspection and Copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Pediatric Associates of Plymouth, Attention: HIPAA Compliance Officer, 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462 in order to inspect/and or obtain a copy of your PHI. Our practice will respond to this request within thirty (30) days. Consistent with the thencurrent Pennsylvania law, our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

   Our office may deny your request to inspect and/or obtain copies in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct such review. You will receive a letter notifying you of the denial and the practice's basis for such decision.

4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Pediatric Associates of Plymouth, Attention: HIPAA Compliance Officer, 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462. You must provide us with a reason that supports your request for the amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. You will receive a letter notifying you of this denial and the practice's basis for such decision.

5. **Accounting of Disclosures:** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim need not be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to Pediatric Associates of Plymouth, Attention: HIPAA Compliance Officer, 3031 Walton Road, Building C, Suite 101, Plymouth Meeting, PA 19462. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first accounting you request within a twelve (12) month period is free of charge. Our practice may charge you a reasonable, cost-based fee for additional accountings

within the same twelve (12) month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the HIPAA Compliance Officer at (610) 825-3500.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of the Health and Human Services. To file a complaint with our practice, contact the HIPAA Compliance Officer at (610) 825-3500. All complaints must be submitted in writing.

To file a complaint with the Department of Health and Human Services, you can do so via:

- OCR Complaint Portal at: https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf
- Electronic Mail to: OCRComplaint@hhs.gov
- Mail or fax to Mid-Atlantic OCR Regional Office at:

  Barbara Holland, Regional Manager
  Office for Civil Rights
  U.S. Department of Health and Human Services
  150 S. Independence Mall West
  Suite 372, Public Ledger Building
  Philadelphia, PA 19106-9111
  Fax: (202) 619-3818

You will not be penalized or retaliated against for filing a complaint with our practice or the Secretary.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.