East Lyme Pediatric Clinic

Welcomes You!

Tell Us About Your Child

Child's Name: Baby (First) Test (Middle) (Last) Today's Date: 2/24/2015

Child's Home Address: 835 BLOOMFIELD AVE (Street) WINDSOR (City) CT (State) 06095 (Zip code)

Home Phone #: (860)327-0955 Child's Social Security #: 000-00-0000 Date of Birth: 1/1/2011

Other Siblings: 1. _____ Age ____ ☐ Male ☐ Female 2. _____ Age ____ ☐ Male ☐ Female

3. _____ Age ____ ☐ Male ☐ Female 4. _____ Age ____ ☐ Male ☐ Female

Language: Race: Ethnicity:

Guardians/Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

☐ Mother ☐ Step-Mother ☐ Guardian Date of Birth: ____/____/____ Home Phone #: (860) 327-0955 Work Phone #: _____

Name: TEDDY TEST Driver's License #: _____ Social Security #: ___-___-____

Address: 835 BLOOMFIELD AVE (Street) WINDSOR (City) CT (State) 06095 (Zip code)

Employer: _____ Cell Phone #: ( )

E-Mail Address: _____

☐ Father ☐ Step-Father ☐ Guardian Date of Birth: ____/____/____ Home Phone #: ( ) - Work Phone #: ( ) -

Name: _____ Driver's License #: _____ Social Security #: ___-___-____

Address: _____ (Street) (City) (State) (Zip code)

Employer: _____ Cell Phone #: _____

E-Mail Address: _____

Insurance Information

Primary Insurance: _____ Insurance I.D: _____

Group #: _____ Social Security #: _____ Subscriber Date of Birth: _____

Subscriber Name: _____ Home Phone #: _____

Address: _____ (Street) (City) (State) (Zip code)

Patient's Relationship to Insured: ☐ Child ☐ Self ☐ Other: _____

Secondary Insurance: _____ Insurance I.D: _____

Group #: _____ Social Security #: ___-___-____ Insurance of Birth: _____

Insured Name: _____ Home Phone #: 0

Address: _____ (Street) (City) (State) (Zip code)

Patient's Relationship to Insured: ☐ Child ☐ Self ☐ Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Lyme Pediatrics to release any information required to process my claims.

LEGAL GUARDIAN'S SIGNATURE: _____

PLEASE PRINT NAME: _____

East Lyme Pediatric Clinic
170 Flanders Road
Niantic, Ct 06357
(860) 739-7444

Medical Authorization Form

Patient Name: _____ Date Of Birth:_____

Parent /Legal Guardian Name:_____ Phone Number:_____

Please list the first and last name of the family members or friend that you trust to make medical decisions with your child. The member must have a driver's license or photo ID with them. **If a custody order is in place please provide our office with a copy, otherwise we legally have the right to provide both biological parents with information regarding your child.**

Please note:

Any family member or friends must have a permission letter to bring in with the child for any vaccines.

First Name: _____ Last Name: _____Relationship:_____

First Name: _____ Last Name: _____Relationship:_____

First Name: _____ Last Name: _____Relationship:_____

First Name: _____ Last Name: _____Relationship:_____

First Name: _____ Last Name: _____Relationship:_____

I have received and reviewed the notice of Medical Authorization.

Parent/legal Guardian Signature Only _____

Date signed_____

East Lyme Pediatric Clinic

Office Policies & Procedures

UPDATES: It is essential that we have all your current information including, address, phone numbers, and insurance.

PAYMENT & INSURANCE: You are responsible for bringing your insurance cards(s) to each visit. **PAYMENT IS DUE AT THE TIME OF SERVICE.** We do offer a discount to self-pay patients. Co-payments must be paid at each visit based on your insurance plan. If you have a deductible it is due upon receiving your invoice. Past due balances will be sent to collections after 90 days, however, payment plans are available and can be set up at the front desk.

LATE ARRIVALS: If you arrive **15** minutes or more late for your appointment you will be allotted the next available time slot. If there are no available time slots you will be asked to reschedule your appointment. Please arrive at your scheduled time to ensure you as well as other patients are seen in a timely manner.

NO SHOW: If you cannot keep your appointment due to an emergency, you must call our office to notify us. We reserve the right to charge a **$100.00** fee for missed appointments. After 3 consecutive missed appointments we reserve the right to discharge you from the practice.

CANCELLATIONS: We require a **24 hour** notice to cancel an appointment. We appreciate your understanding in advance.

PRESCRIPTION REFILLS: A 48 HOUR NOTICE IS REQUIRED FOR REFILLS ON ROUTINE MEDICATIONS. Please call before your child is out of medication as soon as possible. Children are NOT authorized to call in their own prescriptions unless they are 18 years of age or older.

CONTROLLED MEDICATIONS: Parents are expected to pick up and sign for all controlled medications.

HIPPA PRIVACY ACT: Please remember that we will not release any of your child's confidential health information without your written consent on the HIPPA form (Including but not limited to medications, prescriptions, and visit dates.) This is your child's privacy.

TRANSFERING RECORDS: If for any reason you need your child's records transferred we will make every effort to copy the records as quickly as possible. We do however have **30 days** to honor your request. The charge is **$0.45** per page plus the cost of postage if mailed (CT State Law). Payment is due prior to receiving records.

I have read the policies and procedures and understand all the above information.

_____ _____

Parent/ Guardian signature **Child's Full name**

_____ _____

Relationship to Patient **Date**

East Lyme Pediatric Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut law, this practice may not use or disclose you're individually identifiable health information without your authorization except as provided in our Notice of Privacy practices. Your completion of this form means that you are giving us, East Lyme Pediatric Clinic, permission to obtain health records information on the below mentioned child. This information will allow us to provide healthcare services to them.
I hereby authorize East Lyme Pediatric Clinic to obtain health information concerning:

Patient Name:	**D.O.B.**
1. _____	_____/_____/_____
2. _____	_____/_____/_____
3. _____	_____/_____/_____
4._____	_____/_____/_____

Description of health information to disclosed/obtained _____

The types of information below cannot be release/obtained without my specific consent and knowledge, Therefore, I have initialed before each type of record I authorize you to release/obtain:

_____ Alcohol and / or drug abuse treatment records

_____ Mental health treatment records

_____ AIDS , ARC , HIV testing

_____ Drug and / or alcohol testing records

_____ The information disclosed/ obtained is for purposed of transferring my child to East Lyme Pediatric Clinic.

_____ The information disclosed/obtained is for purpose of continued health care.

Please mail the above information to:

East Lyme Pediatrics Clinic
170 Flanders Road
Niantic, CT 06357
Tel: (860) 739-7444
Pease fax the above information to **(860) 739-3252**

Signed: _____ Date: _____

Print Name: _____ Relationship to PT:_____

Records Request from: _____ Phone _____
Fax_____

East Lyme Pediatric Clinic
170 Flanders Road
Niantic, Ct. 06357
(860) 739-7444

RELEASE OF INFORMATION:

I authorize my physician, health care provider, and their representatives to release any information relating to an illness, injury, diagnosis, care or treatment to other healthcare provider company, my insurance company, health plan, Medicare, or third party payers or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, physiological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV related information. I understand that the reason for furnishing such information may include the following: for us in medical, financial or provider auditing as may be legally required for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

_____

Patient/Parent Signature

_____

Date

East Lyme Pediatric Clinic
170 Flanders Road
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(860) 739-7444

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 4/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practice and the term of this notice at any time provided applicable law permits such changes. We reserve the right to make the changes in our privacy practice and the new term of our notice effective for all health information that we maintain including health information we created or receive before we made the changes. Before we make a significant change in our privacy, we will change this notice and make new notice available upon request.

You may request a copy of this notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For Example:

Treatment: We may use or disclose health information to payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health, information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose health information to you as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosures of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing on IX health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person's involvement in your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are we required by law to do so by law.

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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstance.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the form you request unless we cannot do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed below. If you request copies, we reserve the right to charge for each page and for staff time to copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which our business associates or to whom we disclosed your health information for purposes other than treatment, payment. healthcare operation and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based *fee* for responding to these additional request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to *agree* to these additional requests.

Alternative Communication: You have the right to request that we communicate with your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative, means or locations, and provide satisfactory explanation how payment will be handled under the alternative means or locations your request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practice or have questions or concern, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or *in* response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of the notice. You also may submit with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in *any* way If you choose to file a complaint with us or with the *U.S.* Department of Health and Human Services.

Contact officer: Sajda Mailk, M.D.

Telephone**:** (860) 739-7444

Fax: (860) 739-3252

Address: East Lyme Pediatric Clinic
170 Flanders Rd.
Niantic, CT 06357

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ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received the copy of the office's Notice of Privacy Practices.

_____ _____
Please Print Parent / Guardian Name Relationship to Patient

_____
Childs name

_____
Parent's Signature

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could be obtain because

- Individual refuse to sign
- Communicator's barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)