MINOR/CHILD REGISTRATION

(PLEASE PRINT)

PEDIATRICS EAST OF NEW YORK, P.C.
157 EAST 81st STREET
NEW YORK, NY 10028-1844

Date _____

Home Phone _____

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Initial

Sex ☐ M ☐ F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person fiancially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE COVERAGE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ Work Phone _____
(if different from above) If different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____

Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ Work Phone _____
(if different from above) If different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____

Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification # _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia – Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other _____
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease	☐	☐	_____

(OVER)

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toliet Trained _____

HEALTH HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now? _____	☐	☐
Receiving any medication or drugs? _____	☐	☐
Has your child been hospitalized? _____	☐	☐

Date Reason Hospital

_____

_____

Medications _____

_____

_____

_____

Allergies _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Consulsions	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bleeding, Excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

RELEASE AND ASSIGNMENT

This information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fiancially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all iformation necessary to secure the payment of benefits. I authorize the use of this signature on all by insurance submissions whether manual or electronic.

_____ _____

Signature of Patent/Guardian Date

PEDIATRICS EAST OF NEW YORK
157 EAST 81st ST., SUITE 1A
NEW YORK, NY 10028
(212) 879-7014

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

PEDIATRICS EAST OF NEW YORK
157 EAST 81st STREET
NEW YORK, N.Y. 10028
TEL: (212) 879-7014
FAX: (212) 628-8147

Dear Member,

As you know, there are charges for each of the medical services that we will provide to you. The co-payments, deductibles, and co-insurance amounts that we are obligated to collect are determined by the type and extent of health benefit coverage that the health plan provides. This will also apply to any non-covered services this office will provide which is non-payable under your insurance coverage.

Your health benefits, including your responsibility for copays, deductibles and/or co-insurance is a decision made by your health plan and not by this office. For this reason, we are often unable to determine what charges your plan will or will not cover on any given visit or service as your health plan does not guarantee the accuracy of its stated confirmation of coverage or benefits.

As always, our office will work with your health insurance plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals.

Please also be aware that this office makes it a policy to only give copies of a patient's chart directly to the parent and/or legal guardian of the patient. We do not release a patient's chart to other offices or facilities. As per New York State insurance guidelines, this office is required to keep the original copy of the chart. Therefore we must ask for a written and signed request from the the parent and/or guardian for a copy of the chart. There will be a fee of $.75 cents per copied page to a maximum of $25.00 per chart.

Since you as the member are ultimately responsible for payment of medical services provided to you, it is our policy to obtain your credit card infomation and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

In providing the information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including any co-payments, any deductibles, co-insurance, and/or uncovered services). Any balance outstanding more than 90 days will be assigned to this credit card. If no valid credit card is available, any outstanding balance will be eligible for our Collections process with an in-office processing fee of $25.00. Copayments are due on the date of service and, if not paid within 2 weeks of that date, will also be subject to an in-office processing fee of $25.00 unless there is a valid credit card on file in which case the fee will be assigned to this credit card. Statements are sent out at end of business day and monthly.

Please also remember that many times the appointment schedule for the physicains tends to be crowded and appointment slots are at a premium. Our members need appointments for many different and important reasons. We try to accomodate the needs of all of our patients and ask that if you cannot keep a scheduled appointment that you inform this office 24 hours before the appointment date. If you are more than 15 minutes late for an appointment you may have to be rescheduled.

If an office visit is not cancelled 24 hours prior to the scheduled appointment a $25.00 penalty will be applied for the missed appointment.

We will make every effort to work with you to solve any problems. We value you as a member and appreciate that you have entrusted us with your healthcare needs.

Thank You.

Patient's Name: _____

Name of Guarantor :_____

Name on Credit Card :_____

Card Type: (VISA) (MASTERCARD)
Card Number: _____

Expiration date:_____/_____/_____

Signature:_____ Today's Date: _____

RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR OR HOSPITAL

_____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

PEDIATRICS EAST OF NEW YORK, P. C.
157 EAST 81ST STREET
NEW YORK, NY 10028-1844
212 - 879-7014

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)

119-P

PEDIATRICS EAST OF NEW YORK, P.C.
157 EAST 81st STREET
NEW YORK, NY 10028-1844
Edward F. Rossi, M.D.
Juan R. Roure, M.D.
Anna Y. Zou, M.D.

OFFICE POLICY AS OF 3/08

Please notify the front desk of any change of address or phone number.

Insurance cards must be presented at Each visit.

Copays must be paid upon registration.

There is a $25 administrative fee if co-payments are not paid at the time of service.

For self-pay patients, payment is due when services are rendered.

There is NO AFTERNOON WALK-IN. Please call for an appointment.

There is NO SATURDAY WALK-IN. Please call for an appointment.

Please don't eat in the waiting room.

Please arrive on time for scheduled appointments. If you are 15 minutes late, we may be forced to reschedule.

There is a $25 missed appointment charge for all no shows.

Prescriptions will no longer be called into the pharmacy, due to long hold periods.

Non-emergent/ routine question calls will be returned by doctors within 48 hours.

Referrals must be requested 72 hours prior to an appointment.

There is a $5 charge for each camp & school form to be filled out.

Camp & School forms require a minimum of 2 weeks for completion.

Forms can be picked up after 10am Monday- Friday Only.

A stamped- self addressed envelope must be provided if you want forms mailed home to you.

Due to HIPPA regulations, no forms can be mailed or faxed directly to camp or school.

During the busy camp & school season please make an appointment at least 2 months in advance.

There is a charge of 75cents per page with a maximum of $25 per child for Complete Medical Records. A minimum of 2 weeks is required for completion.

Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

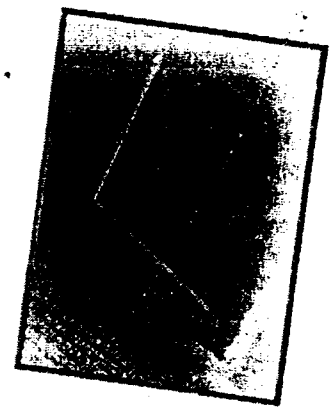
This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: April 14, 2003

PEDIATRICS EAST OF NEW YORK
157 EAST 81st ST., SUITE 1A
NEW YORK, NY 10028
(212) 879-7014

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding

Disclosures and Changes To Your Medical Information

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access To Medical Information

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. You request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.