2019

Registration Packet

Dr Rosa Gamundi-Dr Clotilde Pena

Stages Pediatrics

1/1/2019

Patient Registration

SECTION A: Patient Demographics and Medical History

Patient First Name: _____ Patient Last Name: _____
DOB: _____ Sex: _____ E-mail Address: _____
Patient Address: _____
Primary Phone: _____ Day Phone: _____ Mobile Phone: _____
Emergency Contact: _____ Emer. Phone #: _____
Language: _____ Ethnicity: _Hispanic or Latino _Not Hispanic or Latino
Race: _Asian _Black _White _Hawaiian _Hispano Who referred you? _____
Pharmacy Name: _____ Pharmacy Phone: _____
Preferred Method of Contact: Medical Contact: _Cell _ Phone _Text _Secured Email to Patient Portal
(Appointment Reminders are mostly done via Voice Mail; abnormal Labs report via Phone, Text, or Patient Portal)

Parent Information

Mother's First Name: _____ Mother's Last Name: _____
DOB _____ Sex: _____ E-mail Address: _____
Parent Address: _____
Primary Phone: _____ Work Phone: _____ Mobile Phone: _____
Employer: _____ Employer Phone #: _____
Language: _____
Civil Status: _Single _Married _Widowed _ Separated _Divorced _Common Law
Race: _Asian _Black _White _Hawaiian _Hispano Ethnicity: _Hispanic or Latino _Not Hispanic or Latino Father's First Name: _____ Father's Last Name: _____ Date of Birth: _____ Sex: _____ E-mail Address: _____
Parent Address: _____
Primary Phone: _____ Work Phone: _____ Mobile Phone: _____
Employer: _____ Employer Phone #: _____
Language: _____ Civil Status: _Single _Married _Widowed _ Separated _Divorced _Common Law Race: _Asian _Black _White _Hawaiian _Hispanic

Insurance Information

Primary Insurance Card Holder:_____Rel. to Patient_____
D.O.B:_____ Sex: _____ Insurance Name: _____
Subscriber ID#:_____ P.O. Box: _____
Secondary Insurance Card Holder:_____ Rel. to Patient_____
D.O.B:_____ Sex: _____ Insurance Name: _____
Subscriber ID#:_____ P.O. Box: _____

Your Name_____Relationship_____Date_____

Prior Pediatrician:	Last Dental Visit:	Last Eye Exam:

PREGNANCY & BIRTH
Mother age at Pregnancy: _____
Mother's any illness: _____
(Medication/Alcohol/ Smoking):_____
Birth Place _____
Birth **weight** _____
Birth Age (Earl/Lat/ On time):_____ Type of Delivery: Vaginal ____C/S_____
Problems at Birth: NICU ? _____ Jaundice:
Bilirubin Level ?
Hearing Test: Passed_____ Failed _____
Hep B. Shot given at birth?_____
Feeding Breast _____ Formula _____ Both _____

FAMILY MEDICAL HISTORY: List all blood relatives of your child who have: (F), (M) Mother, (B)Brother, (S) Sister, (MGM) Mother's Mother, (PGM) Mother's Father, (MGF) Father's Mother, (PGF) Father's Father, (A)Aunt, (U) Uncle

Asthma _____ ____
Allergies to Food _____
Epilepsy/Seizures _____
High Blood Pressure _____
Tuberculosis _____
Migraines/Headaches _____
Defects _____
Early Deafness _____
Mental Retardation _____
Cystic Fibrosis _____
Muscular Dystrophy _____
Kidney Disease _____
Allergies (Seasonal) _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
HIV/AIDS _____
Respiratory Problems_____ Birth
Brain Paralysis_____
Anemia/Blood Disorder _____
Cancer _____
Arthritis _____
Drug Addiction _____ Alcoholism _____

CHILD'S PAST MEDICAL HISTORY
Allergic Reactions? (if so, what kind)? □None □Yes
If Yes, to What: _____-
Immunization up-to-date? □No □Yes
Take Medication Daily? □No □Yes
Hospitalizations □No □Yes
When? _____
Where_____
Serious Injuries/Surgeries □No □Yes
When? _____
Where_____

DEVELOPMENT & BEHAVIOR
Development normal for his/her age?
Have you ever been told that your child is Behind in development? Have he/she ever received Early Intervention? How are grades in school? Passing or Failing
_____ Behavioral
Problems or lack of Attention? □No □Yes
_____
Social/ Physiological Issues: Divorced
□ Death of a loved one
□School
□Family Disruption for Divorce or Separation

FEEDING & NUTRITION
Breastfed? □No □Yes
Number of months: _____
Formula fed? □No □Yes
No How much a day? _____
Milk intake: Bottle _____ Cup_____
Take Vitamins? □No □Yes
Special diet? □No □Yes

Recurrent Infections?
Ear: □No □Yes
Eczema: □No □Yes
Throat: □No □Yes
Pneumonia: □No □Yes
Conditions Present:
Seizures: □No □Yes
Autism: □No □Yes
Asthma: □No □Yes
ADD/ADHD? □No □Yes
Problems with hearing □No □Yes

Name Of The Child: _____ DOB_____ Please Initial: _____

SECTION B: GENERAL CONSENT TO TREATMENT

I do hereby authorize **Stages Pediatrics** and the assistant/s that she may designate to perform the treatment/procedure(s) that are reasonable, necessary, and advisable. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk, and possible consequences involved. Understanding this, I authorize **Stages Pediatrics** to perform such examinations, treatment, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent, at any time, to the extent permitted by law.

SECTION C: CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

SECTION D: INSURANCE AUTHORIZATION: I hereby authorize direct payment of medical benefits to **Stages Pediatrics** for services rendered by any provider in person or under *Dr. Clotilde B. Pena or Dr. Rosa Gamundi* supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-insurance amounts, deductibles and co-pays.

SIGNATURE: _____ Date:_____

SECTION E: PATIENT RESPONSIBILITY AGREEMENT

RESPONSIBLE PARTY (GUARANTOR) Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Stages Pediatrics. This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below. Name:_____ Relationship to Patient_____
Home Address:_____ E-mail address:
_____ Occupation: _____
Phone (Home) _____(Cell): _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of being made responsible. Furthermore, I agree to pay any collection cost and legal fees incurred by this office with respect to these charges.

Signature: _____ Relationship To Patient: _____ Date: ___/____/____

CHILD ADVOCACY As advocates for our young patients, Stages Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

Name: _____ Signature: _____Relationship To Patient: _____ Date: ___/____/____

Stages Pediatrics Financial Policy

Please take a moment and review Stages Pediatrics' Finical Policies and sign below. By signing you understand the policies; if you have any question feel free to ask any staff member.

In compliance with the Federal Consumer Protection Act, Stages Pediatrics wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

Insurance: Co-payments are due and payable at the time of visit. **Requesting to be billed might add administrative charges to your account. Please pay upfront.** A courtesy to you, we will bill your insurance company, provided we have the correct billing information at the time of service. **If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility**. **You are financially responsible for charges deemed by the insurance company to be billable to the patient.** You must be familiar with your coverage and any requirements for preauthorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Cash Account: If proof of insurance is not provided, your account will be considered a cash account and **payment in full of all charges will be required at the time of service**. If you subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will bill the charges to your insurance company for you. If we then receive insurance payment we will promptly issue a refund to you of any credit on your account.

Billing: The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement. A **late charge** is assessed on all delinquent patient balances, and we reserve the right to reschedule your appointment until a payment agreement is done with a credit card or balance paid in full. An account is considered delinquent after three months of Day of Service.

Appointments: Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a $ 25.00 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 15 minutes later than scheduled.

Returned Checks: There is a $25 returned check fee in the event a patient's personal check is returned to us for any reason.1

The undersigned has read and agrees to the above financial credit and payment policies of Stages Pediatrics, PC.

_____ _____

Name and Signature Date

HIPAA (Health Insurance Information & Portability Act)

Receipt of Notice of Privacy Policies & Consent Forms

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices,** the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes*:*

1. *Our submission of your health information for processing claims of obtaining payment*

2. *Our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment*

3. *Our submission of your health information to auditors hired by third-party payers and insurers and,*

4. *Other aspects of payments described in our **Notice of Privacy Practices**. Our Notice of **Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.*

When you sign this consent document, you signify that you agree that we can use and disclose your health information to treat you, to obtain payment for services, and to perform health care operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I **have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices**

Your Name_____ Relationship to Patient _____Date_____

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

New York State Department of Health

Patient Name	Date of Birth	Patient Identification Number
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 Stages Pediatrics, PC to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix 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 Healthix's website at www.healthix.org.

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.

☐ **1. I GIVE CONSENT** for Stages Pediatrics, PC to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Stages Pediatrics, PC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

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 Healthix 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) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

- Alcohol or drug use problems & diagnoses
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and Dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summary
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data

Lab Test

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 Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

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.

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 Healthix 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 Stages Pediatrics, PC at 212-923-5050 or visit Healthix's website:

7. www.healthix.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/*.

8. **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 redisclosure.

9. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

10. **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. Organizations that access your health information through Healthix 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.

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

Circle of Care (People you Trust to Bring your Child in your Behalf):

Please Name Family or Friend Authorized to Bring your Child for Sick Visits or Well Child Visits; Any parent is by default authorized unless there is proof of impediment. First time patients need to be accompanied by a parent. With this authorization you allow us to discuss any health matters that is relevant to the reason of the visit with the person listed below; If your Child is brought in by a person that is not named, you must call us (security questions will be asked), send us an **written** request via patient portal, or email (info@stagespediatrics.com) from your email listed in medical records authorizing us to see your child; the doctor will not see your child until you contact us.

Name_____ Relationship _____

Is ok to vaccinate when Brought by this Person? _____

Name_____ Relationship _____

Is ok to vaccinate when Brought by this Person? _____

Name_____ Relationship _____

Is ok to vaccinate when brought by this Person? _____

Name_____ Relationship _____

Is ok to vaccinate when Brought by this Person? _____

Name_____ Relationship _____

Is ok to vaccinate when Brought by this Person? _____

Signature_____ Date_____

Relationship_____