WELCOME TO EAST HAVEN PEDIATRICS, P.C.

We are looking forward to your child's first visit to our practice. In order to make your visit as smooth as possible, please read the following instructions carefully.

1. ALL previous medical records must be transferred to our office. Please sign a record release form with your previous pediatrician to insure that we have the records prior to scheduling your child's first visit.

2. Please complete all the information in the chart, if you have any questions please contact our office for assistance. Bring the completed information with you to your first office visit.

3. Bring any and all insurance cards with you to all appointments. Please have the insurance information as accurate and updated as possible. We must be listed as the "Primary Care Physician". And please contact your insurance company if you have any questions.

4. Bring any co-pays that apply to your insurance. It is the responsibility of the adult who accompanies the child to the office for all co-pays and fees.

5. If you are the guardian or foster parent, please bring legal paperwork identifying you as such.

Thank you for your cooperation and we look forward to seeing you very soon!

Welcome to East Haven Pediatrics PC.
Patient Portal

With the changing times and new requirements by the government, we want to encourage and enhance our patient-provider communications & relationship.

We invite you to register online at our private Patient Portal address:
(https://adsportal.myadsc.com/PatientPortal/ehpeds)

To register, you will need

1. a separate email address for each child,
2. Patient's First Name,
3. Last Name,
4. Date of Birth,
5. Zip code and
6. Either your on file telephone number or last 4 digits of child's social security number.

This information MUST match exactly what we have in our system, so please ask for a demographic printout of your child/children's account information. Prior to final registration, you will be asked for a verification number, an email will be sent to our office and we will either call you with verification number or email you back.

At this time, our portal will be used only for the discharge/recent visit summaries. We hope to implement other options in the future as our technical & software capabilities increase.

If you have any questions about registering, or this portal please do not hesitate to ask. We think this will be a great way for us to interact with you and your family.

What is a Patient Portal?

The Basics: A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as:

- Recent doctor visits
- Discharge summaries
- Medications
- Immunizations
- Allergies
- Lab results

In the future we hope to add some of these depending on our software:

- Download and complete forms
- View educational materials
- Exchange secure e-mail with their health care teams
- Request prescription refills
- Schedule non-urgent appointments
- Check benefits and coverage
- Update contact information
- Make payment

NOTICE OF PRIVACY PRACTICES

EAST HAVEN PEDIATRICS PC
300 MAIN STREET
EAST HAVEN, CT 06512

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVEIW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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. We may also call you by name while in our waiting room.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. **Your authorization is needed to fill out or fax information for school, camp or sports physicals.**

You have the following rights with respect to your protected health information, which you can exercise by presenting in a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. Your request must tell us: 1. What information you want to limit. 2. Whether you want to limit how we use or disclose your information, or both. 3. To whom you want the restriction to apply.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. You must specify how or where you wish to be contacted. We have a right to deny based on our technology.
- The right to inspect and copy your protected health information. This does not include psychotherapy notes. We may also charge a fee for the costs of copying, mailing, or other supplies associated with your requests. We also may deny access in certain specified situations, such as when a health care provider believes access could cause harm to the individual or another. You have the right to have such denials reviewed by a licensed health care professional (who is designated by East Haven Pediatrics PC and who did not participate in the original decision).
- The right to amend your protected health information. Your request must include the reason you are seeking a change. We may deny your request if the information was not created by our practice or you ask to amend a record that is already accurate and complete.
- The right to receive an accounting of disclosures of protected health information. Indicate the time period of requests and a fee may be charged for this information. The time period may not be longer than six years and may not include dates before 4-14-03. The first accounting that you request will be free of charge. There will be a fee for additional lists within the same time period.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20 ___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complain with our office, or with the Department of Health & Human Service, office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

East Haven Pediatrics PC
300 Main Street
East Haven, CT 06512
Telephone: (203) 469-8882
Fax: (203) 467-9973

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
Toll free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

EAST HAVEN PEDIATRICS, P.C.
300 MAIN STREET
EAST HAVEN, CT 06512

I understand that, under the Health Insurance Portablility & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amoung the multiple healthcare proveders who may be involved with that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowlegde that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand tat this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agreee to my requested restrictions, but if you do agree then you are are bound to abide by such restirctions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

EAST HAVEN PEDIATRICS, P.C.

300 MAIN STREET
EAST HAVEN, CONNECTICUT, 06512
TELEPHONE (203) 469-8882
FAX (203)467-9973

East Haven Pediatrics New Policy for Vaccination Refusal
January 1, 2020

On January 1, 2020, East Haven Pediatrics will no longer see existing patients or accept new patients whose parents/guardians refuse to vaccinate their child. Immunizations are an integral foundation of pediatric practice. East Haven Pediatrics philosophy of care is to provide comprehensive, safe and evidence based care to all of our patients.

Our new policy has been implemented for a number of reasons. The American Academy of Pediatrics strongly endorses universal immunization. Unimmunized children pose a risk to other children who lack immunity to vaccine preventable infections (ex. unimmunized infants, immunocompromised children, children undergoing chemotherapy). In addition, the State of Connecticut mandates vaccination for children who attend daycare or public schools.

Communication and trust are key components to any provider-patient relationship. The providers at East Haven Pediatrics are committed to the safety and well-being of your child. As always, we are here to answer any question or concerns you may have regarding this new policy or any issue regarding the care of your child.

Broken Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", late shows and missed appointments, or appointments cancelled without the 24-hour notice are considered Broken Appointments. Your appointment is a time especially reserved for you; we do not double book times. When you break appointments, you inconvenience those individuals who need access to medical care in a timely manner and add to the cost of providing care for all our patients.

As of August 1, 2011, we will now be charging a fee for Broken Appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Our office requires 24 hours' notice to cancel an appointment. If an appointment is missed or cancelled without 24 hours' notice or arriving 15 minutes after your scheduled appointment, you will be charged for the fee. Missed appointment fees are not covered by your insurance.

We will make every effort to conduct a courtesy call to remind you of your scheduled appointment. Please provide us the best possible number to contact you with regards to your appointment. These calls are a courtesy only. You are ultimately responsible to remember these scheduled appointments, and our failure to call does not relieve you of that responsibility. Please hold onto your appointment cards or blue receipts.

Our procedure for Broken appointments

- The first time there is a Broken Appointment, as defined above, without an adequate excuse, it will be documented in your chart, a reminder letter stating the policy again will be sent to you and the fee is waived.
- The 2nd time will result in a fee of $30 billed to patient's account.
- The 3rd time will result in a few of $50 billed to patient's account and you will be asked to seek care with another pediatrician who can better accommodate your scheduling requirements.
- All fees must be paid in full prior to any rescheduled appointments

We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes as best we can. We will work with you to try to schedule times that are best for you. Patients who habitually reschedule for inadequate reason will be referred to another pediatric office.

We have the right to make exceptions based on a case to case basis and reserve the right to change this policy. If you have any questions, we will be happy to answer them for you.

Broken Appointment Policy

I understand the Broken Appointment policy and agree to abide by it.

Child's Names _____

_____ _____ _____

Signature of Parent/Guardian Date Best Contact Number

Rev 04.11.17

ACCOUNT NUMBER:_____

DATE: _____ **FORM FILLED OUT BY:** _____ **RELATIONSHIP:** _____

PATIENT'S LEGAL NAME: _____Male/Female **DATE OF BIRTH:** _____

SSN: _____**Cell:**_____ **PATIENT'S EMAIL:** _____

RACE: Asian, African American, Caucasian, Hispanic, American Indian, Multiracial, Hawaiian/Pacific Islander, Refused or OTHER: _____ **ETHNICITY:** Hispanic, Non-Hispanic, Unknown **LANGUAGE:** _____

Unless we have legal papers in your child's chart indicating otherwise, both parents are presumed to have legal custody/decision making for the child.
IMPORTANT: Please circle below if mother, father, stepparent. (If guardian, please write in relationship.)
If biological or adoptive parents live in separate households, please include both parental addresses and contacts below.

BIOLOGICAL OR ADOPTIVE PARENTS: **Mother:** _____

Father: _____

Parents: **Married** **Unmarried** **Divorced** **Separated** **Widowed**

HOUSEHOLD #1 (PATIENT'S PRIMARY RESIDENCE)

House Phone: _____ Child spends time in this household?_____

Mother/Stepmother/Guardian:_____Relationship:_____DOB:_____SSN:_____

Cell Phone: _____Work Phone: _____Employer Name: _____

Father/Stepfather/Guardian: _____Relationship:_____DOB:_____SSN:_____

Cell Phone: _____Work Phone: _____Employer Name: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

HOUSEHOLD #2

House Phone: _____ Child spends time in this household? _____

Mother/Stepmother/Guardian: _____Relationship:_____DOB:_____SSN:_____

Cell Phone: _____Work Phone: _____Employer Name: _____

Father/Stepfather/Guardian: _____Relationship:_____DOB:_____SSN:_____

Cell Phone: _____Work Phone: _____Employer Name: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

PATIENT INSURANCE SHEET

Account Number: _____

Patient's Name: _____ **Date of Birth:** _____
LAST FIRST

Party responsible for account

PRIMARY HEALTH INSURANCE

Insurance Company: _____ Please circle the following:

Medicaid Commercial Self- pay Underinsured American Indian or Native Alaskan

Name of subscriber: _____Relationship to patient: _____

Date of Birth: _____ SSN: _____

Policy ID: _____ Group Number: _____

Participating Lab: _____
(Quest, Yale, etc.)

SECONDARY HEALTH INSURANCE

Insurance Company: _____ Please circle the following:

Medicaid Commercial Self- pay Underinsured American Indian or Native Alaskan

Name of subscriber: _____Relationship to patient: _____

Date of Birth: _____ SSN: _____

Policy ID: _____ Group Number: _____

Participating Lab: _____
(Quest, Yale, etc.)

PLEASE READ BEFORE SIGNING:

1. **The Guardian/Parent is responsible for all fees regardless of insurance coverage.**
2. Co-payments are to be paid at the time of service to avoid a $20 administration fee.
3. Deductible insurance, balances must be paid at following visit if processed by insurance.
4. Member must have effective insurance and be eligible for services for that date.
5. If no insurance or not eligible on the date of service, payment must be paid at that time.
6. If you have set up a Payment plans or have a previous balance, payments MUST be paid monthly to avoid collections.
7. If account is turned over to a collection agency, a 15% charge will be added and patient/family will be asked to leave.
8. I will present my insurance card at each and every visit and be responsible to inform East Haven Pediatrics, PC of any insurance changes in a timely manner.

I certify that I have given accurate information of ALL ACTIVE INSURANCE POLICIES ON THIS MEMBER. To not do so would be committing State & Federal Insurance Fraud. I have read and understand East Haven Pediatrics HIPPA privacy policy.
As the responsible Parent/Guardian, I hereby assign to East Haven Pediatrics all payments from the above insurance for medical services rendered to my dependents or myself. **I understand that I am responsible for any amount not covered, and applied to the patient's responsibility by the above insurance. I am able to appeal these claims to my insurance but need to notify East Haven Pediatrics.**

SIGNATURE: _____ DATE: _____

EAST HAVEN PEDIATRICS, P.C.
300 MAIN STREET
EAST HAVEN, CT 06512

AUTHORIZED REPRESENTATIVE FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

I,_____ authorize the following people to bring my child(ren) to East Haven Pediatrics, P.C. and to authorize any medical decisions and treatment presented at **SICK VISITS ONLY**.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE: _____ DATE: _____

I understand that I may revoke this authorization at any time by giving written notice to East Haven Pediatrics, P.C.

East Haven Pediatrics, P.C.
300 Main Street
East Haven, CT 06512
(203) 469-8882

Consent to Leave Voicemail on Answering Machine

By signing this "Consent to Leave Voicemails", you consent to East Haven Pediatrics staff leaving voicemail messages containing your child's detailed medical information on the phone number(s) listed below. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, medical information (appointment dates, diagnosis, medications, test results, etc.).

◯ Home Phone_____

◯ Cell Phone _____

◯ Do not leave information on any phone number

I understand that East Haven Pediatrics cannot require me to sign this consent form in order to receive medical care.

I understand that I have the right to revoke this consent at any time by sending a written request to East Haven Pediatrics. This "Consent to Leave Voicemail" is valid until such revocation is received by East Haven Pediatrics. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

I understand that I am entitled to a copy of this completed consent form.

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

_____

Signature of Parent/Guardian Date

Medical History Questionnaire

EAST HAVEN PEDIATRICS, P.C.
300 Main Street
East Haven, CT 06512
(203) 469-8882

Date			
Patient Name	Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):		Ethnicity:

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (List) (Food or Meds)	☐ No	☐ Yes
Asthma/Wheezing	☐ No	☐ Yes
Asthma Action Plan	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Chicken Pox (Year) _____	☐ No	☐ Yes
Frequent Ear Infections	☐ No	☐ Yes
Vision Problems	☐ No	☐ Yes
Hearing Problems	☐ No	☐ Yes
Skin Problems/Eczema/Hives	☐ No	☐ Yes
TB/Lung Disease	☐ No	☐ Yes
Seizures/Epilepsy	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Heart Defects/Disease	☐ No	☐ Yes
Liver Disease/Hepatitis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes
Bladder Infections	☐ No	☐ Yes
Physical or Learning Disabilities	☐ No	☐ Yes
Bleeding Disorders/Hemophilia	☐ No	☐ Ye
Sexually Transmitted Infections	☐ No	☐ Yes
Emotional/Behavioral Problems	☐ No	☐ Yes
Depression/Suicidal Thoughts	☐ No	☐ Yes
Hospitalizations/Surgeries Physical/Sexual Abuse	☐ No	☐ Yes
Emotional Abuse	☐ No	☐ Yes
Bone or Joint Injuries	☐ No	☐ Yes
Dental Problems	☐ No	☐ Yes
Obesity/Overweight	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes
Anorexia Nervosa	☐ No	☐ Yes
Bulimia	☐ No	☐ Yes
Learning Disabilities	☐ No	☐ Yes
Attention Deficit Disorder	☐ No	☐ Yes
Lead Poisoning	☐ No	☐ Yes
Vaccines Up-to-Date	☐ No	☐ Yes

Other Concerns:

_____

_____

Current Medication(s): (List):

_____

_____

_____

_____

Reviewed by:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	☐ No	☐ Yes	Who?
Asthma/Wheezing	☐ No	☐ Yes	Who?
TB/Lung Disease	☐ No	☐ Yes	Who?
Cystic Fibrosis	☐ No	☐ Yes	Who?
HIV/AIDS	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Heart Disease	☐ No	☐ Yes	Who?
Sudden Cardiac Death	☐ No	☐ Yes	Who?
High Blood Pressure/Stroke	☐ No	☐ Yes	Who?
High Cholesterol	☐ No	☐ Yes	Who?
Blood Disorders	☐ No	☐ Yes	Who?
Sickle Cell	☐ No	☐ Yes	Who?
Anemia	☐ No	☐ Yes	Who?
Thalassemia	☐ No	☐ Yes	Who?
Clotting Disorders	☐ No	☐ Yes	Who?
Diabetes	☐ No	☐ Yes	Who?
Seizures	☐ No	☐ Yes	Who?
Mental Illness	☐ No	☐ Yes	Who?
Depression	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Cancer	☐ No	☐ Yes	Who?
Breast	☐ No	☐ Yes	Who?
Cervical	☐ No	☐ Yes	Who?
Colorectal	☐ No	☐ Yes	Who?
Other _____			
Birth Defects	☐ No	☐ Yes	Who?
Hearing Loss	☐ No	☐ Yes	Who?
Speech Problems	☐ No	☐ Yes	Who?
Kidney Disease	☐ No	☐ Yes	Who?
Alcohol/Drug Abuse	☐ No	☐ Yes	Who?
Hepatitis/Liver Disease	☐ No	☐ Yes	Who?
Thyroid Disease	☐ No	☐ Yes	Who?
Learning Problems	☐ No	☐ Yes	Who?
Attention Deficit Disorder	☐ No	☐ Yes	Who?
Mental Retardation	☐ No	☐ Yes	Who?
Family Violence	☐ No	☐ Yes	Who?

Other Concerns:

_____

_____

Has any family member ever had an unexplained, unexpected death before age 50?

☐ No ☐ Yes (if yes, describe on back)

Date of Review:

Medical History Questionnaire

PREGNANCY AND BIRTH HISTORY

Adopted	☐ No	☐ Yes
Prenatal care	☐ No	☐ Yes
Illnesses during pregnancy	☐ No	☐ Yes
Medications during pregnancy	☐ No	☐ Yes
Alcohol/drug abuse	☐ No	☐ Yes
Tobacco use	☐ No	☐ Yes
Problems at birth	☐ No	☐ Yes
Mom		
Miscarriage	☐ No	☐ Yes
Toxemia	☐ No	☐ Yes
Baby		
Jaundice	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes
Infection	☐ No	☐ Yes
Breathing Problems	☐ No	☐ Yes
Birth Defects	☐ No	☐ Yes

Other:

Name of Hospital: _____

Month of gestation when child was born: _____

Type of delivery: ☐ Vaginal ☐ C-section ☐ VBAC

Birth Weight _____

Discharge Weight _____

Newborn Hearing Screen	☐ No	☐ Yes
Did baby receive Hep B vaccine	☐ No	☐ Yes

Date of Hepatitis B immunization: _____

FEEDING AND DIGESTION

Breast fed ☐ Formula ☐

Severe colic in first 3 months	☐ No	☐ Yes
Feeding problems	☐ No	☐ Yes
Good appetite	☐ No	☐ Yes
Takes vitamins	☐ No	☐ Yes
Eats balanced diet	☐ No	☐ Yes
Constipation problems	☐ No	☐ Yes
Food allergies/issues	☐ No	☐ Yes

PSYCHOSOCIAL HISTORY

Who lives in household: _____

☐ Rent ☐ Own ☐ Shelter

Who cares for child: _____

Is child in daycare: ☐ No ☐ Yes

Type: ☐ Center

☐ Private home

☐ Family member home

Date of Birth:

Mother _____

Father _____

Parents divorced/separated: ☐ No ☐ Yes

Parents working:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes

Parents use tobacco:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Child use tobacco (12 yrs +)	☐ No	☐ Yes
Sleep Problems	☐ No	☐ Yes

Foster Care

Dates: _____ _____

Other Languages _____

MEDICAL HISTORY

Broken bones	☐ No	☐ Yes
Serious accidents	☐ No	☐ Yes
Operations	☐ No	☐ Yes
Hospitalizations	☐ No	☐ Yes
ER visits/Urgent Care	☐ No	☐ Yes

Explain: _____

Additional Information: