

**SCHOOLHOUSE
PEDIATRICS**

81 Schoolhouse Road 11835 Rte. 9W, Suite 3 1750 Route 9, Ste. 1
Albany, New York 12203 West Coxsackie, NY 12192 Clifton Park, NY 12065
(518) 456-1211 (518) 731-3800 (518) 334-6706
Fax: (518) 452-2535 Fax: (518) 731-3838 Fax: (518) 357-3341

PEDIATRIC INTAKE HISTORY

PATIENT NAME: _____
DATE OF BIRTH: ____/____/____ AGE: _____
ETHNICITY: _____
PARENTS: MOTHER: _____

NICKNAME: _____
SEX: MALE: _____ FEMALE: _____
** PRIMARY LANGUAGE **: _____ Communication needs?
FATHER: _____

Please ANSWER ALL QUESTIONS AS THEY ALL HAVE A BEARING ON YOUR CHILD'S WELL BEING

PRENATAL HISTORY:

Hospital of Delivery: _____
Length of Pregnancy: _____ Obstetrician: _____
Birth Weight: _____ Length of Labor: _____
Mother's age at the time of delivery: _____ Medications taken during pregnancy: _____
List any illness(es) that mother had during pregnancy: _____
Were there any problems at time of delivery? Yes: _____ No: _____ If yes, what? _____

Baby's Apgar scores at delivery: _____
Did the baby have any of the following problems after delivery? _____
Jaundice _____ Treatment _____
Infections _____ Treatment _____
Other _____ Treatment _____
What, if any, street drugs did mother use during or before pregnancy? _____
Amount _____ Last time used _____
How much alcohol did mother consume during pregnancy? _____

CHILD'S PAST MEDICAL HISTORY:

Name of previous Physician: _____ Date of last Well-Child Exam _____

Please circle any illnesses your child had in the past:

- Anemia
- Chicken Pox
- Eye Problems
- Heart Problems/
murmurs/defects
- Pneumonia
- Whooping Cough
- Asthma
- Concussion
- Frequent Ear Infections
- Hepatitis
- Loss of Hearing
- Rheumatic Fever
- Bronchitis
- Croup
- Frequent Nose Bleeds
- High Cholesterol
- Measles
- Scarlet Fever
- Bladder Infections
- Diabetes
- German Measles
- High Lead Level
- Meningitis
- Sickle Cell Anemia
- Broken Bones
- Eczema
- Hay Fever
- Influenza
- Mumps
- Tonsillitis

ALLERGIC REACTIONS:

Food _____ Medications _____
Environmental _____ Other _____

Type of Reaction _____

Has your child ever been hospitalized? Yes ___ No ___ If yes, for what and when? _____

Does your child take any medications regularly? Yes ___ No ___ If yes, for what and when? _____

Is your child up to date on all his/her immunizations? Yes ___ No ___

Please give your doctor a copy of these records

FAMILY HISTORY: (Please check any areas that apply)

<u>ILLNESS</u>	<u>MOTHER</u>	<u>FATHER</u>	<u>SIBLING</u>	<u>GRANDPARENT</u>	<u>OTHER</u>
Alcohol Problems	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Bleeding Problems	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Ear/Hearing Problems	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
HIV Infection	_____	_____	_____	_____	_____
Immune Problems	_____	_____	_____	_____	_____
Kidney Problems	_____	_____	_____	_____	_____
Lead Poisoning	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Weight Problems	_____	_____	_____	_____	_____
Mental Health Condition	_____	_____	_____	_____	_____
Drug /Alcohol Use	_____	_____	_____	_____	_____
Other (Please List)	_____	_____	_____	_____	_____

SOCIAL HISTORY: Please list everyone that lives in your home, their ages, and relationship to child.

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Does anyone in your home smoke? Yes No
- Are there any pets in your home?..... Yes No
- Does your child always use a seat restraint in the car? Yes No
- Does your child wear a helmet when riding his/her bicycle? Yes No
- Do you live in an older home (old pipes)? Yes No
- Does your child attend a child care center or babysitter? Yes No
- Are there any problems such as peeling paint, mice, insects in your home? Yes No

PREFERRED PHARMACY LOCATION:

NAME: _____
ADDRESS: _____
TELEPHONE: _____
FAX: _____

PREFERRED Primary Care Physician:

Doctor's Name: _____

* having a primary physician will help with continuity of care, this selection can be changed at any time



Parent/Guarantor Information for **SCHOOLHOUSE PEDIATRICS**, Please complete the following:

Father's Name:		Home Phone:
Address:		Cell Phone:
City, State, Zip		DOB:
Email Address:		
Employer:	Work Phone:	Marital Status:

I hereby consent to any treatment necessary, diagnostic tests and/or treatment for my child for whom I am legally responsible. The release of medical information to any insurance carrier for treatment and/or examination rendered is authorized. I hereby accept responsibility for payment of charges for medical services rendered. ***** A SERVICE CHARGE OF \$10.00 WILL BE ADDED TO ACCOUNTS SENT TO COLLECTIONS.*****

Signature:	Date:
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Mother's Name:	MOTHER'S MAIDEN NAME:	Home Phone:
Address:		Cell Phone:
city, State, Zip		DOB:
Email Address:		
Employer:	Work Phone:	Marital Status:

I hereby consent to any treatment necessary, diagnostic tests and/or treatment for my child for whom I am legally responsible. The release of medical information to any insurance carrier for treatment and/or examination rendered is authorized. I hereby accept responsibility for payment of charges for medical services rendered. ***** A SERVICE CHARGE OF \$10.00 WILL BE ADDED TO ACCOUNTS SENT TO COLLECTIONS.*****

Signature:	Date:
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INSURANCE INFORMATION

****24 Hour Appointment Cancellation Policy or a \$25.00 surcharge will be added**
**** Co-Payments MUST be made at the time of the visit or a \$10.00 surcharge will be added**

Primary Insurance	ID#
Secondary Insurance	ID#

Children's Names	DOB



SCHOOLHOUSE PEDIATRICS

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION AND FINANCIAL AGREEMENT

81 Schoolhouse Road
Albany, NY 12203
PH: 518-456-1211
Fax: 518-452-2535

1750 Route 9, Suite 1
Clifton Park, NY 12065
PH: 518-334-6706
Fax: 518-357-3341

11835 Rt. 9W, Suite 3
West Coxsackie, NY 12192
PH: 518-731-3800
Fax: 518-731-3838

Patient Name(s): _____ DOB: _____
Patient Personal Cell Number: (if over the age of 18) _____
Ethnicity (Latino, Non-Latino, Other): _____ Primary Language _____
Race (Asian, Black, Hispanic, White, Other): _____

People/Organizations who may share information: (Please List)

_____ School/College: _____
_____ Camps: _____
_____ Other: _____
_____ Relative (please list names) _____

Please circle YES or NO to the information that you would or would NOT want released:

Yes / No	My Yearly Physicals (including for college)	Yes / No	Any Hospital Visits That I Have Had
Yes / No	My Immunizations	Yes / No	Gynecology Appointments (for females only)
Yes / No	My Med Consults	Yes / No	My Lab Work
Yes / No	My Sick Visits	Yes / No	Specialists (Urology, Psychiatrist, Dermatology...)
Yes / No	My Medication(s) I am Taking	Other:	_____

OR you may choose:

_____ I do not wish to have any of my medical information to be given to anyone.

This authorization is valid for: (check one)

_____ This request only.
_____ One year from the date of this authorization **OR** _____ (insert date)

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is revocable by me in writing, except to the extent that Schoolhouse Road Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Schoolhouse Road Privacy Officer at address listed above. Any health information disclosed by Schoolhouse Road Pediatrics pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal HIPPA privacy regulations. Schoolhouse Road Pediatrics may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. If you have Medicaid Fee for Service, not through a Managed Care Program, and you decide to receive care in our office, you agree that you are a private pay patient and we will render the service under this agreement. This means you will be responsible for the medical bill as we do not participate with the Medicaid Fee for Service Program.

Signature of Patient or Patient Representative

Printed name of Patient or Patient Representative

Today's Date

Relationship to Patient

SCHOOLHOUSE PEDIATRICS

Financial Payment Policy

Schoolhouse Pediatrics requires payment at the time of your child's visit. We accept cash, checks or credit cards. For patients with insurance we ask that you pay the portion not covered by your insurance, such as co-payments and your deductibles, at the time of treatment.

It is your responsibility to notify us of any changes to your insurance. It is also your responsibility to notify your insurance company of any changes to your PCP.

If you have Medicaid Fee for Service, not through a Managed Care Program, and you decide to receive care in our office, you agree that you are a private pay patient and we will render the service under this agreement. This means you will be responsible for the medical bill as we do not participate with the Medicaid Fee for Service Program.

If you cannot pay the doctor's services at the time of treatment, then you must discuss this with our office prior to your appointment.

By signing below you are acknowledging your financial responsibility for any and all services rendered in our office.

Accepted and agreed: _____

(Signed by Parent or Legal Guardian)

Print Name of Patient(s): _____
(INCLUDE ALL SIBLINGS THAT COME TO OUR PRACTICE)

Patient(s)DOB: _____

Today's Date: _____



SCHOOLHOUSE PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have been notified of,
(Name of Patient)
and had the opportunity to receive a copy of Schoolhouse Pediatrics *Notice of Privacy Practices*. This Notice describes how Schoolhouse Pediatrics may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative)

(Date)

(Relationship to Patient)



Hixny Electronic Data Access Consent Form Schoolhouse Road Pediatric Associates, P.C.

In this Consent Form, you can choose whether to allow Schoolhouse Road Pediatric Associates, P.C. to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Schoolhouse Road Pediatric Associates, P.C. to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the "I GIVE CONSENT" box below, you are saying "Yes, Schoolhouse Road Pediatric Associates, P.C.'s staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the "I DENY CONSENT" box below, you are saying "No, Schoolhouse Road Pediatric Associates, P.C. may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.

You have two choices:

PLEASE BOX: CONSENT OR DENY

CHECK (1) BOX

- I GIVE CONSENT for Schoolhouse Road Pediatric Associates, P.C. to access ALL of my medical records through Hixny in connection with providing me any health care services, including emergency care.
- I DENY CONSENT for Schoolhouse Road Pediatric Associates, P.C. to access my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

Print Name of Patient *see below if more than one patient

Date of Birth

Date

Signature of Patient or Patient's Legal Representative

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

*** LIST ADDITIONAL CHILDREN (UNDER 18) IN OUR PRACTICE:**

NAME

DOB:

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Schoolhouse Road Pediatric Associates, P.C. only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Schoolhouse Road Pediatric Associates, P.C. may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Schoolhouse Road Pediatric Associates, P.C.'s medical staff who are involved in your medical care; health care providers who are covering or on call for Schoolhouse Road Pediatric Associates, P.C.'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 Schoolhouse Road Pediatric Associates, P.C. at: 518-456-1211; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Schoolhouse Road Pediatric Associates, P.C. to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Schoolhouse Road Pediatric Associates, P.C. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.