SCHOOLHOUSE PEDIATRICS

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

270 Mansion Street
Coxsackie, NY 12051
(518) 731-3800
Fax: (518) 731-3838

1750 Route 9
Clifton Park, NY 12065
(518) 344-6706
Fax: (518) 357-3341

PEDIATRIC INTAKE HISTORY

PATIENT NAME: _____ NICKNAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____

SEX AT BIRTH: MALE: _____ FEMALE: _____

Race:
□American Indian or Alaska Native
□Asian
□Black or African American
□Declined to Specify
□Hispanic
□Indian
□Native Hawaiian or Pacific Islander
□White

Language:
□English
□Spanish
□Other
□Sign Language
□Spanish

Ethnicity:
□Declined to Specify
□Hispanic or Latino
□Not Hispanic or Latino

Sexual Orientation:
□Straight or Heterosexual
□Lesbian, Gay or Homosexual
□Bisexual
□Something else, please describe
□Choose not to disclose

Gender Identity:
□Identifies as Male
□Identifies as Female
□Female-to-Male/(FTM)/ Transgender
□Male-to-Female/(MTF)/ Transgender
□Genderqueer, neither exclusively male or female
□Choose not to disclose
□Additional category, specify

PRENATAL HISTORY:

Hospital of Delivery: _____
Length of Pregnancy:_____ Obstetrician:_____
Birth Weight:_____ Type of Delivery:_____ 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 before or during 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	Asthma	Bronchitis	Bladder Infections	Broken Bones
Chicken Pox	Concussion	Croup	Diabetes	Eczema
Influenza	Tonsillitis	Mumps	German Measles	Hay Fever
Eye Problems	Hepatitis	High Cholesterol	High Lead Level	Heart Problems/Murmurs/Defects
Pneumonia	Loss of Hearing	Measles	Meningitis	Frequent Nose Bleeds
Whooping Cough	Rheumatic Fever	Scarlet Fever	Sickle Cell Anemia	Frequent Ear Infections

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)

ILLNESS	MOTHER	FATHER	SIBLING	GRANDPARENT	OTHER
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.

NAME	AGE	RELATIONSHIP

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:_____

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:

Mother's Name:	**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:

INSURANCE INFORMATION

**** 24 Hour Appointment Cancellation Policy or a $25.00 surcharge will be added**

**** Co-Payments <u>MUST</u> be made at the time of the visit or a $10.00 surcharge will be added**

Primary Insurance (Include Subscriber Name)	ID#
Secondary Insurance (Include Subscriber Name)	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
Clifton Park, NY 12065
PH: 518-344-6706
Fax: 518-357-3341

270 Mansion Street
Coxsackie, NY 12051
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 Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Schoolhouse Pediatrics Privacy Officer at address listed above. Any health information disclosed by Schoolhouse Pediatrics pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal HIPAA privacy regulations. Schoolhouse 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 — Today's Date

_____ _____
Printed name of Patient or Patient Representative — Relationship to Patient

SCHOOLHOUSE PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have been notified of,
Patient Name(s)

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 or Patient or Patient Representative Today's Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient

SCHOOLHOUSE PEDIATRICS

Financial Payment Policy

Schoolhouse Pediatrics requires payment at the time of your child's visit. We accept cash, check or credit card. For patients with insurance, we ask that you pay the portion not covered by your insurance, such as co-payments and 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:_____
(Signature of Parent or Legal Guardian)

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

Patient DOB(s):_____

Today's Date: _____

Hixny

Schoolhouse Pediatrics

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.