Pediatric Associates of North Riverdale
Boston Children's Health Physicians
Until every child is well™

DATE: __________

PATIENT NAME:____

PATIENT ADDRESS:____

DATE OF BIRTH:________________ AGE:________GENDER: ________

<u>RESPONSIBLE PARTY/GUARDIAN</u>: (WHO IS RESPONSIBLE FOR MEDICAL CARE AND BILLS)

TITLE: <u>Mr. Mrs. Ms. Dr. Rabbi</u> NAME: LAST______________________MAIDEN____________________

FIRST:_______________________MI:____SEX:____DATE OF BIRTH (mm/dd/yyyy): ___________________

ADDRESS:____APT.______________

BOROUGH/CITY:___________________STATE:_____ZIP:________

EMPLOYER:____

TELEPHONE: WORK: (___)_______________CELL: (___)_______________HOME: (___)_______________

SOCIAL SECURITY #:_____________________________EMAIL:_______________________________________

EMERGENCY CONTACT: NAME/RELATION:__________________/____________PHONE:______________

INSURANCE COMPANY:______________________________________

POLICY #______________________GROUP #____________________EFFECTIVE DATE: _______________

<u>SPOUSE INFORMATION</u>

TITLE: <u>Mr. Mrs. Ms. Dr. Rabbi</u> NAME: LAST______________________MAIDEN____________________

FIRST:_______________________MI:____SEX:____DATE OF BIRTH (mm/dd/yyyy): ___________________

ADDRESS:____APT.______________

BOROUGH/CITY:___________________STATE:_____ZIP:________

EMPLOYER:____

TELEPHONE: WORK: (___)_______________CELL: (___)_______________HOME: (___)_______________

SOCIAL SECURITY #:_____________________________EMAIL:_______________________________________

EMERGENCY CONTACT: NAME/RELATION:__________________/____________PHONE:______________

INSURANCE COMPANY:______________________________________

POLICY #______________________GROUP #____________________EFFECTIVE DATE: _______________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

Signature of Patient: ____ Date: ____________________________

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ALAN M. HIRSCHMAN, M.D. RENEE P BRAND, M.D.

PATIENT INFORMATION

DATE OF INITIAL VISIT:__________________________
LAST NAME:____
FIRST NAME:____
ADDRESS:_______________________________________APT.:_____________
BOROUGH/CITY____________________STATE:_______ZIP:_____________
PHONE:____________________________DATE OF BIRTH:_______________

BIRTH HISTORY:
HOSPITAL OF BIRTH:______________________________________
TERM(WEEKS):_______DELIVERY(V/CS):_________BIRTH WEIGHT:__________
APGAR SCORE:___/___BLOOD TYPES: MOTHER_____BABY_____

DEVELOPMENTAL HISTORY: Please fill in the age
Smiled_____Rolled over_____Sat up_____Stood_____
Walked_____First words_____Short sentences_____First teeth_____Toilet trained_____

FEEDING HISTORY: Breast________Formula(which one)_____________

CHILD'S MEDICAL HISTORY
ALLERGIES____
HISTORY OF ASTHMA____
SIGNIFICANT MEDICAL ILLNESSES____
SURGICAL HISTORY____
INJURIES____
HOSPITALIZATIONS____
HAS YOUR CHILD HAD ANY OF THE FOLLOWING?: GIVE DATES
Chickenpox____
Recurrent otitis media(ear infections)__________________
Strep throat_______________________________________
Seizures____
Roseola____

FAMILY MEDICAL HISTORY: Please let us know if there are any significant medical illnesses in the family____

MEDICATIONS: Please list any medications your child takes regularly, whether prescription or over the counter____

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RACE & ETHNICITY PATIENT FORM

The U.S. government now requires that we ask patients for their race and ethnicity. You have the option to provide this information or to decline by checking the box in item 4. All responses will be kept confidential.

Patient Name____ Date of Birth______________________

1. Which category best describes the patient's ethnicity?
   - ☐ Hispanic or Latino or Spanish origin
   - ☐ Not Hispanic or Latino or Spanish origin

2. Which category best describes the patient's race?
   - ☐ American Indian/Alaskan native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Black or African-American
   - ☐ White/Caucasian
   - ☐ Other

3. What is the patient's preferred language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other _______________________

4. ☐ I do not wish to provide this information

Thank you for your time.

I hereby acknowledge that a copy of ***Boston Children's Health Physicians, LLP's*** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *BCHP's* privacy practices or my rights with regard to my personal health information, I may contact *BCHP's* Privacy Officer for further information as set forth in the Notice.

______________________________	______________________________
Name of Patient – Please Print Name	Name of Parent or Guardian
______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian
______________________________	______________________________
Date	Relationship to Patient

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________ Patient Identification #: ______________________

I hereby certify that on ____/____/____ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of BCHP's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name) ____

Signature of Staff Person ________________________________ Date _____________________

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

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Until every child is well℠

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Adopted Under
Health Insurance Portability and Accountability Act ("HIPAA") of 1996

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW THEY CAN GET ACCESS TO THEIR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO PRIVACY

Boston Children's Health Physicians, LLP (hereinafter, "BCHP") is a multispecialty medical practice. We are dedicated to maintaining the privacy of our patients' individually identifiable health information or protected health information ("PHI"). We are required by law to maintain the confidentiality of health information that identifies our patients and to provide them with this notice of our legal duties and our privacy practices concerning their PHI. This notice applies to the PHI of our adult and pediatric patients. Accordingly, use of the terms "you" and "your" in this notice applies to our patients and their PHI and to the personal representatives of our patients, e.g., the parent or guardian of a minor, the guardian of an adult who lacks legal capacity or a person authorized on behalf of a deceased patient.

We are required to furnish our patients with the important information discussed below regarding how we may use and disclose their PHI, our obligations concerning such use and disclosure, and their privacy rights concerning such information. The following briefly summarizes some important rights of patients with respect to their PHI:

- right to receive a copy of this Privacy Notice;
- right to inspect and copy certain health information;
- right to receive an accounting of certain disclosures that we make of their PHI;
- right to request restrictions on how we use and disclose PHI;
- right to be notified after a breach of any of your unsecured PHI has occurred;
- right to request amendments to the PHI;
- right to revoke an authorization that we obtained to disclose the PHI; and
- right to complain about suspected violations of their privacy rights.

The terms of this notice apply to all records containing PHI of our patients created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of the records that our practice has created or maintained in the past and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR SECURITY OFFICER:

Security Officer
Boston Children’s Health Physicians, LLP
40 Sunshine Cottage Road
Skyline Drive
Valhalla, NY 10595

Telephone # 914-922-2271

C. TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

1. Treatment. Our practice may use the PHI of our patients to treat them. For example, we may disclose your PHI (or your child’s PHI) as follows:

- To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.
- To write a prescription, or we might disclose your PHI to a pharmacy when we order a prescription for you.
- To treat or to assist others in the treatment of our patients.
- To inform you of potential treatment options or alternatives or programs.
- To others who you have given authorization to bring your child to the office and/or to consent to their treatment. For example, if you ask a relative or babysitter to bring your child to our office for treatment of a cold, the relative or babysitter may have access to the child’s medical information.
- To other health care providers for purposes related to their treatment of our patients.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items that we provide to our patients. For example, we may disclose your PHI as follows:

- To contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if the insurer will cover or pay for the treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose our patients’ PHI to operate our business. As examples, include, but are not limited to, the following:

- To evaluate the quality of and to improve our care or to conduct cost-management and business planning activities for our practice.
- To a social worker as a part of case management.
- To contact you and remind you of appointments.
- To inform you of health-related benefits or services that may be of interest to you.
- To engage in teaching and learning activities with medical and other health profession students and trainees (e.g., for medical students, residents, nurses, technicians and others).

D. USE AND DISCLOSURE OF PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose individually identifiable health information:

1. Public Health Risks. Our practice may disclose PHI to public health authorities or others that are authorized by law to collect information for the following purposes:

- To maintain vital records, such as births and deaths.
- Reporting child abuse or neglect.
- To prevent or control disease, injury or disability.
- To report potential exposure to a communicable disease.
- To report a potential risk for spreading or contracting a disease or condition.
- To report reactions to drugs or problems with products or devices.
- To report to your employer for certain work-related illness or injuries.

2. Health Oversight Activities. Our practice may disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute where we receive satisfactory assurance that you have been notified of the request and have been given time to object and other appropriate precautions have been taken.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations even if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.

5. Victims of Abuse, Neglect or Domestic Violence. We may disclose personal health information about a child whom we reasonably believe to be a victim of abuse, neglect, exploitation or domestic violence to a government authority, including a social service or protective service agency authorized by law to receive reports of child abuse, neglect, exploitation or domestic violence. Any such disclosures will be made in accordance with applicable law.

6. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

7. Research. Our practice may use and disclose PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose PHI when necessary to reduce or prevent a serious threat to a patient's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

10. Organ Donation. As allowed by law, we may disclose PHI to organ procurement organizations for organ, eye or tissue donation purposes.

11. Business Associates. There are some services that we provide through contracts with our business associates who work on our behalf. In such situations, we may disclose PHI to our business associates so that they can perform the jobs we asked them to do. We require all business associates to execute an agreement that requires them to comply with the HIPAA privacy requirements to safeguard your PHI.

12. Compliance. We are required to disclose PHI to the Secretary of the Department of Health and Human Services or his/her designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to Section E.3 below.

13. Appointment Reminders. We may use or disclose your PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that we believe may be of interest to you. We may remind you of appointments by mailing a postcard to you at the address provided by you or by telephoning your home and leaving a message on your answering machine or with the individual answering the phone. These appointment reminders will disclose the patient's name, address and the time, date and location of the appointment.

14. Required by Law. In addition to those uses and disclosures listed above, we may use and disclose PHI if and to the extent we are otherwise required by law.

E. RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location using alternative mailing addresses or telephone numbers. For instance, you may ask us not to contact you at work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for care, such as family members and friends. **Generally, we are not required to agree to your request, but, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary for treatment.** We must honor your request to restrict disclosure to a health plan if you pay your bill without use of insurance. If your bill is paid in full directly by you or another on your behalf on an "out-of-pocket" basis without submission of a claim to an insurer, you may request that BCHP restrict the disclosure of your PHI to your health plan and BCHP will honor your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- the information that you wish to be restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Upon request, we will provide access to your records that are maintained in electronic form if they are readily available in that format. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. In that case, another health care provider chosen by us who was not involved in denying your original request will review your request and the denial.

4. Amendment. You may ask us to amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the supporting reasons in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of our patients' PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Examples include the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. We also will not provide an accounting of disclosures made to you, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request in writing before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Breach Notification. You have the right to be notified after a breach of your unsecured PHI has occurred.

9. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Without limiting the foregoing, BCHP will not use or disclose your PHI without your written authorization for marketing or to sell your PHI. Our practice also will not use or disclose psychotherapy notes other than as explained in section F.2. below. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing but will not apply to uses or disclosures made prior to our receipt of such revocation. The revocation is not effective with respect to actions we took in reliance on your authorization, or where the authorization was obtained as a

condition of obtaining insurance coverage for your care. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

F. SPECIAL CIRCUMSTANCES

1. Minors. Under New York State law, minors (under the age of 18) have the right to request and receive medical care without parental consent when medical care is provided under the following circumstances:

- A minor of either sex who has a child can consent to his or her own medical care.
- A minor who is requesting specific medical services for pregnancy can consent to her own medical care.
- A minor who is requesting contraceptive services can consent to her own medical care.
- A minor of either sex who is seeking treatment for sexually transmitted disease can consent to his or her own medical care.

Medical information obtained under any of the above circumstances is confidential and cannot be disclosed to anyone, including a parent or guardian, without the minor's consent.

2. Psychological Treatment.

Psychotherapy notes are defined as any notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record. We will not use or disclose your psychotherapy notes without your written authorization except in limited exceptions such as for use by the therapist in the course of your treatment, disclosures to students who are learning under supervision to improve their skills in counseling and to prevent a serious and imminent threat to your health or safety or the health and safety of others.

Medication prescription and monitoring, counseling session start times, modality and frequency of treatment, results of clinical tests and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date are all excluded from the definition of psychotherapy notes.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

Effective Date. This Notice is effective as of December 2, 2013.

Pediatric Associates of North Riverdale
Boston Children's Health Physicians
Until every child is well™

Dear ______________________:

E-mail offers an easy and convenient way to communicate but is not the same as calling your physician's office. You can't tell when your message will be read or responded to, or even if your doctor is readily available or on vacation. Children's and Women's Physicians of Westchester LLP ("BCHP") will communicate with our patients (or their parents or guardians) by email only if we receive your agreement to the terms set forth in this Consent. Your consent to these terms will apply to all BCHP clinical providers as well as non-clinical personnel of BCHP who are involved in your care, scheduling, billing and other activities.

- **Use of e-mail is never appropriate for urgent or emergency health problems!** You must call your physician's office or go to a hospital Emergency Department.
- **BCHP WILL NOT ENGAGE IN OR RESPOND TO TEXT MESSAGING BY USE OF A CELL PHONE OR SIMILAR MOBILE DEVICE.**
- E-mail is not to be used as a substitute for face-to-face medical consultation with your physician and is at your physician's sole discretion.
- E-mail is appropriate for communicating regarding routine matters that don't require a lot of discussion, such as prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. BCHP may utilize e-mail at its discretion to send you information about our practice and services, including appointment reminders, our patient programs and new services.
- Your use of e-mail is not confidential and it may not be encrypted. It is like sending a postcard through the mail. Our staff (clinical and non-clinical) may read your e-mails in the course of their work duties. If you send e-mails through a work email account, your employer may have the legal right to read your email.
- E-mail should never be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail may become a part of the medical record when it contains clinical information, and we believe it is appropriate to include it in the medical record. In such case, the message may be retained in the patient health record.
- By signing below, you represent to BCHP that (a) you are the patient or parent or guardian of **the minor child or person lacking capacity to consent to their treatment** listed below; (b) you are an authorized user of the listed email account, (c) you have authority to consent to our use of the account for communications concerning the patient; and (d) you accept full responsibility for monitoring the security of use of the email account on your end. You agree that BCHP will have no responsibility to use any measure to verify that the recipient or sender utilizing your email address is you.
- Either party can revoke permission to use the e-mail system at any time in writing.
- This email agreement ONLY covers the individual signing below. Each authorized representative of the patient must sign his own email Consent.

I wish to communicate by e-mail with BCHP concerning the patient listed below upon the terms of this Consent.

Patient Name: ____

Patient Signature: ____________________________________ Date: __________________________

Your E-mail Address: ________________________________ Your state of residence: __________

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PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: ___________________________ Date: __________________

Your insurance may not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance may not pay for these services.

Your physician believes that the following services, even if not covered by your health insurance, are still an important part of your child's medical care and recommends that your child receives these services as part of his/her care. They are a requirement for complete preventive health examinations. However, since the services listed here may not be considered to be covered benefits under your health insurance, should you choose to allow your child to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want your child to receive these items or services.

The services recommended by your physician are listed below:

Refraction-99177 (Vision Test)____________________ $15.00
Audiometry-92552 (Hearing Test__________________ $20.00

I acknowledge that I have been informed in advance of receiving these services, that these services may not be covered by my health insurance plan. I have chosen to allow my child to receive these services and understand that I may be financially responsible for the charges indicated above. I also acknowledge that without these services my physician may not be able to completely fill out a physical examination form for my child as required by schools and camps.

Print Patient Name _____________________________________

Patient Signature ______________________________________

Name of Parent or Legal Guardian (if applicable)__________________________

Signature of Parent or Legal Guardian (if applicable)_______________________

Date_________________

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient please note: **THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.**

Patient Name: ____________________________________ Date of birth: _________________________

Patient Address: Street ____

Apartment # ____

City, State, Zip ____

Type of PHI to be restricted or limited. (Please check all that apply.)

- ☐ Home phone #
- ☐ Home address
- ☐ Occupation
- ☐ Name of employer
- ☐ Visit notes
- ☐ Hospital notes
- ☐ Prescription information
- ☐ Patient history
- ☐ Office address
- ☐ Office phone #
- ☐ Spouse's name
- ☐ Spouse's office phone #
- ☐ Other ___________________

How would you like the use and/or disclosure of your PHI restricted: ___________________________

____

____

Signature of Patient

or Parent/Legal Guardian____ Date: ______________

PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments
We are required to collect your co-payment at the time of visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. BCHP accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

No Show/Late Cancel Policy
A $40 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to the late cancel period. Please consult with your physician's office for specific information about the late cancel period.

Insurance
We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

Participating Plans
BCHP participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans
If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

Referrals
If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

______________________________ Name of Patient

______________________________ Date of Birth

______________________________ Signature of Parent or Authorized Person

______________________________ Print name of Parent or Authorized Person

______________________________ Date