GENERAL CONSENT & DEMOGRAPHIC INFORMATION FORM

Patient Name:_____ DOB:_____

Parent Information:

Mother's information:	**Father's information:**
Name: _____ DOB:_____	Name: _____ DOB:_____
Maiden Name: _____	
○Cell Phone: _____	○Cell phone: _____
○Home Phone: _____	○Home Phone:_____
○Work Phone: _____	○Work Phone: _____
○E-mail: _____	○E-mail: _____

Primary Caregiver(s): ○Mother ○Father ○Both ○Other: _____
Legal Guardian(s): ○Mother ○Father ○Both ○Other:

Consent for preferred method of contact: select below how you would like us to contact you with results (labs tests, Radiology testing, etc.) and clinical reminders (annual physical, vaccines due, follow up visits, etc.). **We recommend that you choose more than one method of communication so that we can reach you without delay:**

○Phone:_____ ○Text:_____ ○E-Mail:_____
○Mail to address on record

Name: _____ Signature: _____ Date: _____

Consent for others to bring your child to office

Please list below the persons whom you consent to bring the above named child to our office for sick and well visits, and whom you give authority to consent for any testing, treatment, evaluation and vaccines in your place:

Name	**Relationship to child**
_____	_____
_____	_____
_____	_____

Name: _____ Signature: _____ Date: _____

Prescription consent

I ○Do ○Do not give Brentwood Pediatric & Adolescent Associates, P.C. authorization to obtain all prescription history from any participating pharmacies for the above named child.

Name: _____ Signature: _____ Date: _____

Primary Care Provider selection:

Please select the provider you would like your child to have as their primary care provider*

○Juan Espinoza, MD ○Mayra Nadal, MD ○Michael Lee, MD ○Elizabeth Sill, CPNP

***Please be aware that we cannot guarantee that your child will be seen by the provider of your choice at every visit. We will do our best to comply with your choice of provider based on scheduling availability.**

BRENTWOOD PEDIATRIC & ADOLESCENT ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **DOB:** _____

1. FINANCIAL AGREEMENT & INSURANCE INFORMATION

I hereby agree to pay all charges due or that become due to the Practice for care and treatment provided to me (the patient) by the Practice. I understand the benefits, if any, paid by a third party on my (the patient's) behalf will be credited to my (the patient's) account and that I will be responsible for any remaining balance including any copayments, co-insurance sums (deductibles, etc.) or other fees required by insurer, HMO or other health benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my (the patient's) insurer, HMO or other health benefit plan (e.g., Medicare of Medicaid), which provides me (the patient) with health care coverage, I will be personally responsible for the cost of all care rendered to me (the patient) by the Practice.

2. ASSIGNMENT OF INSURANCE

I hereby assign, transfer and set over to the Practice all monies and/or benefits to which I (the pateint) may be entitled from government agencies, including Medicare and Medicaid programs, insurance carriers, HMOs or others who are financially liable for my (the patient's) hospitalization and/or medical care to cover the costs of the care and treatment rendered.

3. USE AND DISCLOSURE OF INFORMATION

I authorize the Practice, my treating physicians and their respective designees, to use and disclose my (the patient's) health information for all purposes necessary for treatment, payment, and health care operations, including but not limited to: release of information requested by my (the patient's) insurance company (or carrier) and any information necessary for discharge planning purposes.

4. UNDERSTANDING THIS FORM

I confirm that I have read and fully understand this form, and that all questions have been answered fully and to my satisfaction.

_____ _____ _____

Signature of Patient (or Responsibe Party) **(Relationship to Patient)** **Date**

_____ _____

Signature of Interpreter (if required) **Print Name of Interpreter**

PATIENT SOCIAL & FAMILY HISTORY FORM

Patient Name:_____ DOB: _____

In order to continue to provide the best medical care we can, we need to maintain our records with the most up-to-date information. Please answer the following questions as best you can:

About the family

What Medical conditions exist in the family ? check all that apply: **For any entry marked "yes" indicate relation to patient (Example: sister, grandmother, uncle, etc.)**							
Asthma	❍yes	❍no		Kidney problems	❍yes	❍no	
Diabetes	❍yes	❍no		Thyroid disease	❍yes	❍no	
High blood pressure	❍yes	❍no		Mental health or depression	❍yes	❍no	
High Cholesterol	❍yes	❍no		Substance abuse	❍yes	❍no	
Heart disease	❍yes	❍no		Cancer	❍yes	❍no	
Other :							

About the home

1.) Does anyone at home have: ❍ Hearing impairment ❍Vision impairment ❍Mental impairment ❍ None
If yes, who? _____

2.) Is there any exposure to any of the following at or around the home (check all that apply):

❍ Tobacco smoke ❍ Toxic chemicals/fumes ❍ Pets: _____ ❍ Mold ❍ None

3.) Does the patient/family participate in any of the following: (check all that apply)

❍Church/Religious organization ❍Community organizations ❍sports/recreational activities ❍None

4.) Are there any concerns about any of the following at or around the home (check all that apply):

❍ Domestic Violence ❍ Verbal abuse ❍ Physical abuse ❍ Drug abuse ❍ Safety concerns ❍ None

5.) We live in: ❍Ground floor or above apartment ❍Basement apartment ❍Shared home

❍ Own home ❍ Shelter ❍ Other: _____

6.) Who lives with the patient: ❍Mother ❍Father ❍Brother ❍Sister ❍Other:_____

7.) Who do you rely on for emotional/financial support: ❍Family ❍Friends ❍Government programs ❍None

8.) Any concerns about: ❍Transportation ❍Insurance ❍Nutrition help ❍Day care needs ❍Communication needs

9.) Who are the people who care for this patient: ❍ Mother ❍ Father ❍ Baby sitter

❍Day care center ❍ Other family (grandparent, aunt, etc.) ❍Other:_____

Patient Name:_____ DOB: _____

About the patient

For New Patients:

Does the child take any medications on a regular basis? ❍ No ❍Yes

If yes, list any medications: _____

Is the child allergic to any foods, environmental factors or medicines? ❍No ❍Yes

If yes, list any allergies: _____

Does the child have any medical problems? ❍No ❍Yes

❍Asthma ❍Seizures ❍Heart condition ❍Other: _____

Has the child ever been seen by a specialist or had a special test done in the past? ❍No ❍Yes

If yes. Please specify:_____

Has the child ever been hospitalized? ❍No ❍Yes

If yes, please specify approximate date and reason:_____

Has the child ever had any surgery? ❍No ❍Yes

If yes, please specify approximate date and reason:_____

For Established patients:

Since the patient's last visit here:

Has the patient seen a specialist or another doctor since last visit here? ❍No ❍Yes

(Please check below all that apply)

❍Emergency room ❍Urgent care center ❍Specialist ❍Was hospitalized ❍Had surgery
❍Other:_____

Has the patient been prescribed any medication or treatment by another doctor outside of our office? ❍No ❍Yes

(IF YES, PLEASE BE SURE TO INFORM THE MEDICAL STAFF SO THE CHILD'S RECORD CAN BE UPDATED)

Name of person providing information on this form: _____

Relationship to child: ❍Mother ❍Father ❍Legal guardian ❍Foster parent ❍Other:_____

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

BRENTWOOD PEDIATRIC AND ADOLESCENT ASSOCIATES, P.C.

1464 Fifth Ave., Bay Shore, NY 11706 TEL: (631) 231-5070 FAX: (631) 435-3288

Juan C. Espinoza, M.D., F.A.A.P.
Mayra E. Nadal, M.D., F.A.A.P.
Michael Lee, M.D., F.A.A.P.
Elizabeth A. Sill, C.P.N.P.

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. The cost for copying your medical file is $0.75 cents per page. We can also send a copy of your medical records to another physician with a signed medical record release consent free of charge. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** Contact person for Brentwood Pediatric & Adolescent Associates, P.C. is Lisa Espinoza at (631) 231-5070.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____