

# Patient Information Form

## Patient Information:

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.) \_\_\_\_ Sex: Female  Male   
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security # (if available): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Mother's Information:

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.) \_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Work Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_  
Cell Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Father's Information:

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.) \_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Work Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_

## Emergency Contact:

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

## PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

### Primary Insurance:

Person Responsible for Account: Mother  Father   
Occupation: \_\_\_\_\_ Name of Business: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_

### Secondary Insurance:

Person Responsible for Account: Mother  Father   
Occupation: \_\_\_\_\_ Name of Business: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_

### Private Insurance:

### No Insurance:

## Please List Other Children:

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(last) \_\_\_\_\_ (first) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(last) \_\_\_\_\_ (first) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(last) \_\_\_\_\_ (first) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EFFECTIVE DATE: APRIL 14, 2003

**NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD, (AS A PATIENT OF THIS PRACTICE), MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.****A. OUR COMMITMENT TO YOUR PRIVACY**

Pedimedica is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide. We are required by law to maintain the confidentiality of health information that identifies our patients. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time. The laws are complicated, but we must provide you with the following information.

- How we may use and disclose your child's IIHI
- Your privacy rights in regard to your child's IIHI
- Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child's IIHI that are 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 your child's 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:**

Mary Ann Santore, Privacy Officer, at Pedimedica, 870 Palisade Avenue, Suite 204, Teaneck, New Jersey, (201) 928-0748, ext. 110.

**C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

1. **Treatment.** Our practice may use your child's IIHI to treat him/her. For example, we may ask you to have laboratory tests (such as blood or urine tests) done on your child, and we may use the results to help us reach a diagnosis.

810 ABBOTT BOULEVARD  
FORT LEE, NEW JERSEY 07024  
(201) 224-3200  
FAX (201) 224-4045

870 PALISADE AVENUE  
TEANECK, NEW JERSEY 07666  
(201) 692-1661  
FAX (201) 692-9219

500 PIERMONT ROAD  
CLOSTER, NEW JERSEY 07424  
(201) 784-3200  
FAX (201) 784-3321

43 YAWPO AVENUE  
OAKLAND, NEW JERSEY 07436  
(201) 405-0800  
FAX (201) 337-5585

186 ROCHELLE AVENUE  
ROCHELLE PARK, NEW JERSEY 07662  
(201) 291-2323  
FAX (201) 291-2328

2. Pedimedica and our staff – including, but not limited to, our doctors and nurses – may use or disclose your child's IIHI in order to treat your child or to assist others in such treatment. Additionally, we may disclose your child's IIHI to others who may assist in his/her care, such as the both parents, a nanny, or other person who helps care for your child.
3. **Payment.** Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items rendered by this practice. For example, we may contact your health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your child's treatment to determine if your insurer will cover, or pay for, this treatment. We also may use and disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as other family members. Also, we may use your child's IIHI to bill you directly for services and items.
4. **Health Care Operations.** Our practice may use and disclose your child's IIHI to operate our business. Our practice may use your child's IIHI to evaluate the quality of care he/she received from us, or to conduct cost-management and business planning activities for our practice.
5. **Appointment Reminders.** Our practice may use and disclose your child's IIHI to contact you and remind you of an appointment.
6. **Treatment Options.** Our practice may use and disclose your child's IIHI to inform you of potential treatment options or alternatives of health-related benefits or services that may be of interest to
7. **Release of Information to Family/Friends.** Our practice may release your child's IIHI to a friend or family member that is involved in your child's care, or who assists in taking care of him/her. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold.
8. **Disclosures Required By Law.** Our practice will use and disclose your child's IIHI when we are required to do so by federal, state or local law.

#### **D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your child's identifiable health information:

1. **Public Health Risks.** Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:
  - maintaining vital records, such as births and deaths
  - preventing or controlling disease, injury or disability
  - notifying a person regarding potential exposure to a communicable disease
  - reporting reactions to drugs or problems with products or devices
  - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a child (including domestic violence).

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2. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your child's IIHI in response to a court order, if your child is involved in a lawsuit. We also may disclose your child's IIHI in response to a discovery request, subpoena by court order only.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
  - Regarding a crime victim in certain situations
  - Concerning a death we believe has resulted from criminal conduct
  - In response to a warrant, or court order or a subpoena signed by a judge.
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.
6. **Serious Threats to Health or Safety:** Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public.

Except as described in this Notice of Privacy Practices, Pedimedica will not use or disclose your child's health information without your written authorization

#### **E. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI**

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your regular doctor and/or Mary Ann Santore, Privacy Officer, (201) 928-0748, ext. 110, specifying the requested method of contact. Our practice will accommodate **reasonable** requests.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in his/her care or the payment for such care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. Your written request must include the information you wish restricted 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 IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing or by completing a form to your child's regular doctor and/or Mary Ann Santore, Privacy Officer, (201) 928-0748, ext. 110. 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 where patient rights are protected by state and federal law.

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4. **Amendment.** You may ask us to amend your child's health information 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 your child's regular doctor and/or Mary Ann Santore, Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice may deny your request if you fail to submit your request with your reason 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) to part of the IIHI which you would be permitted to inspect and copy; or
  - (c) not created by our practice, unless the individual or entity is unavailable.
  
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 your child's IIHI for non-treatment or operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. You must submit your request in writing to your child's regular doctor and/or Mary Ann Santore, Privacy Officer. Our practice will notify you of the costs involved before you incur any costs.
  
6. **Right to a Paper Copy of This Notice.** Every patient in our practice will be given a copy of this notice on his or her first office visit on or after April 14, 2003. You may request additional copies at any time.
  
7. **Faxing PHI.** Faxing of the following items will no longer be done, school physical forms, camp forms, immunization records, specialist reports, referrals, and any other form containing PHI. Please be advised that parents must sign an authorization to release this information to the specific party and must pick up the forms or we will mail them to the home address that we have in the chart. We will fax information to another doctor's office in emergencies only.
  
8. **Right to File a Complaint.** If you believe your child's 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,  
Office of Civil Rights,  
Hubert H. Humphrey Bldg.,  
200 Independence Ave., S. W.,  
Room 509F, HHH Building,  
Washington, DC 20201  
**You or your child will not be penalized for filing a complaint.**
  
9. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization and consent for treatment and will be keep it your child's chart. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time in writing.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Mary Ann Santore, Privacy Officer at (201) 928-0748, ext. 110.

**Partnering with Parents in Healthcare**

870 PALISADE AVENUE • TEANECK, NJ 07666 • (201) 928-0748 • FAX (201) 928-0842

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
OF PEDIMEDICA AND CONSENT FORM**

By signing below I hereby acknowledge that I have received a copy of PEDIMEDICA'S NOTICE OF PRIVACY PRACTICES as required by Federal Law in accordance with The Health Insurance Portability and Accountability Act of 1996. (HIPAA)

Pedimedica has my consent to use and disclose protected health information, (PHI), about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Pedimedica's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Pedimedica may call my home or other designated location and leave a message on voice mail, or an answering machine in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including test results.

By signing below I am giving my consent to the physicians and staff of Pedmedica to administer medical treatment as deemed necessary in any and all of my child/children's office visits, (this includes sick and well visits. I also give my consent for Pedimedica to submit charges to my insurance company for payment for any and all treatments administered to my child.

I may revoke my consent at any time, in writing and dated signature. However, I agree that I authorized any information released prior to the date that I revoke my consent.

If I do not sign this consent, Pedimedica may decline to provide treatment to my child.

Additional Children in family covered  
Under this Acknowledgement and consent.

I give my consent for the following people to  
bring my children to Pedimedica in my absence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian

Please print name of Parent/Guardian

REFUSED:       Consent       Acknowledgement

\_\_\_\_\_  
Pedimedica Staff

\_\_\_\_\_  
Date

810 ABBOTT BOULEVARD  
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