Jefferson Medical Arts Building
1200 Brooks Lane, Suite 270
Jefferson Hills, PA 15025
P 412.460.8111
F 412.460.8112

Welcome **to *Allegheny Clinic Pediatrics*! Please complete the enclosed forms and present them at the time of your child's appointment. We strongly encourage you to have your child's previous physician forward copies of your child's immunizations and all medical records prior to your appointment. Enclosed is a medical release form which you may provide your previous physician. Thank you for the opportunity to care for your child. We look forward to meeting you and your family.**

Please remember to bring:

INSURANCE CARD

PATIENT INFORMATION SHEET

PATIENT HISTORY FORM

ALL CURRENT PRESCRIPTION BOTTLE(S)

METHOD OF PAYMENT (CASH, CREDIT, OR CHECK)

ADDITIONAL ENCLOSURE:

MEDICAL RELEASE FORMS (PLEASE PROVIDE TO YOUR PREVIOUS PHYSICIAN FOR RELEASE OF RECORD)

HIPPA POLICY

FINANCIAL POLICY

IMMUNIZATION POLICY

PATIENT VISIT AND TREATMENT POLICIES

Pediatric Alliance P.C.
In Collaboration With
Allegheny Health Network

PATIENT INFORMATION					
NAME (LAST, FIRST , MIDDLE)		DOB	SSN	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (IF APPLICABLE)			ETHNICITY
CITY, STATE, ZIP	HOME PHONE	CITY, STATE, ZIP		HOME PHONE	RACE
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME		CONTACT HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER(if appilicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if different from above)				
NAME (LAST, FIRST , MIDDLE)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY /BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE, ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE, ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXP DATE

SECONDARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE, ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXP DATE

I hereby consent to diagnostic / medical treatment of the above named patient as recommended by a physician of Allegheny Clinic Pediatric (ACP), as well as any designee or employee of ACP. I understand this treatment may include tests, examinations, and emergency treatment. I consent to the exchange of medical history with other providers to provide optimal treatment. I request payment of medical benefits be made to ACP. I authorize the release of medical or other info necessary to process claims of the above noted patient. I acknowledge being informed of ACP's "NOTICE OF PRIVACY PRACTICE" (NOPP) and Financial policies. As per the NOPP, I understand that I am participating in Clinical Connect Health Information Exchange unless I sign the specific "Opt Out" form, I understand and agree to these policies.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

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DATE	CHILD'S NAME	NICKNAME	DOB	M F

PREVIOUS PHYSICIAN/OFFICE	REQUEST FOR RECORDS TRANSFER COMPLETED Y N	DATE OF LAST PHYSICAL

MOM'S NAME	AGE		DAD'S NAME	AGE

CHILD LIVES WITH	FORM COMPLETED BY

BIRTH HISTORY

BIRTH WEIGHT _____ PREG# _____ Mom's Age _____ WAS THE DELIVERY ☐ Vaginal? ☐ Cesarean? ☐ Breech?

Was Baby born on time? ☐ Y ☐ N

If Cesarean, why? _____

If early, how many weeks gestation? _____

Did your baby have any problems right after birth Y ☐ N ☐

Did mother have any illness or problems with her pregnancy? _____

Explain? _____

Explain _____

During pregnancy,did mother

Was initial feeding ☐ Breast milk? ☐ Formula ?

Smoke ☐ Y ☐ N Drink Alochol ☐ Y ☐ N

Did your baby go home with mother from the hospital?

Use Drugs or medication ☐ Y ☐ N

☐ Y ☐ N

What When EXPLAIN?

PAST HISTORY

DOES YOUR CHILD HAVE OR HAS HE/SHE EVER HAD:

Chickenpox	☐ Y ☐ N	EXPLAIN?	
Frequent ear infections or sore throats	☐ Y ☐ N	EXPLAIN?	
Problems with ears or hearing	☐ Y ☐ N	EXPLAIN?	
Nasal allergies	☐ Y ☐ N	EXPLAIN?	
Problems with eyes, vision, or teeth	☐ Y ☐ N	EXPLAIN?	
Asthma, recurrent cough, bronchitis, or pheumonia	☐ Y ☐ N	EXPLAIN?	
Blood transfusion	☐ Y ☐ N	EXPLAIN?	
Frequent abdominal pain	☐ Y ☐ N	EXPLAIN?	
Constipation requiring doctor visits	☐ Y ☐ N	EXPLAIN?	
Bladder or kiddney infection	☐ Y ☐ N	EXPLAIN?	
Bed-wetting (after 5 years old)	☐ Y ☐ N	EXPLAIN?	
Any chronic or recurrent skin problems (acne, eczema, etc)	☐ Y ☐ N	EXPLAIN?	
Frequent headache	☐ Y ☐ N	EXPLAIN?	
Convulsions or other neurological problems	☐ Y ☐ N	EXPLAIN?	
Mental health issues (ADHD,anexiety, depression)	☐ Y ☐ N	EXPLAIN?	
Diabetes	☐ Y ☐ N	EXPLAIN?	
Thyroid or other endocrine problem	☐ Y ☐ N	EXPLAIN?	
Use of alcohol or drugs	☐ Y ☐ N	EXPLAIN?	

Other medical or mental health issues /problems _____

Does your child see any specialists? If so , who? For what reason or diagnosis? _____

GENERAL

Do you consider your child to be in good health?	☐ Y	☐ N	EXPLAIN
Does your child have any serious illnesses or chronic medical conditions?	☐ Y	☐ N	EXPLAIN
Has your child had serious injuries or accidnts?	☐ Y	☐ N	EXPLAIN
Has your child had any surgery?	☐ Y	☐ N	EXPLAIN
Has your child ever been hospitalized?	☐ Y	☐ N	EXPLAIN
Has your child had an allergic reaction to any medications or immunizations?	☐ Y	☐ N	EXPLAIN

Patient Name_____

Patient DOB _____

DEVELOPMENT

Are you concerned about your child's physical development?	☐ Y	☐ N	EXPLAIN
Are you concerned about your child's mental or emotional development?	☐ Y	☐ N	EXPLAIN
Are you concerned about your child's behavior?	☐ Y	☐ N	EXPLAIN
Are you concerned about your child's school performance?	☐ Y	☐ N	EXPLAIN
Does your child receive OT, PT, speech or other special services?	☐ Y	☐ N	EXPLAIN
Is your child in special or resource classes in school?	☐ Y	☐ N	EXPLAIN

Other issues or concerns _____

HOUSEHOLD

PLEASE LIST ALL THOSE LIVING IN THE CHILD'S HOME

NAME	RELATIONSHIP TO CHILD	DOB

Child care:_____

Smokers in household? ☐ Y ☐ N

Pets in household? ☐ Y ☐ N

Are there siblings not listied? If so please list their names and ages and where they live._____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?_____

FAMILY HISTORY (PARENTS, SIBLINGS, GRANDPARENTS/AUNTS & UNCLES)

HAS ANY FAMILY MEMBER HAD THE FOLLOWING

Allergies, Eczema	☐ Y	☐ N	WHO	Comment
Cancer	☐ Y	☐ N	WHO	Comment
Diabetes (before 50 years old)	☐ Y	☐ N	WHO	Comment
Gastrointestinal Disease	☐ Y	☐ N	WHO	Comment
Heart Disease, including Heart Attack, High Blood Pressure,	☐ Y	☐ N	WHO	Comment
High Cholesterol (before 50 years old)	☐ Y	☐ N	WHO	Comment
Kidney Disease,Urinary Tract Infection	☐ Y	☐ N	WHO	Comment
Lung Disease, Including Astma	☐ Y	☐ N	WHO	Comment
Mental Health Issues, including ADHD, Anxiety,	☐ Y	☐ N	WHO	Comment
Depression, Alcohol / Substance Abuse	☐ Y	☐ N	WHO	Comment
Neurologic (convulsions), Headaches, Migraines	☐ Y	☐ N	WHO	Comment
Tuberculosis (TB)	☐ Y	☐ N	WHO	Comment
Vision or Hearing Impaired	☐ Y	☐ N	WHO	Comment
Additional family history	☐ Y	☐ N	WHO	Comment

NOTES

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information:

_____

Last Name First Name Middle Initial Date of Birth

_____

Street Address City State Zip Code

I, the undersigned, hereby authorize _____ to release health information to:
Name of Facility/Person

_____ for the purpose of: _____
Name of Facility/Person Reason for Record Request

_____

Street Address City State Zip Code

If transferring records, please state the reason:_____

Date(s) of Service requested: _____

Specific information to be released:

□ Consults
□ Discharge Summary/Instructions
□ Laboratory/Diagnostic Test Results
□ Medical History/Physical Exam
□ Psychiatric/Mental Health/ Substance Abuse Records
□ Medication Records
□ Operative/Emergency Reports
□ Physician Orders
□ Progress Notes
Other_____

□ I request the **entire** medical record be released (including HIV-related information and re-disclosures from other health care providers) **except** for the information specified below:

_____

I understand I have a right to receive a copy of this authorization upon my request.

This release is valid for one year after the date of signature, unless otherwise specified:
_____.

I understand that I have the right to revoke this authorization at any time by submitting a written request to the releasing entity.

Request Date: _____ Copy Received by: _____ Date: _____

Patient's Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____

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CONSENT FOR TREATMENT
IN THE ABSENCE OF A PARENT/GUARDIAN

I hereby give permission and written consent to Allegheny Clinic Pediatrics, its physicians, employees, agents, and servants to render any and all medical treatment (including immunizations) as deemed necessary to my child(ren) listed below, who are minors, in my absence.

Patient Name	**Date of Birth**

Select one:

☐ This permission applies to whomever accompanies my child(ren) to the office.

☐ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

☐ This permission applies to only the people who are listed below:

_____ _____

_____ _____

Parent/Legal Guardian
Signature: _____ Date: _____

Witness: _____ Date: _____

If the patient is a minor under 18 years of age, his or her consent is acceptable for the following reason(s):

☐ Married ☐ High school graduate ☐ Pregnancy/birth of child

Allegheny Clinic Pediatrics Care Manager Form

Allegheny Clinic Pediatrics offers a secure Patient Portal (NextMD) for the convenience of our patients and their families. This internet-based patient portal is a secure and easy-to-use website that gives patients and/or legal guardians access to medical documents and additional convenient features.

This form is two pages. Please sign on page 2 - Please review the terms and conditions on page 2 and sign at the bottom. When finished, please return this form to an Allegheny Clinic Pediatrics staff member. Thank you.

Care Manager Information – Legal Guardian or Patient Over 18: (Be sure to provide all Information including e-mail)

Name _______________________________ **Date of Birth**____/_____/________

Home Address_______________________________ **City:**______________________

State__________ **Zip**______________ **Phone Number**________________________

Email Address (print clearly) ____

Patient Information – Patients under 18 or consenting patients over the age of 18 granting access to a guardian:
*Consenting patients over 18 – by signing, you have read and agree to the terms listed on the reverse side of this form

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

Name_______________________________ **Date of Birth**____/_____/_________

*If patient over 18 and wishes to give portal access to parent - Patient signature here:____________________ **Date**__________

*****Care Manager Signature Required on Reverse Side*****

For any questions related specifically to the NextMD Patient Portal, email portal@pediatricalliance.com or call 412-278-5102.

Allegheny Clinic Pediatrics NextMD Care Manager Terms and Agreement

1. **I understand that NextMD is not to be used in the event of medical emergencies. In the event of an emergency, emergency medical services should be contacted immediately.**
2. I understand that NextMD is intended as a secure online source for confidential medical information.
3. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner and to change my password if I believe it may have been compromised in anyway.
4. I understand that NextMD contains *select* medical information from a patient's medical record and that NextMD does not reflect the complete contents of the medical record. I further understand that NextMD contains information from the Allegheny Clinic Pediatrics' physician offices that use Allegheny Clinic Pediatrics' electronic health record system, and that the care manager will be able to access information from those physician offices. Such information may include information associated with HIV, mental health, drug and alcohol treatment.
5. I understand that by obtaining care manager access, the care manager will be permitted to do the following:
    - Request appointments for healthcare services, on the patient's behalf, with any Pediatric Alliance healthcare provider that participates in NextMD.
    - View all of the patient's medical information that is available within NextMD
    - Communicate via NextMD, by phone or in person with Allegheny Clinic Pediatrics via NextMD regarding tests, treatments, medications, patient advice and administrative tasks
6. I understand that all activities within NextMD will be tracked by computer audit and that entries will be a permanent part of the medical record.
7. I understand that access to NextMD is provided by Allegheny Clinic Pediatrics as a convenience to our patients. Allegheny Clinic Pediatrics has the right to deactivate care manager access to the NextMD account or that of the care manager at any time for any reason, including cases where Allegheny Clinic Pediatrics reasonably believes that it is not in your best interest to continue to provide NextMD access to you as a care manager.
8. I understand that NextMD is provided as a way for parents to collaborate in their child's care. Therefore, an eligible parent/legal guardian may, with limitations, have access to their minor child's medical record through NextMD.
9. Furthermore, I understand that, as a child reaches age 18, access to a child's health record using NextMD will be limited or discontinued due to federal regulations.
10. I understand that there may be no specific reasons other than entry into adulthood that could lead to discontinuations of parental access to the health record of their child. Therefore, no specific reason will be communicated at the time of discontinuation.
11. I will not use NextMD care manager access for frivolous purposes or for proposes unrelated to the care or treatment of the patient.
12. I understand the use of care manager access is for the care of the NextMD member. If I no longer need to have care manager access, I should notify Allegheny Clinic Pediatrics immediately.
13. I am entitled to a copy of this completed form.
14. If patient is over the age of 18, and wishes to grant access to someone other than themselves, by signing this form on page 1 under the Patient Information section, the patient understands that the care manager to whom they grant access can view their medical record, make appointments for healthcare services, discuss diagnostic tests, results, current health issues and treatment recommendations (does not require informed consent) and billing matters, and the patient has read and agrees to the terms and conditions listed above.

By signing below, I acknowledge that I have read and understand this Allegheny Clinic Pediatrics Care Manager Request Form and I agree to its terms and conditions. My signature is my attestation that I am the legal guardian for these patients, that I have access to their medical record and that the information provided is accurate.

➢ _____ / _____ / _____

Signature of Care Manager *(Required)* ***Relationship to Patient(s)*** ***Date***

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As you may know, Allegheny Clinic Pediatrics has implemented an electronic medical record (EMR) system. The federal government is requiring health care providers who have adopted EMR to meet specific criteria. One of the requirements is that we need to identify the following information for each patient.

We are asking that you provide this information on a voluntary basis, and you may decline to do so.

As always, identifying patient information will be kept confidential. If you have any questions, please ask our staff. Thank you for your understanding.

Patient Name:_____ **DOB:**_____

Primary/Preferred Language:_____

Race: Circle All that apply

White
Black Or African American
American Indian or Alaska Native
Asian
Other
Native Hawaiian or other Pacific Islander
Multiracial
Undetermined
Decline to specify

Ethnicity: Circle One

Non-Hispanic or **Non**-Latino
Hispanic or Latino
Unknown
Decline to answer

Sibling Information: Please complete so we can update your other children's information now. Please use the back if you need more room (Please answer using the choices from above):

Name:_____ **DOB:**_____

Primary/Preferred Language:_____

Race:_____ **Ethnicity:**_____

RE/3-15

Name:_____ DOB:_____

IMMUNIZATION POLICY

The physicians of Allegheny Clinic Pediatrics believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines. We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics. The recommended vaccines and their schedule given are the results of years of scientific study and data-gathering on millions of children by thousands of our brightest scientists and physicians.

We *do not* alter the CDC immunization schedule based on individual requests as there is no evidence that altered schedules are safe or confer the proper immunity against disease.

I have read the above policy and understand that failure to follow the recommended vaccine schedule published by the CDC could be cause for dismissal:

Parent / Legal Guardian Signature: _____Date: _____

CLINICALCONNECT HEALTH INFORMATION EXCHANGE STANDARD ADDENDUM TO THE NOTICE OF PRIVACY PRACTICES

Allegheny Clinic Pediatrics participates in the Clinical Connect Health Information Exchange (HIE). Generally, a HIE is an organization that regional providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical errors will occur. By participating in the HIE, UPMC may share your health information with other providers that participate in the HIE (each a "Participating Providers") or participants of other health information exchanges. This health information includes, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including x-rays, MRIs, CT scans etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary notes
- Urgent Care visit progress notes

All Participating Providers have agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws.

As a result, you understand and agree that unless you notify your Provider that you do not wish for your health information to be available through the HIE ("Opt-Out"):

- Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;
- All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;
- Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.;
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

You may Opt-Out at any time by notifying Allegheny Clinic Pediatrics.
A list of Participating Providers may be found at: www.clinicalconnecthie.com.

NOTICE OF PRIVACY PRACTICES

Allegheny Clinic Pediatrics is committed to protecting your personal health information (PHI) as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 2013 Amendments.

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.

We are required by HIPAA to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. This Notice was updated in July 2013, and will remain in effect unless we replace it.

Your personal health information may be shared, if requested, by your health insurance plan for purposes of treatment, payment, and health care operations. Disclosures of information will be limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the disclosure of medical records for treatment purposes because physicians, specialists, and other providers need access to the full record to provide quality care. We may disclose your protected health information to another health care provider when needed by the provider to render treatment to you.

We may also disclose your protected health information to other covered entities or business associates. Business Associates are entities that provide services to our practice and that require access to protected health information of our patients In order to provide those services.

We may also disclose your protected health information for public health activities that are permitted by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

We may also disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

We may disclose your protected health information in response to an order of a court or in response to a subpoena or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

We may disclose your protected health information to someone involved in your care or payment for your care, such as a spouse, parent, etc.

We may use your health information for internal operations within Allegheny Clinic Pediatrics, PC. This includes quality improvement activities, population based activities relating to improving health or reducing health care costs, accreditation, certification, licensing and credentialing activities, etc.

We may use your health information to conduct research, only if approved as necessary and appropriate by a review board (also called an Institutional Review Board or IRB), which is obligated to protect human rights in research.

We may use postcards to send you non-personalized notices such as address changes, periodical health-related notices, and generalized health-related services available to your children.

For all other purposes, (including marketing) we will obtain your written authorization to use or disclose specific information. You are able to revoke your authorization at any time.

Following is a description of your rights with respect to your protected health information.

- You have the right to request copies of your protected health information. You must make this request in writing to obtain access to your protected health information.

- You also have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. Most disclosures are for these reasons.

- You also have a right to request a restriction on the protected health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to these additional restrictions. You may request a restriction in writing by providing to us the specific information you want to limit and how you want to limit this disclosure.

- You have the right to request confidential communications with us. You must make this request in writing and state the means of communication you prefer.

- You have the right to request an amendment to your protected health information. This request must be in writing. You may obtain this form from Allegheny Clinic Pediatrics. This form is titled "REQUEST FOR MEDICAL RECORD AMENDMENT."

- You have a right to receive a copy of this Notice.

- You have a right to receive timely written notice of a breach of your unsecured protected health information.

- If you have any questions or are concerned that Allegheny Clinic Pediatrics may have violated your privacy rights, you may address this issue by contacting the Compliance Officer for Allegheny Clinic Pediatrics and / or Pediatric Alliance, PC. The phone number is (412) 278-5100 during normal business hours. You may also submit a complaint to the Office of Civil Rights, US Department of Health and Human Services.

- Furthermore, all Allegheny Clinic Pediatrics employees and designees agree to abide by the Allegheny Clinic Pediatrics Confidentiality Policy.

Allegheny Clinic Pediatrics Patient Visit and Treatment Policies

Appointment Types: We have several types of appointment schedules. Our provider/physician schedules run simultaneously. While in our waiting room, you may see a patient who came in after you who is taken to the exam room before you because of the way the individual provider schedules are running that day.

Late Appointments: We work hard to keep our appointment times as close to the scheduled times as possible. ***Please arrive 10 minutes in advance of your schedule appointment time to allow time to check in and verify your information.*** If you are more than 15 minutes late, you may be asked to reschedule your appointment.

Visit Length: Allow about one hour for your entire visit with us. Generally we run on time. We will do the best we can to see you in a timely manner

Appointment Cancellations and No Show's: Call us at least 24 hours in advance should you need to cancel or reschedule the appointment. A fee of **$15.00** may be charged to your child's account for a 'No Show" appointment and will be reported to your insurance. If repeated "No Show" appointments occur, dismissal *may* occur from our practice.

Copays: Co-payments & payments of non-covered services are due at the time of service. If payment is not made at the time of service, a $10 fee will be assessed to your child's account. Our fee for returned checks is $35.00. If two returned checks are received within any period of time, we reserve the right to request future services be paid with cash and/or credit card.

Insurance Cards: You will be asked to present your child's insurance card at the time of each visit. We ask that you notify us as soon as possible with any insurance changes. A claim will be filed with your current insurance carrier. **ANY** amounts that are denied or unpaid will be billed to you.

****It is your responsibility to know the benefits associated with your insurance policy.**

Persons Accompanying the patient to the Exam Room : Please limit the number of persons going back to the exam room as space is limited. However, all unaccompanied children must go to the exam room.

Treatment of Minors: The State of Pennsylvania requires that all patients under 18 years of age **must** be accompanied by a parent or legal guardian unless you, the parent or legal guardian, provide **prior** written consent for someone **at least 18 years or older** to accompany your child to the appointment and examination. If needed, see one of our front desk team members to obtain a **Medical Consent Authorization Form.**

Privacy Policy: Pediatric Alliance, PC is committed to protecting your personal health information as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by HIPAA to give you this Notice about our privacy practices, our legal duties and your rights concerning your protected health information. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

Forms and Prescription Refills: Forms and prescription refill requests will be considered only for those patients examined in the past 12 months. If your child has **not** been seen in the past 12 months, the form/prescription request will **not** be filled. Some forms/prescription refills may require an appointment even if your child has been seen in the last 12 months. Call our office to determine if an appointment is required. Prescription refills called in after 3:00pm will be processed, upon physician approval, the next business day.

School or Work Excuses: A school and/or work excuse can be provided for the child who had the appointment and the parent/guardian who accompanied the child. Due to HIPAA regulations, we are not permitted to fax excuses. Ask us for an excuse before you leave our office.

PLEASE KEEP FOR YOUR RECORDS