Pediatric Alliance P.C.

St. Clair Division
1580 McLaughlin Run Road
Suite 208
Pittsburgh, PA 15241
PHONE 412-221-2121
FAX 412-221-2007

Welcome to Pediatric Alliance, St. Clair Division. 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 in 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

METHOD OF PAYMENT (cash, check, or credit)

Additional enclosures:

MEDICAL RELEASE FORM (Please provide your previous physician for release of records)

HIPAA POLICY

FINANCIAL POLICY

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ST. CLAIR DIVISION
1580 McLaughlin Run Road
Pinebridge Commons
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PATIENT INFORMATION SHEET

PATIENT'S NAME_____**DATE OF BIRTH**_____

OTHER NAME THAT CHILD GOES BY_____

HOME PHONE_____ **CELL PHONE**_____

EMERGENCY CONTACT NAME & NUMBER_____

EMAIL ADDRESS_____

DO WE HAVE PERMISSION TO LEAVE A MESSAGE AT THE ABOVE NUMERS REGARDING?:

APPOINTMENTS	___YES	___NO
LAB/TEST RESULTS	___YES	___NO
CHART INFORMATION	___YES	___NO

PRIMARY PHARMACY NAME_____**LOCATION**_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE?

_____

SIGNATURE OF PERSON COMPLETING THIS FORM_____

DATE SIGNED_____

Pediatric Alliance P.C.

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 baby born on time?_____ Early?_____ Late? _____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____
During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean? ☐ Breech?
If cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____
Was initial feeding ☐ Breast milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
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 pneumonia	☐ Y ☐ N	Explain _____
Any heart problem or heart murmur	☐ Y ☐ N	Explain _____
Anemia or bleeding problem	☐ Y ☐ N	Explain _____
Blood transfusion	☐ Y ☐ N	Explain _____
Frequent abdominal pain	☐ Y ☐ N	Explain _____
Constipation requiring doctor visits	☐ Y ☐ N	Explain _____
Bladder or kidney infection	☐ Y ☐ N	Explain _____
Bed-wetting (after 5 years old)	☐ Y ☐ N	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ Y ☐ N	Explain _____
Frequent headaches	☐ Y ☐ N	Explain _____
Convulsions or other neurologic problem	☐ Y ☐ N	Explain _____
Mental health issues (ADHD, anxiety, 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 or medical conditions?	☐ Y ☐ N	Explain _____
Has your child had serious injuries or accidents?	☐ Y ☐ N	Explain _____
Has your child had any surgery?	☐ Y ☐ N	Explain _____
Has your child ever been hospitalized?	☐ Y ☐ N	Explain _____
Is your child allergic to any medicines or drugs or reacted to immunizations?	☐ Y ☐ N	Explain _____

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 listed? 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)

Have any family members had the following:

Allergies, eczema	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes (before 50 years old)	☐ Y ☐ N	Who_____	Comments_____
Gastrointestinal Disease	☐ Y ☐ N	Who_____	Comments_____
Heart Disease, including Heart Attack, High Blood Pressure, High Cholesterol (before 50 years old)	☐ Y ☐ N	Who_____	Comments_____
Kidney Disease- Urinary Tract Infection	☐ Y ☐ N	Who_____	Comments_____
Lung Disease, including Asthma	☐ Y ☐ N	Who_____	Comments_____
Mental health issues, including ADHD, anxiety, depression, alcohol/substance abuse	☐ Y ☐ N	Who_____	Comments_____
Neurologic (convulsions), headaches, migraines	☐ Y ☐ N	Who_____	Comments_____
Tuberculosis (TB)	☐ Y ☐ N	Who_____	Comments_____
Vision or Hearing Impaired	☐ Y ☐ N	Who_____	Comments_____

Additional family history _____

Notes (for Provider Use)

Pediatric Alliance P.C.

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, authorize _____ _____
Name of Facility/Person Address

to release health information to:

Pediatric Alliance, P.C., St. Clair Division
1580 McLaughlin Run Road
Suite 208
Pittsburgh, PA 15241
Phone: 412-221-2121
Fax: 412-221-2007

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: _____

Pediatric Alliance, PC
Administrative Office
1100 Washington Avenue, Suite 215
Carnegie, PA 15106

Dear Parents:

Welcome to our practice and thank you for choosing us as your child's/children's healthcare provider. We wish to advise all new parents of our policies and procedures to prevent any misunderstandings regarding services.

- Prior to your visit, you will be asked to complete a registration/insurance form. This form is to be updated when any changes occur to your insurance or personal information.

- You will be asked to present your insurance card at each visit.

- Payment of co-payments and non-covered services are expected at the time of service.

- If a co-payment is not made at the time of the appointment, a $10 fee will be assessed to each child's account.

- We will file a claim with your insurance carrier. Any amounts that are denied or unpaid will be billed to you.

- In divorce situations, the adult accompanying the child is responsible for payment at the time of service. The parent with whom the child resides is the parent who will be billed for services rendered. We cannot become involved in mediating financial arrangements between parents.

- 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 pain with cash or credit card.

- Our appointment times are limited. Therefore, we have an established fee for missed appointments. Our charge is $15.00. Please call within 24 hours of the scheduled appointment to cancel.

We look forward to serving your child's health needs. If you have any questions regarding these policies, please contact our office manager.

Pediatric Alliance P.C.

NOTICE OF PRIVACY PRACTICES

Pediatric Alliance, PC 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 Pediatric Alliance, 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 Pediatric Alliance. 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 Pediatric Alliance, PC may have violated your privacy rights, you may address this issue by contacting the Compliance Officer for Pediatric Alliance. 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 Pediatric Alliance employees agree to abide by the Pediatric Alliance Confidentiality Policy.

ClinicalConnect
Health Information Exchange

Pediatric Alliance P.C.

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

Update Effective: February 1, 2016

Pediatric Alliance ("Provider") participates in the ClinicalConnect Health Information Exchange (HIE). Generally, a HIE is an organization that providers, payers, and providers of ancillary healthcare related services participate in (each a "Participant") 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, Pediatric Alliance may share your health information with Participants or participants of other health information exchanges, by example P3N (Pennsylvania Patient & Provider Network) and Healtheway (a national network that allows providers to exchange information). This health information includes, but is not limited to:

- Test Results. By example, General laboratory tests, Pathology tests ,Radiology tests, GI tests, cardiac tests, neurological tests, etc.
- Health Maintenance documentation
- Problem lists
- Allergy Information
- Immunizations
- Medication lists
- Consultation and Progress notes
- Discharge summaries and instructions
- Clinical Claims Information

Ancillary healthcare related service providers may include, but are not limited to:

- Organ Procurement
- Diagnostic Testing
- Pharmacies
- Durable medical Equipment Suppliers
- Home Health Services

All Participants 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 Participant 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 and payers. Additionally, you cannot choose to have only certain providers or payers access your health information;
- All Participants who provide services to you will have the ability to access and download your information. However, Participants that do not provide services to you will not have the ability to access or download 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, payers, pharmacies, laboratories, etc.;
- Your information may be disclosed for payment related activities associated with your treatment by a Participant; and your information may be used for healthcare operations related activities by Participants.

You may Opt-Out at any time by notifying Pediatric Alliance.
A list of Participants may be found at:
www.clinicalconnecthie.com.

Pediatric Alliance Care Manager Form

Pediatric Alliance now 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-sided. Please sign on back - Please review the terms and conditions on the reverse side and sign at the bottom of the reverse side. When finished, please return this form to a Pediatric Alliance staff member. Thank you.

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

Parent/Guardian ______________________________ **Date of Birth** ____/____/______

Parent/Guardian ______________________________ **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** ________

*****To receive statements in the Patient Portal, the guarantor is required to be listed as a care manager.***

*****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.

August 2015

Pediatric Alliance 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 Pediatric Alliance physician offices that use Pediatric Alliance's 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 Pediatric Allaince 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 Pediatric Alliance as a convenience to our patients. Pediatric Alliance 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 Pediatric Alliance 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 Pediatric Alliance 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 the reverse side 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 Pediatric Alliance 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***

Pediatric Alliance Inc.

As you may know, Pediatric Alliance 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:**_____

ST. CLAIR DIVISION
1580 McLaughlin Run Road
Pinebridge Commons
Suite 208
Pittsburgh, PA 15241
PHONE 412-221-2121
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PEDIATRIC ALLIANCE, P.C.

CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT/GUARDIAN

I hereby give permission and written consent to Pediatric Alliance, PC, 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.

_____ _____

_____ _____

_____ _____

_____ _____

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

(Revised 01-13-2016)