BAYSIDE PEDIATRIC SPECIALISTS, P.C.
23 - 25 BELL BLVD.
BAYSIDE, N.Y. 11360

Patient's Last Name _____ First Name_____

Date of Birth _____ Age _____ Sex: F M

Address _____ Apt. #____City _____ State _____ Zip _____County_____

Race: _____Language: _____

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Mother's Information _____ DOB _____ Cell Phone_____

Father's Information_____ DOB _____ Cell Phone_____

Patient lives with: _____

Parents are: Married Divorced Separated Other

Primary Medical Insurance

Policy Holder Name _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____Patient's Policy # _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Emergency Contact: _____ Phone #: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Bayside Pediatric Specialists, P.C. notice of privacy practice.**

Responsible Party Signature: _____ *Date:*

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Patient Name: _____ DOB: _____ Date: _____

Pharmacy Name (Include Address &/or Phone)

_____

ALLERGIES? ☐ **No Allergies**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

☐ **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Birth History: **Full Term** **Pre Term** **Vaginal** **C-Section**

Weeks Gestation: _____ Complications: _____ Birth Weight: _____

Circle one: Breast or Bottle fed

Mothers Occupation: _____

Father's Occupation: _____

Siblings: _____

Family Health History (High BP, Diabetes, Cancer, Etc.)

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

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NOTICE OF PRIVACY PRACTICES
Patient Acknowledgement

Patient Name: _____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, mu individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

A statement that this practice is required by law to maintain the privacy of protected health information.
A statement that this practice is required to abide by the terms of the notice currently in effect.
Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations. A description of each of the following purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization. A description of uses and disclosures that are prohibited or materially limited by law. A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization. My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event to such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information this maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____

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Patient's Last Name _____ First Name_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.
Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; **A cancellation fee of $25 may then be added to your account**.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment with the specialist and have it with you at the time of your visit. Please do not request referrals last minute.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Bayside Pediatric Specialists, P.C. will not be involved with separation or divorce disputes.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER CARD and AMEX.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security No.
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York and/or New Jersey State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV- related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450 or the New Jersey Division on Civil Rights (973) 977-4500. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THEN ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from *(insert date)* _____ to *(insert date)* _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials *Name of individual health care provider*

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ❑ Other: _____	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Patient Financial Responsibility & Authorization Form

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However the patient is required to provide the most correct and updated information regarding insurance.
- If your insurance requires a PCP, make sure one of our doctors is selected as your child's primary care physician.
- Patients are responsible for payment of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These changes may include:
    - Charges for returned checks - $25.00
    - Charges for copying and distribution of patient medical records.
    - Charges for form preparation or completion.
- The patient/guardian of a minor is responsible for payment of the minor's account balance. A minor, who is not accompanied by a parent or legal guardian, will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Bayside Pediatric Specialists.
- Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Bayside Pediatrics Specialists has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered.

By my signature below, I hereby authorize assignment of financial benefits directly to Bayside Pediatric Specialists for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient's Name: _____ DOB:_____

Responsible Party Signature:_____ Date:_____

Print Name: _____ Relationship: _____