



Child and Adolescent Health Specialists, PC
 223 Chief Justice Cushing Highway, Suite 201
 Cohasset, MA 02025
 T. 781.383.8380
 F. 781.930.1791

PLEASE CHECK YOUR PRIMARY CARE PHYSICIAN:

- Jocelyn R. Healey, MD, FAAP
 Arlene Dijamco, MD, FAAP

**GENERAL PEDIATRICS
 PATIENT REGISTRATION FORM**

Child's First	Middle	Last Name	Date of Birth	Age	Sex
Street Address		City	State	Zip	
Preferred Phone # (for office to contact you)		How did you hear about us? <input type="checkbox"/> Mailing <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Physician _____		<input type="checkbox"/> Family/Friend _____	
Mother's Name		Father's Name		Parent's Marital Status S M D W	
Legal Guardian (if different from above) – If other than parent, you must provide legal documentation					
Parent/Guardian Street Address (if different from above)		City	State	Zip	
Parent/Guardian Home Phone #		Cell Phone #	Work Phone #	E-mail Address	
Next of Kin/Emergency Contact Name			Relationship	Telephone #	

PRIMARY INSURANCE COMPANY – EFFECTIVE DATE _____

Name of Insurance Company		Policy ID #		Group #	
Street Address		City	State	Zip	
Name of Policy Holder		SS #	Date of Birth	Relationship to Insured	
Employer Name and Address					

SECONDARY INSURANCE COMPANY – EFFECTIVE DATE _____

Name of Insurance Company		Policy ID #		Group #	
Street Address		City	State	Zip	
Name of Policy Holder		SS #	Date of Birth	Relationship to Insured	
Employer Name and Address					

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Signature _____

Date _____

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PATIENT HISTORY FORM

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Child's Name		Date of Birth	Today's Date				
Child lives with: (check one) <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	Language Spoken at Home: _____ Religious Preference: _____	Please Rate this Child's Health: (check one) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor					
Names of Siblings		Date of Birth					
_____		_____					
_____		_____					
_____		_____					
_____		_____					
Please check any conditions that this child or any blood relative has:							
	Child	Relative	Comments		Child	Relative	Comments
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature birth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Growth problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poor nutrition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema / skin problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning disability / ADD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Socialization problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia / blood problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	School problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Name of Previous Physician							
Name of Person Completing this Form						Relationship to Child	

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CONSENT FORM

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**CONSENT TO TREAT A CHILD
IN THE ABSENCE OF A PARENT OR LEGAL GUARDIAN**

We encourage and prefer that you, the parent or legal guardian, bring your child to all appointments with the pediatrician. You know the most about your child and this knowledge may be crucial for the pediatrician to deliver the best care possible.

Unfortunately, you may not always be able to bring your child for an urgent appointment. So that we may treat your child when she/he is accompanied by someone other than you, the parent or legal guardian, please complete the consent form below. Without your consent, we may refuse to treat your child for anything less than a very serious, life-threatening emergency.

If the pediatrician feels that your child's life is in danger, he or she will provide the necessary care without this consent.

*** PLEASE NOTE: A PARENT OR GUARDIAN MUST ACCOMPANY CHILDREN UNDER 18 YEARS OF AGE TO ALL HEALTH SUPERVISION VISITS, DEVELOPMENTAL APPOINTMENTS AND IMMUNIZATION ADMINISTRATIONS.**

Thank you for your understanding and cooperation.

I, _____, give my permission to Child and Adolescent Health Specialists, PC to treat my child in the event that I am unable to be present.

Child's Name

Date of Birth

Signature of Parent / Legal Guardian

Date Signed

Mother's Name

Home Phone #

Work Phone #

Father's Name

Home Phone #

Work Phone #

Patient Eligibility Screening Form

Date _____

Child's Full Name _____

Date of Birth _____

Parent, Guardian, or Legal Representative's Full Name _____

Health Care Provider: Child and Adolescent Health Specialists, PC

This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office for (3) years. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes.

Verification of responses is not required.

Check only one box below

This child:

- is enrolled in Medicaid (includes Mass Health)
- does not have health insurance or is enrolled in the Children's Medical Security Plan
- is Native American (American Indian) or Alaskan Native
- has health insurance (paid for by parents, employers, or both)

Please note that all children seen in Massachusetts's practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program (first three boxes) and which get vaccines paid for by state and other federal funds (last box).

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NOTICE OF PRIVACY PRACTICES

GENERAL PEDIATRICS
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HIPAA PRIVACY PRACTICES

- A. We have a legal duty to protect health information about you.
- B. We may use and disclose Protected Health Information or “PHI” about you in the following circumstances:
1. We may use and disclose PHI about you to provide health care treatment to you.
 2. We may use and disclose PHI about you to obtain payment for services.
 3. We may use and disclose your PHI for health care operations.
 4. We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
 5. You can object to certain uses and disclosures.
 6. We may contact you to provide appointment reminders.
 7. We may contact you with information about treatment, services, products or health care providers.
 8. We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

- C. You have several rights regarding PHI about you.
1. You have the right to request restrictions on uses and disclosures of PHI about you.
 2. You have the right to request different ways to communicate with you.
 3. You have the right to see and copy PHI about you.
 4. You have the right to request amendment of PHI about you.
 5. You have the right to a listing of disclosures we have made.
 6. You have a right to a copy of this notice.
- D. You may file a complaint about our privacy practices.
- E. For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today’s date: _____

Patient’s Name: _____

Parent/Guardian Signature: _____

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NOTICE OF OFFICE CODES

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Office Procedure Codes

The following is a list of our most commonly applied insurance codes for General Pediatric office visits. Codes are based on the type and duration of appointment scheduled. Our fees are based on industry standard Medicare rates. Our rates are reasonable and competitive with other practices similar in scope and nature. **Please note this is not an inclusive list.** Codes may change yearly. Reimbursement for any code is at the discretion of each individual insurance carrier, and can vary within plans based on employer choice. We do not know what each individual plan will cover. If you have any questions or concerns, please contact your insurance provider.

General Pediatric Codes:

If your child is seen in follow-up for treatment or for a sick visit, the following codes would apply:

Evaluation and Management, new patient (99202-99205)
Evaluation and Management, established patient (99212-99215)
Nurse Only Visit, new patient (99201)
Nurse Only Visit, established patient (99211)

General Pediatric **Health Supervision Visits (HSV)** are performed within the first week of newborn nursery discharge, at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and then annually until age 22. Some insurance providers will not reimburse for all Health Supervision Visits. Others will reimburse only up to a certain age. Still others will pay only a portion of the charges. Please check with your insurance provider if you are unsure of your coverage. You are responsible for non-covered charges.

HSV, new patient (99381-99385)
HSV, established patient (99391-99395)

***Vision Screening** (99173)

***Otoacoustic Emissions Hearing Test**, diagnostic (92588)

*A vision and hearing screening exam (99173, 92588) will be performed at each HSV beginning at age 3 yrs. This is in addition to the examination. Please contact your insurance carrier if you are unsure if this is a covered charge.

Immunization Codes:

Certain immunizations are supplied by the state of Massachusetts at no cost to the patient or insurance provider. Other vaccines are purchased by this practice and will need to be reimbursed by your insurance provider. Please check with your insurance provider if you are unsure of your coverage.

Administration fees are charged in addition to the cost of the immunizations (90471-90474, 90465-90468)

Other General Pediatric Codes:

EKG (93000)
Laceration Repair (11201-12011)
Rapid Strep Test (87880)
Tympanometry (92567)

This list is representative and not inclusive. I understand that these or other applicable codes may not be covered by my insurance and, if not, I am responsible for payment in full.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____