Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Highway, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

PLEASE CHECK YOUR CHILD'S PRIMARY CARE PHYSICIAN:

- ❑ **Jocelyn R. Healey, MD, FAAP**
- ❑ **Nicola J. Smith, MD, FAAP**
- ❑ **Corinne M. Conroy, MD, FAAP**
- ❑ **Katherine A. Trier, 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? ❑ Mailing ❑ Newspaper ❑ Internet ❑ Other ___________ ❑ Physician ________________________ ❑ Family/Friend ________________________			
Ok to leave messages Voice ❑ or Text ❑	Email address for Office News and Updates and other correspondence			
Parent A.Mother's Name (Father if 2 dad family)	Parent B. Father's Name (Mother if 2 mom family)		Parent's Marital Status S M D W	
Legal Guardian (if different from above) or if divorced, who has legal and physical custody (Legal documentation required if not joint custody)				
Parent/Guardian Street Address (if different from above)	City		State	Zip
Parent/Guardian Home Phone # if applicable	Mother's Cell Phone #	Father's Cell Phone #	Work Phone # if ok to call	
Next of Kin/Emergency Contact Name		Relationship	Telephone #	

PRIMARY INSURANCE COMPANY – EFFECTIVE DATE _____________

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

SECONDARY INSURANCE COMPANY – EFFECTIVE DATE _____________

Name of Insurance Company		Policy ID #		Group #
Claims Address	City	State	Zip	Telephone #
Name of Policy Holder	Date of Birth	Relationship to Insured		Effective Date
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 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 my health insurance carrier(s), its agents or any other insurance company to determine the benefits payable for related services.

Signature ____ Date ___________________

Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

PATIENT HISTORY FORM

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

Child's Name	Date of Birth	Today's Date

Child lives with: (check one)	Language (s) Spoken at Home:	Please Rate this Child's Health: (check one)
❑ Both parents	______________________	❑ Excellent
❑ Mother	Ethnicity: ______________________	❑ Good
❑ Father	Religious Preference: ______________________	❑ Fair
❑ Other ______________	Race: ______________________	❑ 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	❑	❑	________	Diabetes	❑	❑	________
Premature birth	❑	❑	________	Thyroid disorders	❑	❑	________
Frequent ear infections	❑	❑	________	Growth problems	❑	❑	________
Asthma / wheezing	❑	❑	________	Poor nutrition	❑	❑	________
Eczema / skin problems	❑	❑	________	Hearing loss	❑	❑	________
Allergies	❑	❑	________	Eye problems	❑	❑	________
Sinus trouble	❑	❑	________	Migraines	❑	❑	________
Pneumonia	❑	❑	________	Seizures	❑	❑	________
Tuberculosis	❑	❑	________	Alcoholism	❑	❑	________
Heart disease	❑	❑	________	Substance abuse	❑	❑	________
High blood pressure	❑	❑	________	Depression	❑	❑	________
High cholesterol	❑	❑	________	Psychiatric disorder	❑	❑	________
Urinary tract infections	❑	❑	________	Learning disability / ADD	❑	❑	________
Kidney problems	❑	❑	________	Socialization problems	❑	❑	________
Anemia / blood problems	❑	❑	________	School problems	❑	❑	________
Cancer	❑	❑	________	Other	❑	❑	________

Name of Previous Physician	
Name of Person Completing this Form	Relationship to Child

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

CONSENT FORM

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

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. <u>Without your consent, we may refuse to treat your child for anything less than a very serious, life-threatening emergency.</u>

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/Parent A's Name **Home Phone #** **Cell/Work Phone #**

______________________ ________________ ________________
Father/Parent B's Name **Home Phone #** **Cell/Work Phone #**

MASSACHUSETTS IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

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).

Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

NOTICE OF PRIVACY PRACTICES

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

HIPAA PRIVACY PRACTICES

This is a summary of how we use and disclose your Protected Health Information. Please read the full Notice of Privacy Practices available on our web site or at our front desk or request a copy to be mailed to you, prior to signing this form.

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: ***see full Notice of Privacy Practices for examples***

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 by voice message, text or email.
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. A copy of the full description of Child and Adolescent Health Specialists, PC privacy practices has been made available to me. I understand my rights and how my protected health information can be used by Child and Adolescent Health Specialists, PC.

F. 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: ____

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

NOTICE OF OFFICE CODES

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

Billing for General Pediatrics

Our office will submit claims to the insurances with which we are contracted, which includes most major health insurances. **We are not contracted with all insurances and we are not providers in limited network plans.** You can verify we are in your specific plan network on your insurance website ("Find a Doctor") or by calling your member services department.

The following is a list of our most commonly applied insurance codes for General Pediatric office visits, which we use to bill your insurance. This list is provided to assist you if you have questions about what is covered by your insurance. ***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.

If you have a deductible, please be aware of what is covered. Deductibles may apply to all charges or only to certain types, e.g. labs, diagnostics, procedures, hospitalizations. If you have any questions or concerns please contact your insurance provider **prior to your appointment**. Your insurance company is required to inform you of your financial responsibility within 2 business days of your request.

General Pediatric Codes:
If your child is seen for a sick visit or in follow-up for treatment, the following codes would apply:
Evaluation and Management, new patient (99201-99205) established patient (99211-99215)

General Pediatric **Health Supervision Visits** (HSV) are performed within the first week of newborn nursery discharge, and then at the following ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and then annually until age 22.

HSV, new patient (99381-99385) HSV, established patient (99391-99395)
*Vision screening (99713, 99177) hearing screening (92587) and developmental/emotional/behavioral screenings (96127,96110, 96160, 96161) will be performed at most HSVs beginning at age 3 yrs. in addition to the examination. (92587 may apply to deductible). Multiple units of (96110, 96127) will be administered at certain ages. Some insurances only pay for 1- additional fee is patient responsibility. Urine and blood tests are ordered routinely at certain ages and may apply to your deductible.

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.
Fees to administer immunizations are in addition to the cost of the immunizations (90471-90474, 90460,90461)

Other General Pediatric Codes: Laceration Repair (11201-12011) Rapid Strep Test (87880) Wart Removal (17110) Mental health screenings (96127) Fluoride application (99188)

I understand that these or other applicable codes may not be covered by my insurance or may be subject to my deductible/coinsurance and if not paid by my insurance, I am responsible for payment in full. A copy of the *Office Financial Policies* has been made available to me via the website. I understand that Balances are due upon receipt and are subject to a $10 billing fee if payment or a payment plan is not addressed within 30 days; Returned checks incur a $25 fee; Appointments not cancelled with 24 hours' notice during business hours, are subject to a $50 fee, $15 for Immunization appointments not canceled with 24 hours' notice during business hours. Divorce has no bearing the responsibility for medical care for your child. Whoever schedules or brings the child is responsible for payment of any balance for that appointment.

Child's Name____

Parent/Guardian Signature: ____ Date:___________________

Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

EMAIL CONSENT FORM

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

Risks of using E-Mail

Child and Adolescent Health Specialists, PC offers patients/parents the opportunity to communicate by e-mail with certain limitations. Transmitting patient information by e-mail, however, has a number of risks that patients/parents should consider before using e-mail. These include, but are not limited to the following:

1. E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
2. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
3. E-mail senders can easily misaddress an e-mail.
4. Email can, for various reasons, be delayed or even undelivered to the intended recipient.
5. E-mail is easier to falsify than handwritten or signed documents.
6. Back-up copies of e-mail may exist even after the sender or the recipient has deleted his or her copy. Most electronic data can be retrieved these days even when you think it has been deleted.
7. Employers and on-line services have a right to inspect and archive e-mails transmitted through their systems. Therefore, we strongly advise not using your work e-mail as your employer or other employees could have access to your/your child's medical information.
8. E-mail can be intercepted, altered, forwarded or used without authorization or detection.
9. E-mail can be used to introduce viruses into computer systems.
10. E-mail can be used as evidence in court.

Conditions for the use of E-mail

Child and Adolescent Health Specialists, PC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. Child and Adolescent Health Specialists will enable you to send emails through our patient portal, which is a direct connection into our electronic medical system. This is the safest method of electronic communication available to us. In the event certain documents are unable to be transmitted through the portal, your consent below allows us to send e-mails directly through our e-mail service. Any e-mail which includes patient medical information will be sent by us in an encrypted, password protected manner. This does not include appointment reminders or acknowledgements which will be sent via encrypted e-mail, without password protection. However, because of the risks outlined above, Child and Adolescent Health Specialists cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for the improper disclosure of confidential information that is not caused by intentional misconduct. Thus, patients must consent to the use of e-mail for patient information subject to the terms and conditions described in this consent form. Consent to the use of e-mail includes agreement with the following terms and conditions:

1. Certain issues can only be appropriately addressed through an office visit. You will be informed if a physician believes a particular issue is not appropriate for e-mail and can only be appropriately addressed by an office visit.
2. All e-mails to or from you concerning diagnosis or treatment will be made part of the patient's medical record, and may be printed out and kept in hard copy form in the patient's medical record. Because they are

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

EMAIL CONSENT FORM

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

3. Child and Adolescent Health Specialists may forward e-mails internally to staff and agents as necessary for diagnosis, treatment, reimbursement or other handling. Child and Adolescent Health Specialists will not, however, forward e-mails to independent third parties (e.g. school, therapists) without the patient's/parent's prior written consent, except as authorized or required by law.
4. Although Child and Adolescent Health Specialists will endeavor to read and promptly respond to an e-mail from you, we cannot guarantee that any particular e-mail will be read within any particular period of time. Thus, you shall not use e-mail for medical emergencies or other time-sensitive matters, or to seek medically necessary treatment for you or any family member.
5. If your e-mail requires or invites a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the e-mail and when they will respond.
6. You should not use e-mail for communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
7. You are responsible for informing Child and Adolescent Health Specialists of any types of information you do not want to be sent by e-mail, in addition to those set out above.
8. You are responsible for protecting your password or other means of access to e-mail. Child and Adolescent Health Specialists is not liable for breaches of confidentiality caused by you or any other third party.
9. Child and Adolescent Health Specialists shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
10. It is your responsibility to follow up and/or schedule an appointment if warranted.
11. Child and Adolescent Health Specialists reserves the right to stop e-mail communications with you, or with all patients, at any time.
12. Parental authorization to access the patient portal expires on a child's 18th birthday.

Instructions - To communicate by e-mail, the patient/parent shall:

1. Log into our patient portal to send e-mail to Child and Adolescent Health Specialists.
2. Limit or avoid use of your employment e-mail address.
3. Inform Child and Adolescent Health Specialists of changes to your e-mail address.
4. Put patient's name in the body of the e-mail.
5. Include the category of the communication in the e-mail's subject line, for routing purposes. (e.g billing question, appointment request)
6. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Child and Adolescent Health Specialists.
7. Acknowledge that you received an e-mail from Child and Adolescent Health Specialists by confirming receipt.
8. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding your computer password.
9. Withdraw consent only by e-mail or written communication to Child and Adolescent Health Specialists.

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

EMAIL CONSENT FORM

GENERAL PEDIATRICS
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP

Use of the patient portal is optional and will only be enabled if this signature page is returned to our office. No email communication may occur without this signed release. Upon receipt of this form, we will contact you to provide you with your user name and temporary password along with a link to the Patient Portal.

Acknowledgement

I acknowledge that I have read and fully understand the risks and conditions associated with the communication of e-mail between Child and Adolescent Health Specialists and me, and consent to the conditions outlined herein. In addition, I agree to the instructions that Child and Adolescent Health Specialists may impose to communicate with patients/parents by e-mail. Any questions I may have about e-mail communications with Child and Adolescent Health Specialists have been communicated to Child and Adolescent Health Specialists and have been answered to my satisfaction.

Release from Liability

I hereby indemnify and hold harmless Child and Adolescent Health Specialists, PC and its respective employees, agents, officers, directors, contractors and affiliates from any liability relating to or arising out of the loss of information transmitted or attempted to be transmitted by e-mail, any delay in e-mail transmission, any interception by unauthorized recipients, or breach of confidentiality or privacy resulting from technical or process failures of any nature, from any claim and/or liability relating to or arising out of any breach of my confidentiality or privacy which may result from the use of unencrypted e-mail, and from any other claim and/or liability relating to or arising out of the use of e-mail between me and my family members and Child and Adolescent Health Specialists, PC.

______________________________________ ___________________

Patient Name Date of Birth

_______________________________________ ____________________

Signature of Parent/Guardian Date
Or Patient if over 18 years (circle which)

____

Email address (please write legibly)

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

Robert F. Belknap, MD, MPH, FAAP
Jocelyn R. Healey, MD, FAAP
Nicola J. Smith, MD, FAAP
Corinne M. Conroy, MD, FAAP
Katherine A. Trier, MD, FAAP
Heather Henderson, LICSW

Permission to share information with your child's school or daycare

Any communication between our providers and school/daycare personnel requires your consent, including faxing a copy of your child's well visit form to school/daycare. At each visit our office will provide you with copies of your child's forms which the school needs to have on file. Occasionally, you may need us to send a form directly to their school/daycare. Your written consent is needed to allow us to do this.

I hereby give permission to the providers at Child and Adolescent Health Specialists , PC to share information about my child _____________________________________, with his/her school/daycare personnel, for the purposes of documentation or treatment by school/daycare personnel, to include copies of annual physical exam, vaccination history, medication forms (if administered at school/daycare), consents or excused absences for school or sports activities.

This form will remain in effect until it is rescinded in writing or until your child turns 18 years of age. Child and Adolescent Health Specialists has the right to deny the sharing of information if in their opinion it is not in the best interest of the child and/or providing this information would compromise their relationship with the child.

EXCLUSION of any reference to: drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment or specific learning issues will require a separate release to communicate with specific individuals.

Please list any personnel you wish to exclude from this list.

____

____ __________________
Child's name Date of Birth

____________________________________ ___________________
Signature of Parent/Guardian Date