Welcome to Child and Adolescent Health Specialists, PC. We look forward to meeting your family! Our providers and staff are dedicated to exceeding your expectations. We're confident you will be happy with the care we provide, which includes General Pediatrics, Developmental-Behavioral Pediatrics and Therapy if ever needed. You can learn more about our other providers and specialists by clicking thru the links on the home page.

Many of your questions can be answered through our website, www.childhealthspecialists.com, where you will find our office policies, forms and other resources. Any additional questions will be answered happily by one of our staff. You can call our main number, 781-383-8380 and follow the prompts (choose #3 to speak to a receptionist). If our staff are on other calls, you will have the option to hold or to leave a voice message. Your call will be returned shortly in order of urgency with nonurgent calls by the end of the day.

We expect to be able to extract most of your children's information from their current medical record but would like to assure we have accurate and up to date information, so we are requesting you complete a registration packet for each child for our practice.

We are hoping to make this as seamless a process as possible. Once we receive these forms, we will register your children as Dr. Martin's patients, and will call you to schedule your child's next appointments. At this time, we can also register you for the Patient Gateway aka MyChart.

Please feel free to call us with questions. This packet can me emailed to cahs@drbelknap.com or faxed to 781-383-8382.

Welcome!
From Dr. Martin and all of us at Child and Adolescent Health Specialists

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
- ☐ Katherine A. Trier, MD, FAAP
- ☐ Susan C. Martin, MD MPH, 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	Parent A's Cell Phone #	Parent B'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_____________________

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PATIENT HISTORY FORM **GENERAL PEDIATRICS**

Child's Name	Date of Birth	Today's Date

Child lives with: (check one)

- ☐ Both parents
- ☐ Mother
- ☐ Father
- ☐ Other_______________

Language (s) Spoken at Home: ____________________________

Ethnicity: ____________________________

Religious Preference: ____________________________

Race: ____________________________

Please Rate this Child's Health: (check one)

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Names of Siblings	Date of Birth
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please check any conditions affecting child or any blood relative:

	Child	Relative	Details		Child	Relative	Details
Prematurity	☐	☐	__________	Diabetes	☐	☐	__________
Birth defects	☐	☐	__________	Growth/Thyroid problems	☐	☐	__________
Allergies	☐	☐	__________	Eating/weight problems	☐	☐	__________
Frequent ear infections	☐	☐	__________	Constipation	☐	☐	__________
Eczema / skin problems	☐	☐	__________	Sleep disorder	☐	☐	__________
Asthma/wheezing	☐	☐	__________	Headache/migraines	☐	☐	__________
Other respiratory problems	☐	☐	__________	Seizures	☐	☐	__________
High cholesterol	☐	☐	__________	Alcohol/substance abuse	☐	☐	__________
High blood pressure	☐	☐	__________	Depression/Anxiety	☐	☐	__________
Heart disease/heart attack	☐	☐	__________	Bipolar/mood disorder	☐	☐	__________
Hearing loss	☐	☐	__________	Other psychiatric disorder	☐	☐	__________
Visual problems	☐	☐	__________	ADHD/learning problems	☐	☐	__________
Urinary tract infections	☐	☐	__________	Autistic disorder	☐	☐	__________
Kidney disease	☐	☐	__________	Behavior problems	☐	☐	__________
Anemia / blood problems	☐	☐	__________	Social problems	☐	☐	__________
Cancer	☐	☐	__________	Other	☐	☐	__________

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

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CONSENT FORM **GENERAL PEDIATRICS**

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/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).

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NOTICE OF PRIVACY PRACTICES **GENERAL PEDIATRICS**

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: ____

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NOTICE OF OFFICE CODES **GENERAL PEDIATRICS**

Billing for General Pediatrics

Our office will submit claims to our contracted insurances, which includes most major health plans.
We are not contracted with all insurances. We are not providers in limited network plans.
Third party or other alternative plans including First Health/Coventry, PHCS/Multiplan, Trustmark are considered out of network unless/until an individual agreement for your family is in place. You are responsible for the portion of our charges not covered by your insurance. If you have MassHealth Insurance you must be in the MGB ACO plan regardless of whether MassHealth is primary or secondary.
You may verify whether we are in your specific plan network on your insurance website ("Find a Doctor") or by calling the member services number on your card.

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.*** We are not able to determine all services or procedures will be needed prior to your appointment.

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. We submit labs to Quest lab unless you are sent to SSHospital or BCH lab at the Stetson Building. If you have any questions or concerns, please contact your insurance provider **prior to your appointment to avoid surprise costs to you**.

General Pediatric Codes:
If your child is seen for a "sick visit" (illness, injury, health concern,), or in follow-up for treatment, the following codes would apply:
Evaluation and Management, new patient (99201-99205) established patient (99211-99215)
Telehealth calls Provider: 99441,99442,99443, Telehealth Nurse 98966,98967,98968

General Pediatric **Health Supervision Visits** (HSV/Well child) 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) will be performed at most HSVs beginning at age 3 yrs. in addition to the examination. (92587 may apply to deductible). Multiple units of screenings (96110,96127) for developmental/emotional/behavioral issues 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. **If an issue or concern is addressed by the provider at your/your child's well visit, billing guidelines require it to be billed as a "sick visit" and your copay and deductible rules will apply.**

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 that may apply to your deductible: Laceration Repair (11201-12011)
Wart/Molluscum treatment (17110, 17111)

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/charges 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: ________

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FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

STEP 1: (ONE PATIENT PER FORM)

PATIENT INFORMATION (REQUIRED)

PATIENT FULL LEGAL NAME: ______________________ **PATIENT DATE OF BIRTH:** ____________

PATIENT MEDICAL RECORD #: ______________________ **SEX:** ☐F ☐ M **AGE:** ________

PATIENT ADDRESS: STREET: ______________________ **APT.#:** ________

____

CITY: ______________________ **STATE:** ______ **ZIP CODE:** ________

FOR PATIENTS OVER THE AGE OF 13, CREATE A PG ACCOUNT FOR THE PATIENT ☐NO ☐YES
IF YES, PATIENT'S EMAIL ADDRESS: ______________________

(Note: for patients 13 to 17, a PCR must exist in order for the patient to have a PG account)

STEP 2: (ONE PCR PER FORM)

PATIENT CARE REPRESENTATIVE - PCR INFORMATION (REQUIRED)

PCR FULL LEGAL NAME: ______________________ **PCR DATE OF BIRTH:** ____________

PCR EMAIL: ______________________ **PHONE:** ______________

PCR ADDRESS IS *SAME AS PATIENT* **YES** **NO (ADDRESS BELOW)** **SEX:** ☐F ☐M

PCR ADDRESS: STREET: ______________________ **APT. #:** ________

____

CITY: ______________________ **STATE:** ______ **ZIP CODE:** ________

DOES PCR HAVE A PATIENT GATEWAY ACCOUNT? ☐ **NO** ☐ **YES**

IF YES, PATIENT GATEWAY USERNAME: ______________________

DOES PCR HAVE A MEDICAL RECORD NUMBER? ☐**NO** ☐**YES** **(IF YES, MRN:** ______________**)**

Authorization Received By: ______________________ Date: ____________

Approved By: ______________________

Clinic/Office: ______________________

PCR Identification:

☐License ☐State ID ☐Passport ☐Other Photo ID

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Authorization for Patient Care Representative Access to Patient Gateway application

Note: The information available in Patient Gateway is a subset of information contained in the legal health record. If at any time information is needed for legal or other purposes and/or a full copy of the Patient's Medical record is needed, please contact the patient's provider directly.

I (the Patient) understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare
- I understand that this authorization will remain in effect until one of the following occurs:
  - A patient 12 years or younger reaches the age of 13 years; a new authorization form is required
  - A patient reaches the age of 18 years; a new authorization form is required
  - Closure of account is requested in writing by the patient, their Legal Guardian, or Patient Care Representative
  - In the event of death of the patient or Patient Care Representative
- Partners, the patient, their Legal Guardian, and/or the patient's Patient Care Representative may elect to suspend or terminate authorization to Patient Gateway access at any time, for any reason

Patient Authorization for Release of Health Information to Patient Gateway Patient Care Representative

I have carefully read and understand the above, and have had any questions explained to my satisfaction.

Patient Care Representative Signature: ________________________________ **Date:** ____________

Print Name: ______________________ **Relationship to patient:** ___________________________

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to the person or agency listed above for the purposes of enrollment and utilization of the Patient Gateway application.

Patient's Signature: ____ **Date:** ___________

Print Patient's Name: ____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: ___________________________________ **Date:** ___________

Print Name: ______________________ **Relationship to patient:** ___________________________

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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