A New Day In Pediatrics

Child and Adolescent Health Specialists, PC

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS

Robert F. Belknap, MD, MPH, FAAP
Nicola J. Smith, MD, FAAP
Katherine A. Trier, MD, FAAP

About Developmental-Behavioral Pediatrics

Thank you for your interest in Developmental-Behavioral Pediatric Services at Child and Adolescent Health Specialists, PC. Dr. Belknap, Dr. Smith and Dr. Trier have many years of experience specializing in diagnosing and treating children with autism spectrum disorders, problems of attention/learning, many mood disorders, developmental delay and behavior problems associated with these issues. Dr. Belknap, Dr. Smith and Dr. Trier are certified as diplomates in Developmental-Behavioral Pediatrics by the American Board of Pediatrics.

For additional information see our website: www.childhealthspecialists.com

Insurance/Billing/Referrals

Our office will submit claims for Developmental-Behavioral appointments to the insurances with which we are contracted, including most major health insurances. You can verify we are in your specific plan network on your insurance website ("Find a Doctor") or by calling your member services department. *Please note we are contracted medical providers, **not** mental health.*

If your child is covered by any insurance that does not list our providers, we recommend that you call the insurance company to verify whether they will reimburse for these services as "out of network." In that case, you would be required to pay the full amount at the time of the appointment. We will give you a receipt with the appropriate codes to submit to your insurance company for reimbursement.

If your insurance is an **HMO**, you will need to obtain a referral from your primary care doctor (PCP). If you wish to be placed on our cancellation list for a sooner appointment, you may request that your doctor date the referral effective the day you call for it rather than the date of the appointment you were originally given. Otherwise, in the event that your appointment is moved to an earlier time, your primary care doctor would need to provide a new referral reflecting the new date. **If you do not have a referral on the date of your appointment, you will be required to pay for the visit in full in advance.** You may then submit our statement to your insurance company for reimbursement.

To bill any insurance company for a consultation appointment, a request from a professional is required. If you have an HMO, the referral from your child's PCP will serve as this request.

If your insurance is a **PPO**, we will need a written request for a consultation from the referring provider, whether this is your PCP, a therapist, teacher, etc. Please have the enclosed **Request for Consultation** form completed by your referring professional.

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

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Scheduling Appointments

To schedule an appointment, complete and return the enclosed registration packet as soon as possible*. We will review your information to determine the appropriate type and time for your appointment(s). Following review, our office will contact you to schedule your appointment(s).

Outside Testing/Reports

Please bring copies of any relevant information to our office on the day of your appointment (eg. IEP, most recent school testing or reports, other evaluations). Please bring copies, **not** originals. Our office will not be able to copy them for you and we will not be responsible for loss of the originals. If you wish to have copies of any materials that Dr. Belknap, Dr. Smith or Dr. Trier send home for completion (e.g. developmental questionnaires), please copy them **prior** to returning them to the office. We will not be able to copy them for you and originals must be kept as part of our medical records.

The First Consultation Visit

We recommend that children other than the one who is being seen for the appointment **not** accompany you to the appointment as this can be a significant distraction. Children must be over 8 years of age to remain in the reception room without adult supervision. Please set aside approximately 1 ½ hours for your initial consultation appointment.

All efforts are made to make your child's experience comfortable. A nurse will obtain measurements, vital signs, and typically will perform an evoked otoacoustic hearing evaluation, and a vision screening (3 years of age or greater).

Following your consultation appointment, a summary letter will be sent to the referring physician or other professional with a copy to the parents.

Please be aware that additional reports (e.g. letters to schools) are typically not covered by health insurance plans. Such requests will require payment in advance.

Neurodevelopmental Testing Appointments

The doctor may schedule your child for neurodevelopmental testing following your consultation. Please set aside approximately 1½ hours for this appointment. Note that this is not the same testing provided by schools for a school based evaluation and it is not a Neuropsychological Evaluation. Either of these may be recommended depending on the doctors findings.

***The registration forms should be filled out with black or blue ink as other colors will not show through fax or scanner.**

Please feel free to call our office if you have any additional questions or concerns.

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☐ **First Available**

PATIENT REGISTRATION FORM

Child's First	Middle	Last Name	Date of Birth	Sex

Street Address	City	State	Zip

Preferred Phone # (for office to contact you)	How did you hear about us? ❑ Physician ❑ Family/Friend ❑ Mailing ❑ Newspaper ❑ Internet ❑ Other _____
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 #	Parent A Cell Phone #	Parent B Cell Phone #	Work # 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	Type of Plan- HMO, PPO Deductible? Referrals Needed?

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	Type of Plan- HMO, PPO Deductible? Referrals?

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 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

Child's Name: _____ DOB: _____

Your Name: _____ Relation to child: _____

Child lives with: _____ Relation to Child: _____ DOB:_____

Language (s) Spoken at Home: _____

Ethnicity: _____ **Race:** _____

Referred by: _____

Has your child ever been seen by one of our specialists? Yes No If yes, when _____

Any Previous Evaluations / Testing? Yes No If yes,

Where: _____ Performed by:_____

When: _____

What did you learn from this? _____

Current or Previous Diagnoses: _____

Name of School / Daycare: _____

Address:_____

Is your child currently on an IEP or 504 plan? Yes No

Date of last school-based evaluation: _____

How would you rate your child's school performance at this time?

____ Good ____ Fair ____ Poor

Child's Primary Care Physician:_____

Address: _____

Telephone: _____

Current Medication(s): _____ Dose _____

_____ Dose _____

_____ Dose _____

Name of doctor who is currently managing medications: _____

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Please list previous medications and reason for discontinuation:

_____

_____

Is your child currently receiving or has s/he in the past received any services or therapies? (e.g. Speech, Occupational, Physical Therapies, ABA, other)
Please include dates, where performed, and frequency.

_____

_____

Has your child been seen or currently being followed by any other Specialists?
Yes No If so when, by whom:

_____

_____

Please indicate if your child has experienced any of the following:

Seizures	No	Yes	Weight loss or gain	No	Yes
Tics (repetitive movements or sounds)	No	Yes	Problems with urinating or with kidneys	No	Yes
Easy bleeding/bruising	No	Yes	Constipation or diarrhea	No	Yes
Heart beating “funny” or fast	No	Yes	Abdominal pain	No	Yes
Chest Pain	No	Yes	Rash or other skin problem	No	Yes
Difficulty breathing	No	Yes	Broken bone	No	Yes
Problems with hearing	No	Yes	Problems with vision	No	Yes
Problems with immune system	No	Yes	Recent febrile illness	No	Yes

To assist us in making an accurate assessment of your child’s issues, we need a detailed picture of your child’s development and behaviors. Please answer the following questions to the best of your ability. Completion of this detailed history will allow more time for discussion and observation during your appointment.

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Were there any concerns during the pregnancy? _____

_____

_____

Were there any medications taken besides iron and vitamins?

☐ Yes, Please list ☐ No

_____ _____ _____

Any alcohol ☐ Yes, Please list amount/frequency _____ ☐ No

Drugs ☐ Yes, Please list amount/frequency _____ ☐ No

Cigarettes ☐ Yes, Please list amount/frequency _____ ☐ No

Any particular stressors ☐ Yes ☐ No Please describe if yes _____

_____

_____

Was this pregnancy Full-term? ☐ Yes ☐ No _____

Type of delivery? _____ If C-section reason _____Birth weight? _____

Any troubles at the time of birth or while in the hospital? _____

_____

_____

After coming home, what was your child like as a baby? _____

_____

Any feeding issues or colic? _____

Any trouble establishing rhythms of eating and sleeping? _____

_____

Any problems with typical milestones such as sitting, standing, or walking? _____

_____

Did s/he babble (e.g. *dada, baba*) before 12 months? ☐ Yes ☐ No

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How old when s/he said first word? _____ Put 2 words together? _____

When you called his/her name at 10 months of age, did s/he look at you? ☐ Yes ☐ No

Did s/he follow where you were pointing to an object of interest? ☐ Yes ☐ No

Did s/he point to objects of interest to him/her as he got a little older? ☐ Yes ☐ No

☐ Sometimes

Did s/he bring books or games to you to play with him/her after s/he learned to walk?

☐ Yes ☐ No

What was his/her play like when s/he was 18 months of age? _____

_____

Did s/he like miniatures such as toy kitchen sets, tool sets, farm animals, etc.? ☐ Yes ☐ No

Between 2 and 3 years of age did you see make-believe play begin? ☐ Yes ☐ No

Did you ever see him/her focus in an unusual way at a part of a toy such as a wheel or a

reflection of light on a toy? ☐ Yes ☐ No

Did s/he ever pass objects slowly in front of his/her eye or look at them only from the side?

☐ Yes ☐ No

Has your child ever displayed rituals or obsessions or other repetitive behaviors? ☐ Yes ☐ No

If yes, please describe and indicate age when first appeared:_____

_____

When did s/he feed himself independently with fork, cup and spoon? _____

When did s/he assist with dressing and undressing? _____

When was s/he toilet trained? _____

Any difficulties with learning how to use buttons, snaps and zippers? ☐ Yes ☐ No

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Did your child receive Early Intervention services (below 3 yrs) ☐ Yes ☐ No If so, what type of service and for how long? _____

_____

Did s/he go to preschool or daycare? ☐ Yes ☐ No

Were there any problems there? ☐ Yes ☐ No Was s/he able to follow a routine? ☐ Yes ☐ No

Did s/he show interest in what other children were playing? ☐ Yes ☐ No

Did s/he want to join in with their play after age 4? ☐ Yes ☐ No

Were there difficulties with the transition to kindergarten ☐ Yes ☐ No

Has s/he had any problems learning sounds associated with symbols such as letters and numbers? ☐ Yes ☐ No

Is s/he hypersensitive to touch (tags bother, sock line has to be "just right") ☐ Yes ☐ No

Is s/he either attracted to or repelled by any types of food including issues of texture, taste or smell? ☐ Yes ☐ No

Does s/he seek out physical play or pressure? ☐ Yes ☐ No

Is s/he hypersensitive to sounds? ☐ Yes ☐ No

Does your child strongly react to change, such as stopping a favorite activity to go in the car? ☐ Yes ☐ No

In general, have these problems improved over time? ☐ Yes ☐ No

Does s/he notice familiar routes in the car and comment on them? ☐ Yes ☐ No

Does s/he get upset if there is a deviation from the expected route/routine? ☐ Yes ☐ No

Does s/he have any intense interests (e.g. a subject that s/he knows everything about, or a topic that s/he persistently returns to in conversation or play)? ☐ Yes _____ ☐ No

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Does s/he have any difficulty socializing or making friends? ☐ Yes ☐ No

Are you concerned about her/his ability to play (eg. parties and playdates)? ☐ Yes ☐ No

Is s/he interested in sports? ☐ Yes ☐ No

Are you concerned about her/his motor coordination? ☐ Yes ☐ No

Does s/he understand facial expressions? ☐ Yes ☐ No

Can s/he carry on a typical back and forth conversation? ☐ Yes ☐ No

Do you have any concerns about his/her diet? ☐ Yes _____ ☐ No

Does s/he eat breakfast? ☐ Yes ☐ No

Are there any problems with elimination (e.g. urinating/defecating)? ☐ Yes _____ ☐ No

Does s/he have any allergies? ☐ Yes _____ ☐ No

Has s/he ever lost consciousness or had a serious head injury? ☐ Yes ☐ No
If Yes give details:_____

Please explain any visits to the emergency room or surgeries: _____

_____

_____

Have there ever been any unusual episodes in which you thought s/he was "not there" or possibly having a seizure? ☐ Yes ☐ No

What time does your child get into bed at night? _____

How long does it take him/her to fall asleep? _____

Does s/he routinely wake up during the night? ☐ Yes _____ ☐ No

Is s/he a restless sleeper? ☐ Yes ☐ No

Does s/he snore? ☐ Yes ☐ No

Have you ever thought that s/he might have stopped breathing during sleep? ☐ Yes ☐ No

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At what time does s/he usually wake up in the morning? _____

Does s/he seem rested in the morning? ☐ Yes ☐ No

How long have you lived in your present home and community? _____

Are there any particular stresses at home? _____

_____

_____

_____

Who lives in the home and what is their relation to your child? _____

_____

_____

Parent A age/education/occupation: _____

Parent B age/education/occupation: _____

FAMILY HISTORY: Please indicate conditions that run in the family by writing the relation of the person to your child e.g. Maternal/Paternal grandmother, brother (include grandparents, aunts & uncles)

School Problems
No Yes _____
Attention Disorders
No Yes _____
Learning Disability
No Yes _____
Anxiety Disorders
No Yes _____
Tics/Tourette Syndrome
No Yes _____
Panic Attacks
No Yes _____
Depression
No Yes _____
Suicide Attempts
No Yes _____
Alcoholism
No Yes _____
Other Mental Health issues
No Yes _____

Autism/PDD/Asperger Syndrome
No Yes _____
Genetic Disorders
No Yes _____
Mental Retardation
No Yes _____
Seizures/Epilepsy
No Yes _____
Hereditary deafness or blindness
No Yes _____
Allergy/Asthma
No Yes _____
Heart disease before 50 years of age
No Yes _____
Unexpected/unexplained death
No Yes _____
Substance Abuse
No Yes _____
Any other problems of development
No Yes _____

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What specific questions or concerns do you wish to be addressed?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please Note: A parent or legal guardian must accompany any minor child to a developmental-behavioral pediatric appointment.

As a reminder, we recommend that children other than the one who is being seen for the appointments, not accompany you to the appointments as this can be a significant distraction. We realize sometimes this is not possible. In this case please bring something to occupy your child for approximately 1 1/2 hours.

Children must be over 8 years of age to remain in the reception room without adult supervision.

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NOTICE OF 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. ***See full Notice of Privacy Practices for instructions.*** Contact the Office Manager with questions or concerns.

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.

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

Patient's Name: _____

Parent/Guardian Signature: _____

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CANCELLATION and PAYMENT POLICY

Child's Name: _____ **Date of Birth:** _____

Due to the considerable time involved with Developmental Appointments, our office has developed the following Cancellation and Payment Policy:

- **Consultation and Testing appointment cancellations require 5 days notice during regular business hours, to avoid incurring a charge of $300.00.**
- **Follow Up appointment cancellations require *48* hours notice during regular business hours to avoid incurring a $150 charge.**

Calls for cancellations must be received during regular business hours Monday-Friday. Calls will not be accepted by the afterhours emergency answering service for cancellations.
Monday appointments must be cancelled by 5pm the preceding Friday.

An active credit card number is required to be kept on file with our PCI compliant secure gateway, to which we will bill all outstanding balances which may include deductible, copayment/coinsurance, appointments missed or cancelled without required notice, insurance denials for non-covered services, partial payment, no referral or inactive insurance.

Your signature below indicates that you authorize Child and Adolescent Health Specialists, PC to charge your credit card for patient balances as listed above. A receipt will be sent to you once your payment has been processed.

Credit Card to reserve your appointment time: Type: (circle one) MasterCard or Visa

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

CV # (3 letter code on back): _____

Cardholder's SIGNATURE: _____ **Date**: _____

* ***We cannot schedule your appointment until we have received pages 3-15.***

Upon receipt of **all pages** our office staff will contact you to schedule your appointment.

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Insurance and Billing Information:

Our office will submit claims for Developmental-Behavioral appointments to all insurances we are contracted with if you have a verifiable active policy.

The following is a list of our most commonly applied insurance codes for Developmental-Behavioral Appointments. *Please note this is not an inclusive list and may change without notice.* If you have any questions or concerns about what your insurance will pay, or **if you have a deductible plan**, please contact your insurance provider's member services department for ***medical services*** prior to scheduling your appointment (s). Your insurance is required to inform you of your responsibility for services within 2 business days of your request. Please call our office if your insurance denies any of the codes listed below. By signing this waiver you understand that you are responsible for payment of non-covered procedures and insurance determined balances and agree to payment via your credit card on file.

Developmental Behavioral Pediatrics Codes:
Consultation visit:
Developmental-Behavioral Consultation, new patient (99245,99244) or (99205+99354/9355 for Blue Cross, Fallon, MassHealth-consultation codes not covered) 99354/9355 not covered by BC, Mass Health.
Otoacoustics Emissions hearing screening (92587) Vision screening (99173)
Assessment and screening questionnaires (96127,96110, 96160, 96161) more than one screening may be administered, insurance may only pay for 1, or charge to deductible, any not covered are patient/parent responsibility)
Neurobehavioral Testing Appointment
Developmental Testing (96116/**96121** or 96112/**96113**) #units may exceed allowed and not be covered.
Parent Conference Office visit codes - 99214 or 99215
Follow up appointments Office visit codes 99213, 99214, 99215.
Prolonged visit code - if your parent conference or follow up appointment runs longer than 40 minutes (99354,99355) ***Not covered by certain insurances***- BC, HP, MassHealth, others
Review of records outside of your appointment time (99358) ***Not covered by certain insurances***

Please be aware that review of records outside of your appointment time, requests for telephone consultations with parents, therapists, or school personnel and **additional** reports (e.g. letters to schools) will not be covered by your insurance and will require payment in advance.

This list is representative but not inclusive **I understand that these or other applicable codes may not be covered by my insurance or may be subject to my deductible and if not paid by my insurance, I am responsible for payment in full. I understand I may contact my insurance prior to my appointment to verify coverage for these services, otherwise they will become my responsibility.** 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 or declined charges will incur a $25 fee.

Child's Name: _____ Date: _____

Parent/Guardian Signature: _____

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REQUEST FOR CONSULTATION

(This form applies ONLY if your INSURANCE is a PPO)

To bill any insurance company for a consultation appointment, a written request from a professional in a related field is required.

If your insurance is an HMO, the referral from your child's PCP will serve as this request and this form does not need to be completed.

If your insurance is a PPO, please have this **Request for Consultation** form completed by your **referring professional** (eg. your PCP, a therapist, teacher, etc.).

To: Robert F. Belknap, MD, MPH / Nicola J. Smith, MD/ Katherine A. Trier, MD

From: (professional requesting consultation) _____

Address: _____

Phone: _____ Fax: _____

Date:

Patient:

DOB:

Reason for consultation:

Pertinent history:

Signature of requesting provider: _____

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PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

PATIENT CARE REPRESENTATIVE (PCR)
ACCESS AUTHORIZATION FOR PATIENT GATEWAY APPLICATION

Practice/Provider: (or Stamp with Practice/Provider Information)
Child and Adolescent Health Specialists
223 Chief Justice Cushing Hwy
Ste 201
Cohasset, MA 02025

Step 1: One Patient per form – Print Legibly

PATIENT INFORMATION (REQUIRED)

PATIENT FULL LEGAL NAME:

LAST: FIRST:

PATIENT DATE OF BIRTH: SEX: F M AGE

PATIENT ADDRESS: STREET:

APT # CITY:

STATE: ZIP CODE:

FOR PATIENTS OVER THE AGE OF 13, CREATE A PG SELF ACCOUNT FOR TEEN? 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 self account. A self account generates a user ID for the teen to log in.)*

Step 2: One PCR per form – Print Legibly

PATIENT CARE REPRESENTATIVE - PCR INFORMATION (REQUIRED)

PCR FULL LEGAL NAME:

LAST: FIRST:

PCR DATE OF BIRTH: SEX: F M

PCR EMAIL:

PCR PHONE:

PCR ADDRESS: (IF DIFFERENT FROM ABOVE) SAME

PCR ADDRESS: STREET:

APT # CITY:

STATE: ZIP CODE:

HAVE THERE BEEN ANY CHANGES TO NAME OR ADDRESS IN THE PAST 12 MONTHS?

NO YES _____

DOES PCR HAVE A PATIENT GATEWAY ACCOUNT? NO YES

IF YES, USERNAME:

Authorization Received & Approved by: _____ Date: _____

PCR Identification Verification:

License State ID Passport Other Photo ID

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

CHILD/ADULT

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:** _____

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:** _____

TEENS

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:** _____

Patient Care Representative Signature: _____ **Date:** _____

Print Name: _____ **Relationship to patient:** _____