PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.

117 W. Liberty Street
Rome, NY 13440
(315) 339-0401
Fax (315) 339-2957

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child's Name:_____ DOB:_____

Address: _____

I hereby authorize Pediatric & Adolescent Medical Associates, P.C. to

*1. Obtain my child's individually identifiable health information from:

_____
(Doctor or Hospital)

_____
(Address) (Fax #)

*2. Information to be sent / obtained:

___ Complete health record
___ Immunization record only
___ Other (specify information & dates): _____
___ Laboratory tests
___ X-ray reports

_____

*3. Reason for disclosure: _____ Transferring Records _____ Consultation with above physician

Other: _____

*4. This authorization will remain in effect for (check one only)

_____ The period necessary to complete the above transaction _____ One year _____ 90 days

*Parent/Guardian Signature _____ Relationship_____ Date_____

Patients age 18 & up Signature _____ Self _____ Date _____

5. Separate authorization is required for the release of information related to the items below. Initial each line if required.

___ AIDS or HIV care
___ Behavioral health services/psychiataric care
___ Alcohol or drug treatment
___ Pregnancy, contraceptives & sexually transmitted diseases
___ Other_____

Parent/Guardian Signature _____ Relationship_____ Date_____

Patients age 18 & up Signature _____ Self _____ Date _____

For release of information in item 6 only.

6. I understand this authorization may be revoked in writing at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: Compliance Officer, Pediatric & Adolescent Medical Associates, 117 W. Liberty Street, Rome, NY 13440.
7. The recipient of the above information might disclose it to other people. PAMA has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.
8. By signing this authorization, I release & agree to indemnify & hold harmless PAMA, its successors and assigns, and its agents & employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.
9. I understand I do not have to sign this authorization. My failure or refusal to sign will not affect your child's treatment at PAMA.

*Must be answered to be a valid authorization to disclose information.

PATIENT'S NAME _____ **BIRTHDATE** _____

__ Male __ Female Insurance Company _____ ID# _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE (____) _____ Cell __ or Home __

MOM CELL PHONE (____) _____ DAD CELL PHONE (____) _____

EMAIL: _____

MOTHER'S NAME _____ **DOB** _____ **SS#** _____

ADDRESS (if different than above) _____

MOTHER'S EMPLOYER _____OCCUPATION _____

EMPLOYER'S ADDRESS & PHONE _____

FATHER'S NAME _____ **DOB** _____ **SS#** _____

ADDRESS (if different than above) _____

FATHER'S EMPLOYER _____OCCUPATION _____

EMPLOYER'S ADDRESS & PHONE _____

FOSTER PARENT / GUARDIAN NAME _____ **DOB** _____

HOME ADDRESS _____ PHONE _____

EMPLOYER'S NAME / PHONE _____

I have read, understand, and authorize the disclosures / consents on the back of this form.

Parent / Guardian Name (please print) _____

Parent / Guardian Signature _____

Relationship to Patient(s) _____ **Date** _____

Please list children with the same information on the back of this form.

Patient's Name _____ **Date of Birth** _____

__ Male __ Female Insurance Company _____ ID# _____

Patient's Name _____ **Date of Birth** _____

__ Male __ Female Insurance Company _____ ID# _____

Patient's Name _____ **Date of Birth** _____

__ Male __ Female Insurance Company _____ ID# _____

Patient's Name _____ **Date of Birth** _____

__ Male __ Female Insurance Company _____ ID# _____

Patient's Name _____ **Date of Birth** _____

__ Male __ Female Insurance Company _____ ID# _____

Disclosures & Consents

I understand that it is my responsibility to provide Pediatric & Adolescent Medical Associates (PAMA) with my child's most up-to-date contact information and insurance information.

Consent for Care: I hereby give my permission to the professional staff at PAMA to examine, provide treatment, refer, obtain records and/or perform any tests deemed necessary for the care of my child.

Assignment of Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to PAMA.
I understand that it is my responsibility to know my insurance benefits, and whether or not the services rendered are a covered benefit. I acknowledge that I am financially responsible for any copays at the time of service or unpaid balance after my insurance claim has settled. I also authorize PAMA to release any information required by my insurance company.

I authorize PAMA to mail or call me with communications regarding my child's healthcare, including, but not limited to such things as appointment reminders, referral arrangements, and laboratory results.
This authorization extends to my home answering machine and/or cell phone voice mail.

Notice of Privacy: I certify that I have received a copy of PAMA's Summary of Privacy Practices.
I understand that I may receive a copy of PAMA's Complete Notice of Privacy Practices upon request.

I understand that I may revoke my authorization at any time by notifying PAMA in writing.
The revocation will only be effective from the date it is received by PAMA, and will not apply retroactively.

We strive for a mutually trusting relationship with our patients and their families. Noncompliance with medical appointments or medical recommendations, rude or disruptive behavior, or nonpayment of bills may lead to discontinuation from our practice.

PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.
117 W. LIBERTY STREET
ROME NY 13440
(315) 339-0401

AUTHORIZATION FOR MEDICAL TREATMENT AND/OR IMMUNIZATIONS

NAME OF MINOR: _____

DATE OF BIRTH: _____

I, _____, being the parent or legal guardian of the above-named minor, do hereby give my permission for:

NAME: _____

ADDRESS _____

PHONE: _____

to act on my behalf in authorizing medical and surgical care, including immunizations, for the above-named minor.

_____ _____
Signature of Parent / Guardian **Date**

Phone number where I can be contacted: _____

This authorization will remain in effect until revoked by the parent or guardian.
If the above information needs to be changed, you are liable to notify Pediatric Associates as soon as possible.

PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.

No-Show Policy

(Effective January 1, 2022)

Thank you for entrusting us with your child(ren)'s medical care. When you schedule an appointment with our providers, we set aside an appointment time to provide your child(ren) with the highest quality care.

Should you need to cancel or reschedule an appointment, we ask that you contact us as soon as possible and at least 24 hours prior to your scheduled appointment. This allows us time to contact other patients who need care.

Effective January 1, 2022, any patient that No Shows **will be charged a $50 fee. This is an out of pocket fee that cannot be submitted to insurance for payment.**

In addition: Same-day cancellations are considered a no show and will be charged accordingly.

We reserve the right to collect this fee prior to scheduling your next appointment.

If there is a third No-Show in a 12 month period the family may be discharged from the practice.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.
117 W. Liberty Street
Rome NY 13440

THIS NOTICE IS A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION

This Summary Notice of Privacy Practices describes how our physicians, office staff and others outside our office that are involved in your child's care may use and disclose your child's protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your child's PHI. Protected Health Information is about your child, including demographic information, that relates to your child's past, present or future physical or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information: Your child's PHI may be used and disclosed for the purpose of providing health care services, to pay your child's health care bills, to support the operation of the physician's practice, and any other uses required by law.

Treatment: We will use and disclose your child's PHI to provide, coordinate or manage your child's health care and any related services. This includes coordination and management of your child's health care by a third party. For example, your child's PHI may be provided to a specialist to whom your child has been referred to ensure that the provider has the necessary information to diagnose and treat your child.

Payment: Your child's PHI will be used, as needed, to obtain payment for health care services.
For example, we may contact your health care insurer to verify that your child is eligible for benefits or we may use your child's PHI to bill you directly for services.

Health Care Operations: We may use or disclose, as needed, your child's PHI to operate our business. For example, we may call your child from the waiting room by name or use your child's PHI to remind you of an upcoming appointment. We may also disclose information to a medical school student who sees patients in our office.

Release of PHI to Family or Friends: We may release your child's PHI to a family member or friend who is involved in his or her care. For example, a parent / guardian may ask that a grandparent or babysitter bring their child to our office for a cold. In this example, the caregiver may have access to the child's medical information.

We may use or disclose your child's PHI in the following situations, among others, without your authorization: Public Health Issues as required by law: Vital Records such as births & deaths, Communicable Diseases, Abuse or Neglect, Food & Drug Administration requirements, Legal Proceedings, Law Enforcement, Organ Donation, Military Activity & National Security,
Worker's Compensation.

Your Rights Regarding Your Child's PHI:

You have the right to inspect and copy your child's PHI with the exception of psychotherapy notes, information compiled in reasonable anticipation of our use in a civil, criminal or administrative proceeding, and PHI that is prohibited by law.

You have a right to request a restriction of your child's protected health information. You may ask us not to use or disclose any part of your child's PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your child's PHI not be disclosed to family members or friends who may be involved in their case. Your request must state the specific restriction requested, and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you request. If the physician believes it is in your child's best interest to permit use and disclosure of PHI, the information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at work, rather than at home. Our practice will accommodate reasonable requests.

You have the right to request that your physician amend your child's PHI. Our office may deny your request for an amendment under certain circumstances. If we deny your request, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to request an accounting of certain disclosures we have made, if any, of your child's PHI. See our complete Notice of Privacy Practices to request an accounting of disclosures.

You have the right to file a complaint if you believe your child's privacy rights have been violated.
See our complete Notice of Privacy Practices on how to file a complaint.

You have the right to revoke any authorizations or restrictions you have placed on your child's PHI at any time, except to the extent that our practice has taken action in reliance on the use or disclosure indicated in the authorization or authorization.

Our office has between 10 to 60 days to honor your requests. All requests must be reviewed and approved by your child's physician. There may be a fee of .75 per page for copies.

This Notice is a Summary of how your child's PHI may be used and disclosed, and how you can get access to this information. You have the right to receive a paper copy of our complete Notice of Privacy Practices. A copy of our complete Notice of Privacy Practices is posted in our waiting rooms. You may ask us for a copy of the complete Notice at any time.