Pediatric Associates of Medford

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The physicians here at Pediatric Associates of Medford want to ensure that all aspects of your health and development are covered during your yearly physical visit, including your learning and development, moods and behaviors, growth, and social life and interactions. Forms such as the Y PSC-17 are important tools to help evaluate and care for our patients.

Your Name: _____

DOB: _____ **Today's Date:** _____

Please mark under the heading that best describes you:	**NEVER**	**SOMETIMES**	**OFTEN**
Fidgety, unable to sit still	☐	☐	☐
Feel sad, unhapy	☐	☐	☐
Daydream too much	☐	☐	☐
Refuse to share	☐	☐	☐
Do not understand other people's feelings	☐	☐	☐
Feel hopeless	☐	☐	☐
Have trouble concentrating	☐	☐	☐
Fight with other children	☐	☐	☐
Down on yourself	☐	☐	☐
Blame others for your troubles	☐	☐	☐
Seem to be having less fun	☐	☐	☐
Do not listen to rules	☐	☐	☐
Act as if driven by a motor	☐	☐	☐
Tease others	☐	☐	☐
Worry a lot	☐	☐	☐
Take things that do not belong to you	☐	☐	☐
Distract easily	☐	☐	☐

Patient Name_____Date of Birth_____

Today's Date_____Age_____

Please circle Yes or No

Anemia Risk Assessment Ages 4 months – 21 years

Some children are at risk for anemia at various ages under certain circumstances. Please circle your answer to the following questions *if they apply to your child.*

If your child is 4 months of age:

1. Was your child premature or low birth weight? ☐ Yes ☐ No

If your child is between 18 months and 5 years of age:

1. Does he/she have special health needs? ☐ Yes ☐ No
2. Does he/she eat a low iron diet (non-meat diet)? ☐ Yes ☐ No
3. Does he/she have limited access to food due to financial circumstances? ☐ Yes ☐ No

If your child is 6 years of age and up:

1. Is your child strictly vegetarian and not receiving an iron supplement? ☐ Yes ☐ No

If your child is an adolescent female:

1. Does she have heavy menses? ☐ Yes ☐ No

Oral Health Risk Assessment Ages 6 months – 6 years

1. Does your child drink tap water? ☐ Yes ☐ No
2. Do you live in Wilmington, Woburn, or a community, which does not have fluoridated tap water? ☐ Yes ☐ No
3. If your child is over 1 year of age, does he/she still use a bottle? ☐ Yes ☐ No
4. Do you brush your child's teeth at least twice per day? ☐ Yes ☐ No
5. Is the second time just before bedtime? ☐ Yes ☐ No
6. Do you allow your child to drink anything except water after he/she goes to bed at night? ☐ Yes ☐ No
7. Does your child routinely drink juice or soda? ☐ Yes ☐ No
8. Has a parent or primary care giver had active tooth decay or a cavity diagnosed in the last year? ☐ Yes ☐ No
9. Would you like your child to see a pediatric dentist at this time? ☐ Yes ☐ No

High Cholesterol/Triglycerides Risk Assessment Ages 2 years – 21 years

Children and adolescents should have a fasting lipid profile after age 2 but no later than 10 years of age if you answer yes to the questions below. The doctor will discuss the results with you at your child's next physical exam.

1. Is there a family history of high cholesterol and/or Triglycerides? ☐ Yes ☐ No
2. Is there a family history of premature cardiovascular disease? (<55 years for men or <65 years for women) ☐ Yes ☐ No
3. Are you unfamiliar with your child's family history? ☐ Yes ☐ No
4. Is the child's BMI >85th%? ☐ Yes ☐ No
5. Does the child have a diagnosis of high blood pressure? ☐ Yes ☐ No
6. Does the child smoke? ☐ Yes ☐ No
7. Does the child have diabetes? ☐ Yes ☐ No

OVER

Lead Poisoning Risk Assessment Ages 6 months – 6 years

Below is a questionnaire that helps us decide which children are at risk for lead poisoning. Lead poisoning can cause long-lasting severe effects on children such as seizures, brain damage, hyperactivity, stomachaches and anemia.

Massachusetts's policy is to obtain a lead test starting at age 1 and yearly after that until age 3 or 4. However, if your child is at a higher risk for lead poisoning screening may be done at 6 months of age and/or more often if needed.

1. a) Does your child live in or regularly visit a house built before 1960?	☐ Yes	☐ No
b) Does the house have peeling or chipping paint, plaster, or putty?	☐ Yes	☐ No
2. a) Was your child's day-care center, preschool or baby-sitter's home built before 1960?	☐ Yes	☐ No
b) Does the building have chipping or peeling paint, plaster or putty?	☐ Yes	☐ No
3. Does your child live in a house built before 1978 with recent, ongoing or planned renovation or remodeling?	☐ Yes	☐ No
4. Does your home's plumbing have lead pipes or copper pipes with lead solder joints?	☐ Yes	☐ No
5. Have any of your children or their playmates had lead poisoning?	☐ Yes	☐ No
6. Does your child frequently come in contact with an adult who works with lead?	☐ Yes	☐ No
7. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?	☐ Yes	☐ No
8. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?	☐ Yes	☐ No
9. Do you give your child home or folk remedies that may contain lead?	☐ Yes	☐ No

Tuberculosis Risk Assessment Ages 1 month – 21 years

Below is a questionnaire that helps us decide which children should have a skin test for tuberculosis. Tuberculosis is a contagious disease, which most often affects the lungs but can spread to other parts of the body. If a test is indicated the child will be tested with a Mantoux test at his or her next yearly physical exam.

1. Has your child lived with or spent time with anyone who possibly or definitely had tuberculosis or a positive skin test for tuberculosis?	☐ Yes	☐ No
2. Did you, your child or anyone else living in your household come to the US from Asia, the Middle East, Africa, Soviet Union, Eastern Europe, former socialist economies, or Latin America and the Caribbean (except Puerto Rico)?	☐ Yes	☐ No
If yes, which country? _____.		
3. Has your child traveled to or lived in another country for more than a month?	☐ Yes	☐ No
If yes, which country? _____.		
4. If your child was born in another country, has he/she received the BCG vaccine?	☐ Yes	☐ No
5. Has your child ever had a positive skin test before?	☐ Yes	☐ No

Pediatric Associates of Medford
Social History

Date:
Patient Name& Date of Birth:
Form Completed by:

Please answer the following questions to help us learn about your child's environment.
Please be advised the information obtained will be kept confidential.

1) Do both parents live in the household?

2) Does your family live in a house or apartment?

3) What languages are spoken in home?

4) If more than one language is spoken in home, which is most commonly used?

5) Does your child attend daycare? In what type of setting?

6) Are there any guns or ammunition in the home?

7) Are there any pets in the home? What type?

8) Has anyone in the household traveled outside the U.S.A? Where?

9) What type of work do adult household members do?

10) Where does your water supply come from i.e. city, well? Does it contain fluoride?

11) Does anyone in the home use tobacco/smoke?

12) Does anyone in the home use/used illegal drugs?

13) Does anyone in the home use/used alcohol in excess?

14) Are there any concerns about safety or violence in the home?

15) Is or has the Department of Children and Families (DSS/DCF) been involved with anyone in the home?

Pediatric Associates of Medford-Family Medical History

Date
Patient Name **Sex:**
Form Completed by: **Date of birth:**

Has father (F), mother (M), sister (S), brother (B) paternal grandfather (PGF), paternal grandmother (PGM), paternal aunt (PA), paternal uncle (PU), maternal grandfather (MGF), Maternal grandmother (MGM), Maternal aunt (MA), or Maternal uncle (MU) had: please incidate by using abbreviation in parenthesis

	NO	YES	WHO?		NO	YES	WHO?
Asthma/Wheezing	☐	☐		Kidney Disease	☐	☐	
TB/Lung disease	☐	☐		Cysts	☐	☐	
Cystic fibrosis	☐	☐		Stones	☐	☐	
Heart Disease	☐	☐		Failure/Transplant	☐	☐	
Congenital heart disease	☐	☐		Mental Illness	☐	☐	
Heart murmur	☐	☐		Depression	☐	☐	
Heart attack	☐	☐		Suicide	☐	☐	
Heart valve problem	☐	☐		Anxiety	☐	☐	
Arrhythmia	☐	☐		Bipolar	☐	☐	
Stroke	☐	☐		Schizophrenia	☐	☐	
High blood pressure	☐	☐		Migraine	☐	☐	
High cholesterol	☐	☐		Skin Disease	☐	☐	
Overweight	☐	☐		Eczema/Psoriasis	☐	☐	
Blood Disorders	☐	☐		Pigment disorder	☐	☐	
Sickle Cell	☐	☐		Scoliosis	☐	☐	
Anemia	☐	☐		Substance Abuse	☐	☐	
G6PD/Sulfur allergy	☐	☐		Immune Disorder	☐	☐	
Clotting disorder	☐	☐		HIV/AIDS	☐	☐	
Bleeding disorder	☐	☐		Learning/Behavior d/o	☐	☐	
Diabetes	☐	☐		ADD/ADHD	☐	☐	
Seizures	☐	☐		Autism	☐	☐	
Vision problem	☐	☐		Mental Retardation	☐	☐	
Cataract	☐	☐		PDD	☐	☐	
Glaucoma	☐	☐		Digestive disorder	☐	☐	
Blindness	☐	☐		Crohn's	☐	☐	
Strabismus/"lazy eye"	☐	☐		Ulcerative colitis	☐	☐	
Cancer	☐	☐		GE Reflux	☐	☐	
Leukemia/Lymphoma	☐	☐		Celiac	☐	☐	
Other _____	☐	☐		Polyps	☐	☐	
Hearing loss	☐	☐		Lupus	☐	☐	
Thyroid disease	☐	☐		Down syndrome	☐	☐	
Liver Disease/Hepatitis	☐	☐		Marfan syndrome	☐	☐	
Urine Infections/ Reflux	☐	☐		Anesthesia reaction	☐	☐	

Has any family member had an unexplained, unexpected death as an infant or adult <50 years old? ☐ yes ☐ no

**** If you answer yes, please explain in the space below:***

Pediatric Associates of Medford, P.C. 101 Main Street, Suite 201 Medford, MA 02215 **(781) 396-1288**

PATIENT INFORMATION

Patient Name: _____ M [ ] F [ ] DOB: _____

Home Address: _____

Primary Phone: _____ Secondary Phone: _____
Circle one: home cell work beeper home cell work beeper

Email: _____ Social Security #: _____

INSURANCE INFORMATION

- **PRIMARY INSURANCE:**

Primary Holder's Name: _____ DOB: _____

Father [ ] Mother [ ] Other [ ] _____ SSN#: _____

Address: _____
Same as above [ ]
Primary Phone: _____ Secondary Phone: _____
Same as above [ ]

Insurance Company Name: _____ P.O. Box: _____

Member ID Number: _____ Group ID Number: _____

- **SECONDARY INSURANCE:**

Primary Holder's Name: _____ DOB: _____

Father [ ] Mother [ ] Other [ ] _____ Social Security Number: _____

Address: _____
Same as above [ ]
Primary Phone: _____ Secondary Phone: _____
Same as above [ ]

Insurance Company Name: _____ P.O. Box: _____

Member ID Number: _____ Group ID Number: _____

(OVER)

SIBLINGS IN THE PRACTICE:

1) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

This patient's address and insurance information are the same as above [ ]

2) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

This patient's address and insurance information are the same as above [ ]

3) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

This patient's address and insurance information are the same as above [ ]

4) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

This patient's address and insurance information are the same as above [ ]

If any child has a different address or insurance information, please indicate below:

1) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

2) Name: _____ M [ ] F [ ] DOB: _____

Member ID Number: _____ SSN: _____

Primary Holder's Name: _____ DOB: _____

Father [ ] Mother [ ] Other [ ] _____

Address: _____

Same as above [ ]

Primary Phone: _____ Secondary Phone: _____

Circle one: home cell work beeper home cell work beeper

Same as above [ ]

Social Security Number: _____

Insurance Company Name: _____ P.O. Box: _____

Member ID Number: _____ Group ID Number: _____

Pediatric Associates of Medford, PC
101 Main Street, Suite 201
Medford, MA 02155
781-396-1288 | fax 781-391-1989
www.medfordpedi.com

Financial Policy

Due to the new federal regulations regarding patient rights, we have been mandated to implement the following policies as they apply to our office.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered, unless other arrangements are made in advance. This includes applicable co-insurances and co-payments for participating companies. Co-payments must be paid at the time of service regardless of who brings the child into the office. In cases, such as divorce, where the custodial parent is not the insurance holder, the person accompanying the child is responsible to pay co-payments at the time of service. Our office will not bill for co-pays. As a one time courtesy we may bill a co-pay with an additional $3.00 charge. Pediatric Associates of Medford accepts cash, personal checks, VISA, American Express, and Master Card. There is a service charge of $10.00 for all returned checks.

Patients with an outstanding balance of 60 days past due must make arrangements to pay balance with the Billing Office prior to scheduling well child appointments. Accounts over 90 days overdue will be considered seriously delinquent and referred to our Collection Agency. We do realize that there are extenuating circumstances, and that people do have financial difficulties, and we are willing to work with you. Please call the office and speak to the Billing Personnel to make special payment arrangements.

INSURANCE

Your insurance card must be presented at every visit. We bill insurance companies as a courtesy to you. It is your responsibility to notify this office of any insurance change. It is essential that you enroll newborn infants with your insurance carrier within 30 days of the child's date of birth. Unless this is done, your child will have no coverage under your policy. If you fail to do this within 30 days following the birth, you will be billed for the services that we have provided. We do not bill secondary insurance companies for co-pays. If we do not receive payment from your insurance company within 60 days from the date of service, you will be expected to pay the bill in full. You are ultimately responsible for all charges. If you need assistance or have any questions, please contact our Billing Office at 781-391-1366.

RESPONSIBLE FOR MEDICAL CARE

Every minor child under the age of 18 must be accompanied by a parent/legal guardian or by an adult who has obtained written consent for treatment from the parent/legal guardian. An exception is an adolescent presenting for confidential services which we are permitted by state law to provide without consent of parent.

REFERRALS

If you are enrolled in a managed care insurance plan (HMO) that requires a referral, you must receive that referral from our office before seeing a specialist. This must be done with the referral coordinator and you must allow 5 business days to process your referral. Our referral coordinator is available Monday-Friday 9:00 am—2:30 pm. Please have the necessary information available when calling (child's name, date of birth, phone number, insurance, specialist's name and phone number, why you need the referral, and the date of the appointment).

NO SHOWS/LATE/CANCELLATIONS

Cancelled appointments are a cost to us, to you, and to other patients who could have used the time set aside for your child. Please notify us of a cancellation 24 hrs in advance of the appointment. **Well Visit appointments require a 48 hour cancellation notice**. We reserve the right to charge a $25.00 fee for missed appointments or late cancelled appointments. Our staff will attempt to call you to remind you of your appointment, however, these reminders are a courtesy and the responsibility to keep the appointment is yours. Persistent missed appointments may result in discharge from the practice.

MEDICAL RECORDS TRANSFER

If for some reason you request a copy of your child's medical record to be sent either to you or to another physician, it is required you complete a medical release form authorizing the transfer along with a fee of $15. There is a maximum charge of $30.00 per family. However, we do not charge if we are sending records to specialist. If your child has not been seen in this office for over 3 years the records will have to be returned from a medical storage facility, at the cost of $50.00 per record may be charged. Payment is required prior to ordering the record.

I have read and understand the FINANCIAL POLICY OF PEDIATRIC ASSOCIATES OF MEDFORD. I also agree that if it becomes necessary to forward my account to a Collection Agency, in addition to the amount owed, I may also be responsible for the fee charged by the Collection Agency for costs of collections. I certify that the insurance information I have given is correct. I authorize the release of any medical information necessary to process a claim. I authorize payment made directly to PEDIATRIC ASSOCIATES OF MEDFORD.

Patient's Name_____ Date of Birth _____

Patient's Name_____ Date of Birth _____

Patient's Name_____ Date of Birth _____

Patient's Name_____ Date of Birth _____

Signature of Parent/Legal Guardian _____ Date: _____
(or Patient, if age 18 and older)

Pediatric Associates of Medford, PC
Enrollment to use Patient Portal for 18 yr olds and older

Patient Name _____ Date of Birth_____

Address:_____

Personal E-mail Address of Patient:_____

Patient Portal Guidelines and Security Purpose of this Form

The Patient Portal offers secure viewing and communication as a service to patients and families who wish to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain limitations. By agreement to use the Patient Portal, you must agree to the conditions in the enrollment form and our Terms of Service.

How Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log in to the portal site.

How to Participate in our Patient Portal

Once this form is agreed to and signed, we will give you the URL (internet address) of the web site where you can log in. We also will provide you with a user name and password in person. Use the provided internet address in your Internet browser and go to the Patient Portal web site. You will then be able to log in using the user name and password provided. You should change your password to a password that only you will know.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors:

1. **We need you to make sure we have your correct email address and you MUST inform us if it ever changes. Do not use your work e-mail address, as this information might be available to your employer**

2. You need to keep unauthorized individuals from learning your Patient Portal password. If you think someone has learned your password, you should promptly go to the Patient Portal and change it.

Conditions of Participating in the Patient Portal

We understand the importance of privacy in regards to your health care and will continue to strive to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices.

Access to this secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service, we will notify you as promptly as we reasonably can.

Before you were given this form, we provided you with our Terms of Service for using this web portal. We need you to understand and comply with these and by signing this form below, you will acknowledge that the Terms of Service were explained to you and that you agree to comply with them. If you have any questions we will gladly provide more information.

User Responsibilities

In return for access to the Patient Portal, you agree not to:

1. Transmit any electronic information that violates the rights or privacy of any party.
2. Use the web portal in any way that violates local, state, or federal laws;
3. Transmit materials that are obscene, defamatory, abusive, slanderous, hateful or otherwise likely to result in harm to others; or
4. Intentionally distribute viruses or other harmful computer code or take any other action that could compromise the security of our computer system.

If you wish to enroll in this service, please sign below.

Patient Acknowledgement

Signature_____ Date_____

Pediatric Associates of Medford, PC

101 Main St., Suite 201

Medford, MA 02155

www.medfordpedi.com

Patient Portal Terms of Service

1. These terms of service apply to the use of the electronic patient portal that is part of our electronic medical record system. The purpose of the Patient Portal is to make routine, non-emergency communication more convenient and to provide parents with better access to their children's health information. With a parent's permission, we also will allow adolescent patients with direct access to their medical information through the Patient Portal. Please follow these guidelines and contact us if you have any questions.
2. ***DO NOT*** use the Patient Portal to communicate if there is an medical emergency. Please dial 911, and then contact your child's doctor by telephone as soon as possible to inform us of your child's issue.
3. You agree not to use the Patient Portal for any purpose other than to communicate with us about your health needs or the health needs of your child. You agree not to attempt to circumvent any security safeguard that we use to protect the security of our information systems.
4. On enrollment, you will provide us with your personal email address. You will receive an e-mail whenever you have a message waiting for you on the Patient Portal. The e-mail will not contain confidential health information, but will prompt you to sign into the Patient Portal and read your messages. You agree to use only your personal e-mail for this purpose, and not your work e-mail. If you change your personal e-mail, please update it using the portal right away, otherwise you will not receive notices of new messages. We will keep your email address confidential and will not share this with other parties except as required by law.
5. All communication via Patient Portal will be included in your child's permanent patient record.
6. A parent's access to an adolescent's medical record may be limited by law under certain circumstances or for certain kinds of health information.
7. We will normally respond to messages within forty-eight hours, but no later than three business days after receipt in most cases.
8. If we are unable to access the Patient Portal for any reason we will attempt to have an automatic response inform you of this as soon as possible. The proper operation of the Patient Portal may be interrupted by problems with computer hardware or software, interruptions in internet services, computer viruses or other problems beyond our control. If you need to reach us and the portal is not working, please call us.

9. All electronic communication from you to the practice should be through the Patient Portal. Do not use your regular e-mail account to send us confidential information since regular e-mail is not secure.

10. Any of our staff may read your messages or reply in order to assist in your child's healthcare. This is similar to how we handle telephone messages.

11. When we send you a message, our system will let us know when you have viewed it., so you do not need to reply that you have read it.

12. Proper subject matter for the Patient Portal includes prescription refills, non-urgent medical questions, appointment reminders or requests, routine follow-up questions, and similar topics. Please avoid discussion around sensitive subject matter such as mental health issues, sexually transmitted diseases, genetic tests, or substance abuse treatment. These topics should be handled by direct, in person discussion with a Pediatrician or other health care professional. Please try to be concise when typing a message.

13. You can send refill requests for most medicines. Please make sure we have your correct pharmacy information. We cannot refill requests for narcotics, stimulants or other controlled substances through the portal. You will need a face-to-face encounter at our office or to call our office by telephone for this purpose.

14. You can use the Patient Portal to view and print a "continuity of health record" which is a standard summary of your health information. You also can view and update some of your health information - (allergies, medications, current problems, past Medical History). However, updates will not be added to your record until reviewed and approved by the pediatrician or another clinician.

15. You can make referral requests and appointment requests, and we will make every effort to honor those requests. We cannot, however, guarantee that these will be honored exactly as requested.

16. You can submit billing questions and update selected demographic information (address, phone number, and contact information).

17. These Policies and Procedures are subject to change without prior notice. We retain the right to modify, discontinue or suspend the Portal service for any reason at any time.

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
FOR PATIENTS 18 YEARS OF AGE OR OLDER

Patient Name:_____ Date of birth:_____

Pediatric Associates of Medford keeps medical records confidential. However, at times we may want to share your information with other people to provide better health care to you – for example, to assess your health needs, notify your school of your illness or treatment, or provide additional treatment or referrals. This may require disclosing some of your confidential medical information to others. In some cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purposes.

Part I: Please read the following paragraphs closely, then initial either box A or B below:

A: [ ] I give Pediatric Associates of Medford permission to share or disclose medical records and medical information related to care that I consented to for myself with the persons and agencies specified under Part II below. This may include contact and appointment information; information about immunizations; pregnancy; birth control; STD testing and treatment; or basic progress or diagnosis information about mental health counseling. **This release does NOT authorize Pediatric Associates of Medford to disclose information regarding HIV testing, treatment, or status; drug or alcohol abuse diagnosis or treatment; inpatient mental health services; details of mental health counseling; or psychotherapy notes.**

B: [ ] I give Pediatric Associates of Medford permission to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under Part II below, **except the information indicated below**. Pediatric Associates of Medford must have a separate authorization from me to disclose the information I describe on these lines.

_____

_____

_____

Part II: Pediatric Associates of Medford may share this information with the following persons and agencies (please initial your consent in the box provided, and indicate the specific name(s) of each):

Please be advised that all information described in the paragraph you initialed above (either A & B) can be shared with people or agencies you indicate in this section. Please also be aware that we cannot speak with your parent or guardian to book appointments or refill medications if you do not consent to share your medical information with them.

[ ] My school: _____

[ ] My parent/guardian(s): _____

[ ] Others (please specify): _____

_____

Please complete both sides of this form

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
CONSENT TO COMMUNICATE WITH PATIENT

[ ] Pediatric Associates of Medford may **call my home phone number** and leave a message on voice mail in reference to any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my clinical care, including laboratory results. **My home phone number is:**_____

[ ] Pediatric Associates of Medford may **call my cell phone number** and leave a message on voice mail in reference to any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my clinical care, including laboratory results. **My cell phone number is:**_____

[ ] Pediatric Associates of Medford **may mail to my home address** any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my clinical care, including laboratory results.

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
NOTICES AND EXPLANATION OF RIGHTS

I understand that Pediatric Associates of Medford may share or be required to share my health care information with certain persons or agencies for purposes of treatment, health care operations, and billing and payment, or as otherwise required by law, without having to ask my permission or needing a signed authorization. Further information about these uses can be found in the Notice of Privacy Practices, which I have had a chance to review before signing this form.

I understand that I may change my mind and decide I do not want Pediatric Associates of Medford to disclose information as described above. This is called a revocation. I understand that I may revoke this authorization by writing to: Medical Records Department, Pediatric Associates of Medford, 101 Main Street, Suite 201, Medford, MA 02155

Once the Medical Records Department of Pediatric Associates of Medford receives my written notice of revocation, the office will stop sharing information from that point on. I understand that revocation does not apply to the information Pediatric Associates of Medford may have released previously.

I understand that I have the right to refuse to sign this authorization. I understand that Pediatric Associates of Medford may not deny me treatment or eligibility for benefits just because I choose not to sign this authorization.

I understand that if Pediatric Associates of Medford discloses information to a person or organization that is not legally required to keep it confidential, the information may be redisclosed by that person or organization and no longer be protected.

I understand that I have a right to receive a copy of this signed authorization, and that this authorization will last one year from the date below.

Signature of Patient: _____ Date:_____

Please complete both sides of this form