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)? If yes, which country? _____.	☐ Yes	☐ No
3. Has your child traveled to or lived in another country for more than a month? If yes, which country? _____.	☐ Yes	☐ No
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, P.C.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
FOR PATIENTS FROM BIRTH THROUGH AGE 17

Patient Name:_____ Date of birth:_____

Pediatric Associates of Medford keeps medical records confidential. However, at times we may want to share your child's information with other people – for example, to notify your child's school of illness or treatment, or provide additional treatment or referrals. This may require disclosing some of your child's 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.

It is important to note that patients 15 and older may consent to receive certain health care services on their own, often called "minor consent" services. Some examples of "minor consent" services include mental health counseling, treatment for addiction, diagnosis and treatment of sexually transmitted diseases, and contraception. **Please refer to our Adolescent Confidentiality Policy for further information regarding how Pediatric Associates of Medford handles this type of protected health information.**

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 my child with the persons and agencies specified under Part II below. This may include contact and appointment information, information about immunizations, 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, indicating the specific name(s) of each, and whether this person is able to accompany the patient for medical treatment by circling yes or no):

[ ] Other parent/guardian: _____ **Yes** **No**

[ ] Other responsible adult(s): _____ **Yes** **No**

_____ **Yes** **No**

_____ **Yes** **No**

[ ] My child's school: _____

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 child's 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 child's 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 child's 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 child's 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 my child's 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 my child's information from that point on. I understand that revocation does not apply to 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 my child treatment or eligibility for benefits just because I choose not to sign this authorization.

I understand that if Pediatric Associates of Medford discloses my child's 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

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)

Adolescent Confidentiality Policy

At Pediatric Associates of Medford, we want to recognize and support our teenage patients' evolving maturity and independence. Adolescence is a time of transition toward adulthood, and we believe that we should support this healthy transition in our office. Toward this goal, we want our teens and parents to be aware of the following:

During our adolescent well visits, we will have part of each visit alone with our teens. We see this as an opportunity for teens to become more comfortable speaking alone with an adult healthcare provider, something that they will need to do independently once they are adults themselves. We also want to give all teens an opportunity to address any and all of their healthcare concerns in a private and confidential manner, should they need to.

When teens share something with us that they ask to remain confidential, we will honor that request, unless they plan to harm themselves or someone else. Although we always encourage adolescent patients to be open and honest with their parents, we also want them to have a safe place to go with any health concern, and sometimes we can be that safe place. We hope that parents will trust us to take the best care of our teens in these situations.

We are also happy to speak privately with parents during the visit, at their request, about any concerns that they may want to share with us about their teen. We will maintain our patient's confidentiality in these discussions, however.

These confidentiality parameters also extend to any telephone calls that we may have with our teen patients about their healthcare, including discussions about appropriate lab/imaging evaluations and results.

This policy is consistent with Massachusetts state law surrounding adolescent confidentiality, as well as the policies of the Society for Adolescent Medicine, and the American Academy of Pediatrics. We consider it a privilege to take care of our teens, and we look forward to working together, with this policy in mind, as our teens grow up!

Pediatric Associates of Medford, P.C.