Four Seasons Pediatrics

Well Visit Form for Adult Well Visit

Name: _____ Birth Date: _____ Age: _____

Today's Date: _____

General Questions:

Please check off what best describes you:

- ☐ In school full time – Name of school: _____
- ☐ Working full time – Occupation: _____
- ☐ I identify my gender as a: _____
- ☐ Other – describe: _____

Please make a check if the following statements are true:

- ☐ I attend loud concerts, ear buds frequently or hear loud noises
- ☐ I do not wear my seat belt
- ☐ I have access to a gun
- ☐ I am worried about violence or my safety
- ☐ I have been in trouble with the police
- ☐ I am not happy about my weight
- ☐ I skip meals, or have taken medications to reduce my weight
- ☐ I currently smoke
- ☐ I have tried alcohol (more than a few sips)
- ☐ I drink alcohol regularly
- ☐ I smoke marijuana
- ☐ I have used another substance to get high
- ☐ I am worried about drugs, mental health or alcohol use of someone who lives in my home
- ☐ I feel nervous, anxious or on edge
- ☐ I am not able to stop or control my worry
- ☐ I would like to get counseling about something that is bothering me
- ☐ In the past few weeks, I have been very sad, depressed or felt I have nothing to look forward to
- ☐ In the past few weeks, I have lost interest and pleasure in things I usually enjoy
- ☐ I have had thoughts of harming myself or committing suicide
- ☐ I have been abused in the past
- ☐ I have been forced to do something sexual against my will
- ☐ I am worried about pregnancy
- ☐ I would like to be tested for sexually transmitted diseases
- ☐ I am in need of birth control

Screening – Please check the box if any of the following are true:

- ☐ I have been exposed to tuberculosis or a person with a positive skin test
- ☐ There is a family history of high cholesterol of > 240 in either parent or grandparents
- ☐ There is a family history of heart disease before 55 in either parent or grandparents

Social:

Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? _____

Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? _____

Vaccine Information Statements (Check One)

- [ ] I will review the in-room copy
- [ ] I will review the on-line copy at your website
- [ ] I would like a paper copy

Four Seasons Pediatrics
532 Moe Road
Clifton Park, NY 12065

Authorization for Release of Health Information to Parents/Guardian

I, the undersigned, hereby authorize **Four Seasons Pediatrics, 532 Moe Road Clifton Park, NY 12065** to release/ disclose medical information to the person(s) specified below:

Person(s) Information is being disclosed to:

Name _____ Name _____

Address _____ Address _____

_____ _____

Phone number _____ Phone number _____

Relationship: _____ Relationship: _____

By signing this release you authorize release of the following:

- Routine Medical Care (sore throat, broken bones, etc) – please list any exclusions _____
- Insurance issues including authorizations, referrals.
- Balances due, including outstanding co-payments.

<u>In Addition</u> if authorizing release of the following information please sign and date for each you are authorizing:

- Alcohol/Drug Treatment signature _____ date: _____
- Mental Health information: signature _____date: _____
- HIV- related information: signature _____ date: _____
- GYN / Contraception: signature _____date: _____

Duration: This authorization will become effective immediately and shall remain in effect while you are a patient of Four Seasons Pediatrics unless specified here by dates or defined event: _____.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. Written revocation may be addressed to: Privacy Officer, Four Seasons Pediatrics 532 Moe Road, Clifton Park, NY 12065.

Redisclosure: I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. If this authorization indicates by signature HIV, Drug/ Alcohol treatment, mental health information is being disclosed the recipient is prohibited from redisclosing such information without authorization unless permitted to do so under federal and state law.

A Copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Print Name _____

Signature _____ Date _____

Address _____

Phone Number _____

E – mail address _____

Four Seasons Pediatrics, LLC

Please answer the following questions:

1. Race:

   ☐ American Indian or Alaska Native
   ☐ Black or African American
   ☐ White
   ☐ Other _____
   ☐ Unknown
   ☐ I do not wish to answer

2. Ethnicity:

   ☐ Hispanic
   ☐ Non – Hispanic
   ☐ Unknown
   ☐ I do not wish to answer

3. Primary Language:

   ☐ English
   ☐ Other _____
   ☐ I do not wish to Answer

4. May the doctors have your permission to view prescriptions prescribed outside this office?

   ☐ Yes
   ☐ No

Name (print) _____ Signature _____

ABOUT THIS INFORMATION:
Four Seasons Pediatrics participates in federal programs that report quality of care in health care, as such, we are required to collect information about your child. This information is not reported individually to any other organizations outside of Four Seasons Pediatrics. Your response to these questions is not required and will not be used to affect your care in any way.

Patient Consent for Treatment, Payment and Healthcare Operations
Four Seasons Pediatrics

We are a Patient Centered Medical Home. Patient Centered Medical Homes (PCMH) are about what patients want: a focus on patients themselves and their health care needs. Medical Homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and cost. Four Seasons Pediatrics embodies the spirit and practice of the Patient Centered Medical Home. Everyone in the practice – from clinicians to front desk staff – works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

- We will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.
- We will provide whole person care at the first contact. Everyone in the practice – from physicians and practice nurses to medical assistants and frontline staff will practice to the highest level of their training and license in teams, to support better access, self care and care coordination.
- We will be respectful of and responsive to individual patient preferences, needs and values, and ensure that patient values guide all clinical decisions. Individuals and families will get help to be actively engaged in their own healthy behaviors, health care, and in decisions about their care.

What is your role in this process? We ask that you help us coordinate your care. If you seek care elsewhere (without us sending you there), kindly notify us about your visit (self referral to a specialist, visit to the urgent care or emergency room etc). We will obtain and review the records and send necessary information to coordinate your care.

Privacy Use: Patient Consent for Use and Disclosure of Protected Health Information

With this consent, Four Seasons Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Four Seasons Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and acknowledge I have received a copy. Four Seasons Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Four Seasons Pediatrics, LLC Privacy Officer at 532 Moe Road, Clifton Park, NY 12065.

With this consent, Four Seasons Pediatrics may call my home, cell phone numbers listed with Four Seasons Pediatrics, my work phone if designated by me, mail to my home, email me, or other designated location selected by me and leave a message on voice mail, by text message, or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items, billing and debt collection and any information pertaining to my clinical care, including test results and medical information. I also agree to accept email with PHI attached if I verbally request such information to be sent to my private email.

Financial Policy: Agreement for Payment

No Show/Late Cancellation Charges: Four Seasons Pediatrics cannot bill the insurance for these charges, but are permitted by insurance companies to bill the patient for them. We kindly ask for 24 hours notice if you are unable to come to an appointment previously made. Notifying us 24 hours in advance allows us to offer the appointment time to others. Failure to give 24 hours notice to cancel an appointment previously made is subject to a Late Cancellation charge (currently $25). Failure to show up for an appointment without notification is subject to a No Show charge (currently $50). I understand that if I miss appointments, I will be asked to transfer my records to another doctor and I will still be responsible for the balance owed. Please note - reminder calls are sent out as a courtesy, it is still the patient's responsibility to keep all appointments, unless there is 24 hours notice.

*Initial _____

Listing Four Seasons Pediatrics as Primary Care Provider (PCP): I understand that it is my responsibility to notify my insurance company of the change in PCP to Four Seasons Pediatrics prior to my first visit with Four Seasons Pediatrics. Failure to do so will make me responsible for the services rendered during any visits with Four Seasons Pediatrics.

Co-Payments are due at the time of the office visit. Failure to pay the co-payment at the time of service is subject to a co-pay surcharge (currently $5, subject to change).

Monthly Statements will reflect the amount I owe to Four Seasons Pediatrics. Unpaid balances will have a finance charge (currently $5 per month, subject to change).

Past Due Accounts: Accounts that are past due greater than 60 days are subject to being referred to a collection agency. Four Seasons Pediatrics will make every effort to inform me of this action. It is my responsibility to inform Four Seasons Pediatrics of any change in address, phone numbers, or insurance information important for medical payments and correspondence. Failure to notify Four Seasons Pediatrics of changes in address, phone number or insurance information does not relieve me of my responsibility of any charges incurred or balances due. Once accounts are turned over to collections, I understand that I will be responsible for late fees, and any collection costs incurred. If the account is turned over for legal action, I agree to pay all lawyers fees and court costs incurred by Four Seasons Pediatrics as a result of such action.

*Initial _____

Waiver of Confidentiality: I understand that if this account is submitted to an attorney or collection agency, if Four Seasons Pediatrics has to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at your office may become a matter of public record.

Returned Checks: There is a fee (currently Four Seasons Pediatrics is charged $32) that will be passed on to me for any checks returned by the bank for insufficient funds.

Fees: I understand that Four Seasons Pediatrics may reasonably adjust the above fees, from time to time based on fees incurred by Four Seasons Pediatrics, and that these fees are re-assessed on an annual basis.

Copying of Records: I will need to request in writing and pay a reasonable fee (currently $0.75 per page) if I want copies of my records.

Forms

Forms completed during a physical appointment: Four Seasons Pediatrics has developed computer generated forms. These forms are developed from state requirements and meet the demands for almost all situations. Forms generated from our system at the time of your physical exam will be given on request free of charge. The physical forms are good for one year and can be used for sports and camp (unless they have specific custom forms) so if you think you may need one for the upcoming year let the staff know. You will be given one copy. Additional copies or a computer generated form at times other than while you are in the office during your physical will be charged a fee of $5 per form, $1 additional if mailed to your home. School forms require an annual exam done within 12 months of the request.

Forms completed during a sick visit: Forms will be filled out at no charge if they are related to the sick visit (e.g. note to return to daycare/school/work, note to administer medication related to a sick visit, and they are requested at the time of the visit. Additional copies or a request for a form not done while you are in the office at the time of the visit will be subject to a fee of $5 per form, $1 additional if mailed to your home.

Custom forms: While our computer generated forms will be applicable for almost all schools, there are some schools and organizations that require their own custom forms to be filled out. The fee for custom forms is $5 per form, $1 additional if mailed to your home. This fee applies for custom forms done at any time whether done in the office at your physical exam or not.

Turn around time: Although we usually accomplish these in a shorter time frame, please allow a turn around time of up to 2 business days for forms. In addition to the $5 form fee if the form is needed within 24 hour time period there will an additional fee of $5.

Form release: Forms will be held here for you to pick up. We will mail forms to the home address on file at your request, subject to the above fees and if the form is paid in advance. Please note – Due to HIPAA, Four Seasons Pediatrics does not email or fax forms.

*Initial _____

I have ☐ **received a copy (please request copy)** ☐ **read and declined a copy** of the Four Seasons Pediatrics Patient consent for Treatment, Payment and Healthcare Operations, and understand the responsibilities of me and Four Seasons Pediatrics, LLC. **This is also sent to you through our patient portal when you a web enabled as well as being available on our web site, fourseasonspediatrics.com.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures or provided services in reliance upon my prior consent. If I do not sign this consent, I understand that Four Seasons Pediatrics is under no obligation to provide treatment to me.

I authorize the use of my signature for all my insurance submissions and to carry out activities related to treatment, payment and healthcare operations with all my insurance companies. I understand that I am responsible for any fees not covered by my insurance company, unless my insurance company prohibits billing for such services. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original.

_____ _____ _____

PRINT name SIGNATURE Date

IF MANAGED MEDICAID/CHILD HEALTH PLUS- PLEASE ALSO SIGN BELOW:

Managed Medicaid/Child Health Plus: Failure to name Four Seasons Pediatrics as PCP with the insurance company for any visit will make my care to be viewed as an uncovered service delivered on a fee-for-service basis. As a Private Pay Patient, this and all other uncovered services are delivered on a fee-for-service basis. I will be responsible for the cost of these and all other uncovered services. I further understand that I may obtain medical care at no cost from another provider that participates in my Managed Care Plan.

_____ _____ _____

PRINT name SIGNATURE Date

Young Adult Newsletter

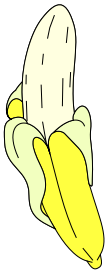
For those 18 years and Older

Injury Prevention

The most common cause of death in young adults:

- **Auto Accidents:** Approximately 200,000 young adults (under age 24) die per year from an auto-accident. Wear a seat belt while driving or riding. Never drive or allow others to drive after drinking. Do not ride with a driver who has been drinking.

Nutrition



Eat 3 meals a day. Don't forget breakfast. It is still very important to eat 3 servings of vegetables and 2 servings of fruits per day.

- If you are on the run, try: bread, bagels, crackers with peanut butter or cheese, bananas, apples, oranges, carrots, veggies, milk, yogurt, and juice.
- Young women should have a diet with sufficient calcium – two to three servings of dairy daily. If you cannot tolerate dairy, speak with us. Females also need more iron, due to menstrual blood loss. You may want to take a multi-vitamin.

Healthy Habits

Stay drug free and respect the decision of others to do so. Talk to us about any questions you have about steroids, alcohol, tobacco, diet pills, drugs or concerns about your weight.

Remember the following recommendations for a healthy body:

- 5 servings of fruits/veggies per day
- 2 hours of screen time per day (TV, Video, Computer)
- 1 hour of physical activity per day (that increases heart rate)
- 0 intake of sweetened beverages

Continue oral health with brushing and flossing. Be sure to continue dental cleanings twice a year.

Remember that drugs, alcohol and smoking are largely determined by who you hang out with.

Sexuality

The decision to have sex is a serious one. Consequences can change your life permanently (pregnancy, AIDS, diseases, and depression). Not having sex is the safest choice. Express your affection by kissing, touching, and hugging. Be clear in your own mind what you do not want to do. If any part of you says no, the answer is NO. Unsafe sex includes unprotected contact between genitals, (including intercourse), genitals and the mouth (oral sex), or genitals and the anus. Safer (but not risk free) sex includes using a condom and using birth control. Condoms and birth control do not always protect you from pregnancy or sexually transmitted diseases, including AIDS.

Date rape is when someone you know forces you into sexual activity against your will. This could happen if you choose to participate in some intimate activity like kissing, but want to stop and your partner will not let you. Avoid this situation by:

- Meeting in places where there are more than just the two of you.
- Be assertive.
- Making a scene so someone will help you.
- Remember you are in better control of an intimate situation if you are not using drugs or alcohol.

Transitioning to Adult Care

Four Seasons Pediatrics is committed to helping our patients make a smooth transition from pediatric to adult health care. Our practice supports our patients through their college and work transition years until the age of approximately 22. There are steps that we have already taken to assist in this manner. By now, you will have had practice making the transition from when your parents made all the decisions to an "adult" model of care where youth take full responsibility for decision-making. (e.g. By now we would have offered to see you without your parent present in order to assist you in setting health priorities and supporting you in becoming more independent with your own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with your consent will we be able to discuss any personal health information with family members. If you have a condition that prevents you from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer take place near or after age 22 but no later than age 23. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about your unique needs. Our providers will assess special care needs, obstacles to transitioning to an adult care clinician and assess your response to the transition.