Four Seasons Pediatrics
532 Moe Road
Clifton Park, NY 12065
Ph 518-383-2425
Fax 518-383-3255

Consent to Discuss Health Information with Others

I, the undersigned, hereby authorize **Four Seasons Pediatrics,** located at **532 Moe Road Clifton Park, NY 12065,** to release / disclose / discuss medical information with the following individuals:

Individual 1 ________________________________

Relationship ________________________________

Phone Number ________________________________

Address ________________________________

____

Individual 2 ________________________________ (optional)

Relationship ________________________________

Phone Number ________________________________

Address ________________________________

____

Individual 3 ________________________________ (optional)

Relationship ________________________________

Phone Number ________________________________

Address ________________________________

____

Specific information allowed in this consent:

- ❑ Routine medical information regarding office visits, treatments and findings
- ❑ Medical insurance details, account balances, prior authorizations, referrals

- ❑ Limitations or exclusions? ____

____

____

- ❑ **Items below need specific authorization**. Please indicate by signature to include the following:

Alcohol/Drug Treatment	signature ______________________	date ____________
Mental Health information	signature ______________________	date ____________
HIV- related information	signature ______________________	date ____________

Duration:
This authorization will become effective immediately and shall remain in effect unless specified by dates

or defined events noted here: ____

____

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.

Re-disclosure:
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 ________________________________**DOB**______________

Signature ____________________________________

Best contact phone # ____________________________________

Email address ____

Date ______________________

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

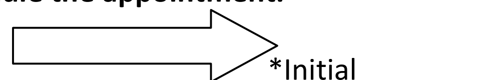
- With this consent, Four Seasons Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Four Seasons Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

- 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. **No Show fees and Late Cancellation fees must be paid to reschedule the appointment.**



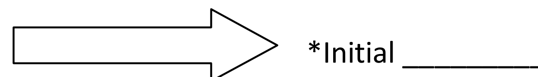
*Initial _________

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 child's 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 our 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 child's physical will be charged a fee of $5 per form, $1 additional if mailed to your home. Forms for siblings will also be charged this fee, unless they are requested at the time of their separate physical exam. 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

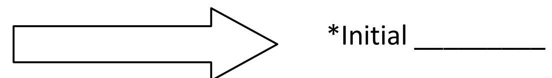
- While our computer generated forms will be applicable for almost all school and daycare forms there are some school, daycare and organizations that require their own custom forms to be filled out. The fee for custom forms is $5 per form, $1 additional if mailed to your home. This fee applies for custom forms done at any time whether done in the office at your child's 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 per item. There is a fee of $ 1.00 for mailing the forms.

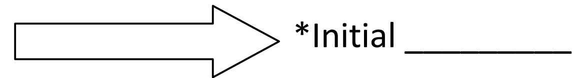
Form release

- Due to the Health Insurance Portability and Accountability Act ("HIPAA") regulations, forms will be released to parents or guardians only, unless a 3rd party release form is submitted or on file. We will mail forms to the home address on file at your request, subject to the above fees. <u>All forms must be paid for before they are released.</u>


*Initial _________

Vaccine compliance policy

- **Four Seasons Pediatrics has an office wide policy that requires the vaccination schedule recommended by the American of Pediatrics (AAP) and The Center for Disease Control (CDC). This policy requires pediatric and adolescent vaccination compliance for all patients. This policy is in effect to protect patients in the practice who have Immune Deficiency, those who have had Bone Marrow Transplants, those being treated with chemotherapy, and Newborns too young to be vaccinated. I understand that failure to follow the Vaccine Schedule within 2 weeks of notification will result in discharge from the practice. This policy does not apply to the flu vaccine nor the HPV vaccine, though the practice strongly recommends both of these vaccines.**


*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. The individual signing below will be responsible for all financial and billing activities.

______________________________ ______________________________ ___________

Printed Name **Signature** **Date**

Hixny Electronic Data Access Consent Form
Four Seasons Pediatrics, LLC

In this Consent Form, you can choose whether to allow Four Seasons Pediatrics, LLC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Four Seasons Pediatrics, LLC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Four Seasons Pediatrics, LLC's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Four Seasons Pediatrics, LLC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

I GIVE CONSENT for Four Seasons Pediatrics, LLC to access ALL of my medical records through Hixny in connection with providing me any health care services, including emergency care.

I DENY CONSENT for Four Seasons Pediatrics, LLC to access my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_______________________________________ ______________ ________________
Print Name of Patient Date of Birth Date

_______________________________________ ________________________________
Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Four Seasons Pediatrics, LLC only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Four Seasons Pediatrics, LLC may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Four Seasons Pediatrics, LLC's medical staff who are involved in your medical care; health care providers who are covering or on call for Four Seasons Pediatrics, LLC's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Four Seasons Pediatrics, LLC at: 518-383-2425; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-487-4117.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Four Seasons Pediatrics, LLC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Four Seasons Pediatrics, LLC. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for ____________________________ (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

______________________________ Print Name

______________________________ Date of Birth

______________________________ Signature

______________________________ Date