Kenneth M. Klebanow, MD & Associates P.A.

Patient Information

Last Name: ______________________________________ First :____

Date of Birth:_____________________________ Sex: _________ Primary Phone #: ________________________

Address: ____

City: ___________________________________State: ____________Zip code: _______________

Primary Provider Selected: ________________________ Born in what hospital? ___________________________

Names of patient's siblings in this practice: ____
Language (optional): _________________ Ethnicity (optional): ________________ Race (optional):_____________
How did you hear about us? ___________________ Did you have a prenatal with us? ________________________

Guardian Information

Last Name: ___________________________________ First Name: ____

Soc. Sec. # :___________________Date of Birth: ___________ Relationship to patient: _______________________

Address : ____

City: ______________________________State: ______________ Zip Code: _______________

Primary Phone #: ________________________________ Work #: ___________________________________

E-mail Address: ____ Occupation: ______________________

Last Name: ________________________________ First Name: _______________________________________

Soc. Sec. # :___________________Date of Birth: ___________ Relationship to patient: _______________________

Address : ____

City: ______________________________State: ______________ Zip Code: ____________________

Primary Phone #: ________________________________ Work #: ___________________________________

E-mail Address: ____Occupation: _______________________

Insurance information

Name of Primary Insurance Company: ____

Policy #:_____________________________________ Group #: _________________________________

Insurance Address : ____

Policy Holder's Name: __________________________________ Policy Holder's Date of Birth: ________________

Employer: _____________________________

Name of Secondary Insurance Company: ____

Policy #:_____________________________________ Group #: ____________________________________

Insurance Address : ____

Policy Holder's Name: __________________________________ Policy Holder's Date of Birth: ________________

Employer: ___________________________________

Kenneth M. Klebanow, MD & Associates P.A.

Notice of Privacy Practices

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THE SIGNATURE PAGE.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:
Privacy Officer Peggy O'Callaghan Phone number: 410-992-0513

Section A: Our Pledge Regarding Medical Information

We understand that medical information about your child(ren's) health is personal. We are committed to protecting their medical information. We create a record of the care and services your child(ren) receive(s) by the Provider. We need this record to provide them with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your child(ren's) care generated or maintained by the Provider, whether made by the Provider personnel or personal doctor.
This Notice will tell you about the ways in which we may use and disclose medical information about your child(ren). We may also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
We are required by law to:

- Make sure that medical information that identifies your child(ren) is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about your child(ren); and
- Follow the terms of the Notice that is currently in effect.

Section B: How We May Use and Disclose Medical Information About Your Child(ren)

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment**. We may use medical information about your child(ren) to provide medical treatment or services. We may disclose medical information to doctors, school nurses, technicians, health care students, or other Provider personnel who are involved in taking care of your child(ren) at the Provider.
- **Payment**. We may use and disclose medical information so that the treatment and services received at the Provider may be billed and payment may be collected from you, an insurance company, or a third party.
- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder about an appointment for treatment or medical care at the Provider.
- **Photographs**. We may display any cards and/or photograph of your child(ren) that you bring in or mail.
- **Authorization Required.** We will not use protected health information (PHI) for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes use of your PHI for marketing or sales activities.
- **Emergencies**. We may use or disclose your child(ren's) medical information if they need emergency treatment or if we are required by law to treat them but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat them.
- **Communication Barriers**. We may use and disclose health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat your child(ren) if we could communicate with you.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about your child(ren) to a friend or family member who is involved in their medical care and we may also give information to someone who helps pay for their care, unless you object in writing and ask us not to provide this information to specific individuals.
  In addition, we may disclose medical information about your child(ren) to an entity assisting in a disaster relief effort so that your family can be notified about their condition, status, and location.

- **As Required By Law**. We will disclose medical information about your child(ren) when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about your child(ren) when necessary to prevent a serious threat to their health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section C: Special Situations

- **Public Health Risks**. We may disclose medical information about you child(ren) for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medication or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuit and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about child(ren) in response to a court or administrative order. We may also disclose medical information about them in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.
- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct at the Provider; and
  - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Section D: Your Rights Regarding Medical Information About Your Child(ren)
You have the following rights regarding medical information we maintain about your child(ren):

- **Right to Access, Inspect, and Copy**. You have the right to access, inspect, and copy the medical information that may be used to make decisions about your child(ren's) care, with a few exceptions. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.
- We may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. If you feel that medical information we have about your child(ren) is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the Provider;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about your child(ren). Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in which form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about your child(ren) for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about your child(ren) to someone who is involved in their care or the payment for their care, like a family member or friend.
  You also have the right to restrict use and disclosure of your child(ren's) medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.
- **Right to Receive Notice of a Breach**. We are required to notify you by first class mail of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:
  - A brief description of the breach, including the date of the breach and the date of its discovery, if known;
  - A description of the type of Unsecured Protected Health Information involved in the breach;
  - Steps you should take to protect yourself from potential harm resulting from the breach;
  - A brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
  - Contact information, including a toll-free telephone number, e-mail address, website, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date, we will post a notice of the breach on the homepage of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and maintain a written log of beaches involving less than 500 patients.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are till entitled to a paper copy of this Notice. You may obtain a copy of this Notice on our website. www.KlebanowandAssociates.com.

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section E: Changes to This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at, or are admitted to, the Provider for treatment or health care services as an impatient or outpatient, we will offer you a copy of the current Notice in effect.

Section F: Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hippa/complaints/index.html.
To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section G: Other uses of Medical Information. Other uses and disclosures of medical information not covered by this Notice, or the laws that apply to us, will be made only with your written permission. If you provide us permission to use or disclose medical information about your child(ren), you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Section H: Organized Healthcare Arrangement. The Provider, the independent contractor, members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment, or health care operations. This enables us to better address your healthcare needs.

____

Printed Name   Signature   Date

Child/ Children's Names: ____

Important Information

Welcome to Kenneth M. Klebanow, M.D. and Associates, P.A. We look forward to serving your pediatric care needs. ☺ To avoid any misunderstanding concerning your medical bill and/ or our payment policy, please read the following information and feel free to discuss any questions you might have with our billing staff. A member of the billing staff is available to meet with you in the office at the time of your visit Monday through Friday from 9:00a.m. to 4:00p.m. or by phone at 410-964-0903.

You will need to present your current insurance card and we must be able to verify active coverage, or you will be required to pay in full for services extended to you at the time of your visit. Co-payments must be made each visit. Your health insurance benefits are determined by your policy. Please read your benefit book carefully so that you are familiar with your insurer's requirements for co-payments, deductibles, or coinsurance, referrals, or services requiring pre-certification. We will assist you in receiving the maximum benefit allowed for your child's treatment here. However, the filing of any insurance claim form on your behalf does not release you of the responsibility for seeing that your bill is paid in full. **If your child is covered under more than one policy, you must disclose that fact. Failure to do so can result in retroactive denial of claims with retraction of payment and you could be responsible for the entire amount of the claim.**

Insurance Claim Submission: We need your child's insurance information to file claims in a timely fashion for reimbursement. If you do not provide the correct information to us within your insurance company's allowable time for filing and your claim is denied due to timely filing, you will be responsible for all services rendered. **We will submit a claim for you. You are responsible for any amounts not paid by your insurance. This includes deductibles, co-insurance, or co-payments.**

***If medical conditions beyond the scope of a routine well exam are discussed during your child's well visit, there may be additional charges to your insurance company. The insurance company may require you to pay a copay, deductible, or co-insurance.**

Medical Assistance: We participate with Maryland Medical Assistance and Priority Partners MCO. **We do not accept any other MCO's or any out of state medical assistance.**

HMO/ PPO Policies: In order for treatment to be covered, one of our physicians must be listed as your child's Primary Care Physician, or the office listed as your center/ site, with your insurance carrier. Otherwise, the HMO/ PPO may deny or reduce benefits and you will be responsible for the unpaid portion.

Legal Cases: We are unable to extend credit service until your case is settled or litigated. However, we will send you a copy of your receipt to submit to your attorney if you request so in writing.

Divorce/Separation: We are not parties in your separation agreement/ divorce decree. Payment for services is the responsibility of both parents, unless otherwise stated by a court document signed by a judge.

Important Information

I understand that I am responsible for payment for my child/ children's medical services and I agree to the following fees:

Missed Appointments: If you cancel your appointment, with less than 24 hours' notice, or miss your appointment, you will be charged $25 for well visits and $50 for Behavioral Health Consultations.

Fee for Health Forms: There is a $10 fee per set for the completion of all health forms (Pre-School, Kindergarten, Outdoor Ed, Sports, Camps, College, etc.) Please allow 5-7 business days for completion and be sure the parent's part is completed before giving to the office.

Returned Check Fee: If your check is returned from the bank, due to insufficient funds, a fee of $10 will be charged to your account, in addition to the amount of the check.

Fees for Medical Records: If you need a copy of an immunization record, there is no charge. To get a copy of the abbreviated record, there is a $5 fee. To get your entire record, there is a fee of $15. A discount is given for records of each additional child. Please allow 2 weeks for completion.

Collections Fee: **If your child/ children's account is referred to a collection agency because of nonpayment of balance due, you will be responsible for any and all costs of collection, including 33.5% collection fee and any attorney fees.**

Forms of Payment: We accept cash, checks, money orders, MasterCard, Visa, American Express, and Discover.

If you are arranging to have an adult, other than yourself, to bring your child to the office, please make sure that you have provided us with a signed **HIPPA Authorization/ Emergency Contact Form**, which we will provide to you, so that we may treat your child in your absence. Also, make sure to provide them with your child's copay and current insurance card.

I hereby authorize Kenneth M. Klebanow, M.D. and Associates, P.A. to apply on my behalf for benefits for services rendered to my child/ children by Kenneth M. Klebanow, M.D. and Associates, P.A. I also authorize Kenneth M. Klebanow, M.D. and Associates, P.A. to release all necessary information including medical information for this and any subsequent claim to determine benefits to which I am entitled. I permit a copy of this authorization to be used in place of the original. Further, I certify that the information I have reported about my insurance coverage is correct.

I read and agree to the terms set forth above on both pages.

____

Printed Name   Signature   Date

Child/ Children's Names: ____

Kenneth M. Klebanow, MD & Associates P.A.

Patient's Name: ____ Date of Birth: _____________________

Welcome to Kenneth M. Klebanow, M.D. and Associates. We are pleased to be entrusted with your child's medical care. In order to do so effectively, we would appreciate some background information. We feel that the following information is helpful for your child's care. Please help us by answering the following questions. If you do not feel comfortable answering some of these, please feel free to leave them blank.

If newborn appointment, which hospital was your baby born at? ____________________ Doctor your child saw:___________________

Pregnancy and Birth

	Yes	No
1. Did you have any medical problems during pregnancy, such as high blood pressure, diabetes, urinary infections, etc.? If yes, explain: ____	☐	☐
2. Were you on any medications during pregnancy? Which? ____	☐	☐
3. Did you have any prenatal tests (Ultrasounds, amniocentesis, etc.?) If yes, were any abnormal? ____	☐	☐
4. During pregnancy did you smoke, drink alcohol, or use recreational drugs? If yes, explain: ____	☐	☐
5. During pregnancy did you use over-the- counter medications? If yes, explain: ____	☐	☐
6. Were there any problems with labor? If yes, explain: ____	☐	☐
7. Vaginal birth? If no, reason for C-section: ____	☐	☐
8. Was your baby born more than 3 weeks before your due date? If yes, how many weeks early? ___________________________	☐	☐
9. Was your baby born more than 2 weeks late? If yes, how many weeks late? ____________________________	☐	☐
10. Were there any problems in the nursery? If yes, circle all that apply: Heart murmur requiring evaluation — On antibiotics for infection Breathing problems — Jaundice requiring treatment with lights Other: ____	☐	☐
11. Did the baby go home at the same time the mother was discharged? If not, how long did baby have to stay? ________________________________	☐	☐
12. Did your child receive the Hepatitis B vaccine in the hospital? If yes, what date? ____	☐	☐

Kenneth M. Klebanow, MD & Associates P.A.

Past Medical Problems

	Yes	No
1. Does your child take any medications regularly?	☐	☐
2. Has your child had any hospital admissions? (not just ER visits)	☐	☐
3. Has your child had any surgical procedures?	☐	☐
5. Does your child see a specialist regularly?	☐	☐
6. Does your child have any emotional problems?	☐	☐
7. Does your child have any school problems?	☐	☐

1. Does your child take any medications regularly?
   If yes, please list:
   Medication: ________________________________Dose: ______ Frequency: ____________________
   Medication: ________________________________Dose:_______ Frequency: ____________________
   Medication: ________________________________Dose: _______Frequency: ____________________
2. Has your child had any hospital admissions? (not just ER visits)
   If yes, please explain: ___________________________________
3. Has your child had any surgical procedures?
   If yes, please list:
   Age: __________________ Type of surgery: __________________________
   Age: __________________ Type of surgery: __________________________
   Age: __________________ Type of surgery: __________________________
4. Has your child had significant injuries such as: (include child's age at time of injury)
   Broken bones: ____
   Skin wounds requiring stitches: ____
   Second degree burns: ____
   Head injuries: ____
5. Does your child see a specialist regularly?
   If yes, which specialty? ____
6. Does your child have any emotional problems?
   If yes, explain: ____
7. Does your child have any school problems?
   If yes, explain: ____

Ongoing medical conditions

Does your child have any ongoing medical problems such as: (circle all that apply)

Frequent ear infections	Frequent headaches	Recurrent belly pains	Frequent strep throat
Recurrent urinary infections	Asthma	Diabetes	Seizures

Other:____

Kenneth M. Klebanow, MD & Associates P.A.

Allergies

	Yes	No
1. Does your child have any allergies? (Include type of reaction)	☐	☐
2. Does your child have an Epi-Pen?	☐	☐

Sub-items under question 1:

a. Seasonal (which seasons):____
b. Food (please list): ____
c. Animals: ____
d. Medications: ____
e. Dust/ molds: ____
f. Other: ____

Family History

Please list any medical problems that family members have.

(F= father, M= mother, S= Sister, B= Brother, MM= mother's mother, MF= mother's father, FM= father's mother, FF= father's father, MB= mother's brother, etc.) Please note, the codes above are relative to the **child**. For example, if you are the father filling this out and **your** mother has asthma, write "FM" next to asthma, not "M".

Asthma _______________________ High blood pressure ______________________ Strokes _______________

Heart disease _____________________________ Heart attacks ___________________

Did anyone have a heart attack or stroke <55 years of age_________________________

Diabetes ______________________ Seizures ___________________________ Migraines __________________

High cholesterol ____________________ Hay fever _________________ Other Allergies___________________

Cancer(what type)__________________________ Alcoholism _______________ Drug problems ____________

Sudden unexpected death ___________________________ Other problems _____________________________

Social

1. Parent's marital status: married, divorced, separated _________________________________
2. Who lives with the child? ____
3. Is the child in school or daycare or home all day? ____________________________________
4. Are there any pets in the house? ____
5. Is there anything you feel we should know about your child? (hobbies/ interests/ concerns)

   ____

Kenneth M. Klebanow, MD & Associates P.A.

HIPPA Authorization / Emergency Contacts

Emergency Contact / HIPPA Authorization

Please check box if authorized to treat in your absence

	Yes	No
Name: ______________________________ Relationship to patient: ______________________________ Phone #: ______________________________	☐	☐
Name: ______________________________ Relationship to patient: ______________________________ Phone #: ______________________________	☐	☐
Name: ______________________________ Relationship to patient: ______________________________ Phone #: ______________________________	☐	☐

Children covered under authorization

Name: ______________________________ Date of Birth: ____________________

Name: ______________________________ Date of Birth: ____________________

Name: ______________________________ Date of Birth: ____________________

Name: ______________________________ Date of Birth: ____________________

Name: ______________________________ Date of Birth: ____________________

Name: ______________________________ Date of Birth: ____________________

Guardian Consent

I, ______________________________, authorize the following named person/ persons to authorize medical treatment for child/ children by Kenneth M. Klebanow, M.D. and Associates, P.A.
I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.
I understand that I may terminate this authorization form. I must notify Kenneth M. Klebanow, M.D. and Associates, P.A. in writing regarding termination and effective date.

Signature : ______________________________

Relationship to patient: ______________________________ Date: ____________________