

PEDIATRIC HEALTHCARE ASSOCIATES
(203) 452-8322

Dear Caregiver / Patient,

Today you are being asked to complete one or more of the following developmental and/or emotional tests. The appropriate tests, based on your child's age, are included in this packet.

- ☐ **ASQ Screening** – for all children 9 months to 15 months of age (this will be given in the office)
- ☐ **MCHAT Test** – done at 18 months and 24 months
- ☐ **Pediatric Symptom Checklist (PSC-17)** – for all children 6 to 15 years of age
- ☐ **Modified Testing for Teens (PHQ-9)** – for all teens 16 & 17 years of age
- ☐ **Patient Health Questionnaire (PHQ-9)** – 18 years and older
- ☐ **Edinburgh Postnatal Depression Scale (EPDS)**
- ☐ **Social Determinants of Health (SDoH)** – all annual well exams
- ☐ **Preschool Pediatric Symptom Checklist (PPSC)** – 30 months to 5 years of age
- ☐ **Tuberculosis Screening**

All of these standardized tests are recommended by the American Academy of Pediatrics to determine any signs of developmental and/or emotional concerns.

These tests will be submitted to your insurance company. Depending on your plan, the testing might be subject to a deductible or co-insurance.

<u>If so, you will be billed for any patient balance.</u>

Parents of 18 Year Olds at PHA

We recently provided your child with information regarding turning 18. In order to help you through this process, we are providing you with information as well.

Upon turning 18, your child is now considered to be an adult and is responsible for their own healthcare. Because of this, we asked your child to complete a new patient registration form. Your child has been given a new patient account separate from your family.

What you need to know as a parent:

1. In the past, we were able to talk to you about your child's health. Now that your child is 18, he or she is considered an adult and, therefore, we will not be able to discuss anything with you without your child's consent. Due to federal laws, we are required to talk with your child regarding these issues. We can talk to you if your child completes the Consent to Discuss and Share Protected Health Information form. Your child was given this consent form to complete. This needs to be received and be on file in order for us to discuss any health issues with you. Please note that your child does not have to complete the consent form but, if it is not completed, we will only be able to talk with your child about their care even if they are away at college.

2. Due to federal law, as an adult, your child is the only one who can access their medical record. Your child may request that the information is released to you, but again, we must have written authorization for this. This means, if they are away at college and need information, they will need to complete a medical records release form themselves and fax or mail it to us.

3. Your child now has their own patient account. The bills may come to your address but will be under their name. If this causes concern, please talk to your child. You may request that the bills come to you at your address, but this must be a mutual request from your child as well.

4. We will still bill your insurance for your child as long as he or she is eligible and has given you access to both medical and account information. Even though the explanation of benefit comes to you, the bill is still your child's responsibility, and we are not able to discuss billing with you unless the previously discussed consent form has been completed.

These changes are not intended to cause difficulty. However, due to federal law, when your child turned 18, they became a legal adult. All these changes are designed to appropriately treat your child as an adult. Please take the time to talk to your child and discuss this new responsibility with them.

After Turning 18 at PHA

When you turn 18, or older, seeking medical care is a new responsibility. As an adult, you have the right and the responsibility for your medical care. This means that you can now seek medical care without your parents' consent.

Here are a few things to remember:

1. You may call for an appointment whenever you need.

2. Your parents may come to the appointment with you, but you will need to check in yourself and sign appropriate forms if needed. Some of these forms are contact information verification, financial responsibility, and medical treatment consent forms.

3. You will need to provide insurance information that shows you have active coverage. If you do not have insurance, you will be asked to sign a financial responsibility form.

4. You will need to pay for co-pays at time of service.

5. You will need to sign for any medical treatment consents, including vaccinations. Your parents can no longer sign for you.

6. If you are covered by a state Medicaid plan, when you turn 19, you are no longer eligible to receive free vaccines through the state.

7. Unless specific consent is given, we are not permitted to talk with your parents about your health care. Your parents can only be involved if you provide written consent to do so.

8. If you refuse to give access to your parents to your medical information, know that you must either pay cash for your visit or provide other health insurance that your parents do not hold for you. If we submit your confidential visits to your parents' health insurance, they will be receiving your medical information via the Explanation of Benefits (EOB) that comes directly from the insurance carrier. Denying parental access to PHI means both for records and for payment. Therefore, you cannot use your coverage under your parent's policy if you refuse them access to your medical record.

PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY) DATE: _____

OFFICE: _____

PATIENT INFORMATION

Name_____ Date of Birth_____

Address_____ Home Phone ( )_____

City_____ Cell Phone ( )_____

State_____ Zip Code_____ Work Phone ( )_____

Employer Name_____ E-mail Address _____

Primary Care Physician_____

EMERGENCY CONTACTS

Name_____ Relationship_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

ACCESS TO MEDICAL RECORDS

I give access to my medical records and account information for personal inspection and/or discussion to:

_____ **Relationship**_____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial I _____ authorize PHA to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives PHA permission to leave this information on my cell phone or with a member of my household.

Phone number to call with information: ( )_____

_____ Initial I authorize PHA or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. PHA has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care.

PAYMENT POLICIES

_____ Initial **Insurance Information**: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances**: When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** We accept cash, checks or credit cards. PHA reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. All returned checks will be subject to a service charge of $15.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

_____ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows:** A $50 no show fee will be assessed for all well and specialty consult visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE:

- ☐ Caucasian
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Asian Pacific American
- ☐ Pacific Islander
- ☐ Subcontinent Asian American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Black Non-Hispanic
- ☐ Other Race or Ethnicity
- ☐ White Non-Hispanic
- ☐ Race Not Reported – Refusal
- ☐ Race Not Reported – Don't Know
- ☐ Race Not Reported – Not Ascertained

ETHNICITY: ☐ Latino/Hispanic ☐ Not Latino or Hispanic ☐ Other ☐ Refused

Language predominantly spoken _____

COMPLETION OF THIS SECTION IS OPTIONAL

GENDER IDENTITY **Child's Name:** _____

- ☐ (M)ale – person specifies gender identity as male.
- ☐ (F)emale – person specifies gender as female.
- ☐ (FTM) Transgender Male / Female-to-Male – person specifies gender identity as transgender male.
- ☐ (MTF) Transgender Female / Male-to-Female – person specifies gender identity as transgender female.
- ☐ (G) Genderqueer – neither exclusively Male nor Female.
- ☐ (O)ther – person specifies a gender identity that is other than the options of Male, Female, Transgender Male, Transgender Female, or Genderqueer.
- ☐ (D)eclined

My signature below indicates I am the patient listed on the front page and that I have provided accurate information to the best of my knowledge and I understand and agree to all the provisions as stated.

Patient Signature _____ Date _____

Tuberculosis Risk-Assessment Questionnaire

1. Was this child born in a country other than the United States? YES NO

   If yes, where was he/she born and when did they come to the U.S.?

   _____

2. Was this child's mother or father born in a country other than the United States? YES NO

   If yes, where were they born and when did they come to the U.S.?

   _____

3. Has this child traveled to another country since their last physical exam? YES NO

   If yes, where did he/she travel? _____

   With whom did he/she stay? Friends / Relatives Hotel

   Were they there for one month or more? YES NO

4. Has this child been exposed to anyone with tuberculosis or a positive TB skin test since his/her last physical exam? YES NO

PHQ-9: MODIFIED FOR TEENS

PATIENT: _____ **DOB:** _____ **DATE:** _____

INSTRUCTIONS: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom, put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	*(1)* Several Days	*(2)* More Than Half The Days	*(3)* Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? *Or the opposite* – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the past year, have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] YES [ ] NO

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
[ ] NOT DIFFICULT AT ALL [ ] SOMEWHAT DIFFICULT [ ] VERY DIFFICULT [ ] EXTREMELY DIFFICULT

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] YES [ ] NO

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?
[ ] YES [ ] NO

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your health care clinician, go to a hospital emergency room, or call 911.

OFFICE USE ONLY **SEVERITY SCORE:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999). Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000).

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Shelton - Business Office
100 Beard Sawmill Rd. - 430
Shelton, CT 06484

SDoH Screening Tool

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Date: _____

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

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Understanding Meningococcal B Vaccine
Helping Parents / Teens Decide

Meningococcal disease is a serious infection caused by bacteria called "Neisseria meningitides", which cause meningitis (infection of the protective covering of the brain and spinal cord) and septicemia (infection of the blood stream). Meningitis can be fatal or lead to permanent disabilities such as hearing loss and brain damage. Septicemia can also be fatal or cause serious damage to organs and skin sometimes resulting in amputation of toes, fingers or limbs.

Of the many serogroups (types) of these bacteria, five cause most of the disease (A, B, C, W and Y). We routinely give a meningococcal vaccine at age 11 years, with a booster dose given at age 16 years, that helps prevent infection from four of the groups (A, C, W and Y).

In early 2015, vaccines to help prevent infection by serogroup B were approved by the Food and Drug Administration (FDA) and Center for Disease Control (CDC) for everyone 10 years and older who have an increased risk for the infection, including:

- Immune deficiencies that involve the "complement pathway"
- People who don't have a spleen or whose spleen does not function well
- Scientists who routinely work with the bacteria
- People at risk during an outbreak of the disease

In June of 2015 the CDC Advisory Committee on Immunization Practices (ACIP) stated that a **meningococcal B vaccine series MAY be administered to adolescents and adults 16 through 23 years of age without the risk factors listed above who choose to be vaccinated.** For low risk individuals, Men B vaccination is a two dose series, 6 months apart. **The preferred age for the vaccine is 16 through 18 years**, prior to college entrance, since college freshman are at increased risk for meningococcal disease compared to the general population.

The main reason the ACIP did not recommend routine vaccination for the entire population is that, although the infection can be devastating, the number of cases of infection with meningococcal group B bacteria is low and the cost to society would be high to prevent a small number of infections.

SOME COLLEGES MAY REQUIRE STUDENTS TO BE VACCINATED AGAINST MEN B. MANY COLLEGES RECOMMEND IT.

The vaccination is covered by all insurances.

Please let us know if you have other questions so we can help you decide about choosing meningitis B vaccine for your teen.

Pre-Concussion Screening
also-known-as
Baseline ImPACT Testing



We at PHA recommend that all student athletes age 12 and older take the ImPACT test every two years. The test is used to establish a baseline for future use, helping guide the best treatment if your child sustains a concussion.

This 25 minute computerized test evaluates multiple aspects of brain function.

Baseline ImPACT Test costs $30.00 which is due at the time of service.

Call our office (203) 452-8322 to schedule an appointment for your child.

PHA

Pediatric Healthcare Associates

www.PHA4KIDS.com

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Pre-Concussion Screening
also known as
Baseline ImPACT Testing

What is a Pre-Concussion Screening (Baseline ImPACT Test) & why is it important?

- The test is to establish a baseline for future use in helping to determine the best post concussion treatment if your child should be injured in a sporting or non-sporting event.
- ImPACT does not diagnose a concussion but informs the provider if there is a change in the way your child's brain functions after an injury.
- Baseline scores are valid for two years and should be repeated if two years has lapsed.

What is ImPACT testing?

- ImPACT testing is a computerized brain measurement tool for children and teens who have sustained a concussion.
- Through a series of computerized tests completed in our office, ImPACT identifies subtle changes in brain function, evaluates post-injury condition, and tracks recovery.
- By comparing pre-injury baseline and post-injury tests results, ImPACT can help track recovery following a concussion.

How does ImPACT testing work?

- An ImPACT test is a 25-minute computerized assessment test that evaulates multiple aspects of brain function including verbal memory, visual memory, processing speed, reaction time and post-concussive symptoms.
- By comparing pre-injury baseline and post-injury test results, it helps determine when brain function has returned to normal and if it is safe to return to sports and school activities.

Who can take the ImPACT test?

- We recommend that all student athletes age 12 and older (for example: football players, soccer players, hockey players, baseball players, rugby players, cheerleaders, softball players, skateboarders, gymnasts, lacrosse players, cyclists, and skiers) take the test.

How can my child get tested?

- Call PHA (203) 452-8322 for an appointment.
- The Baseline ImPACT Tests costs $30.00. The test is not covered by insurance and payment is due at time of service.