

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>

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

PATIENT: _____ DOB: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

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PEDIATRIC HEALTHCARE ASSOCIATES
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www.pha4kids.com

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50 Unquowa Place
Fairfield, CT 06824

Shelton
4 Corporate Dr. - 290
Shelton, CT 06484

Stratford
99 Hawley Lane
Stratford, CT 06614

Trumbull
15 Corporate Dr.
Trumbull, CT 06611

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

SDoH Screening Tool

Patient Name: _____ Phone Number: _____

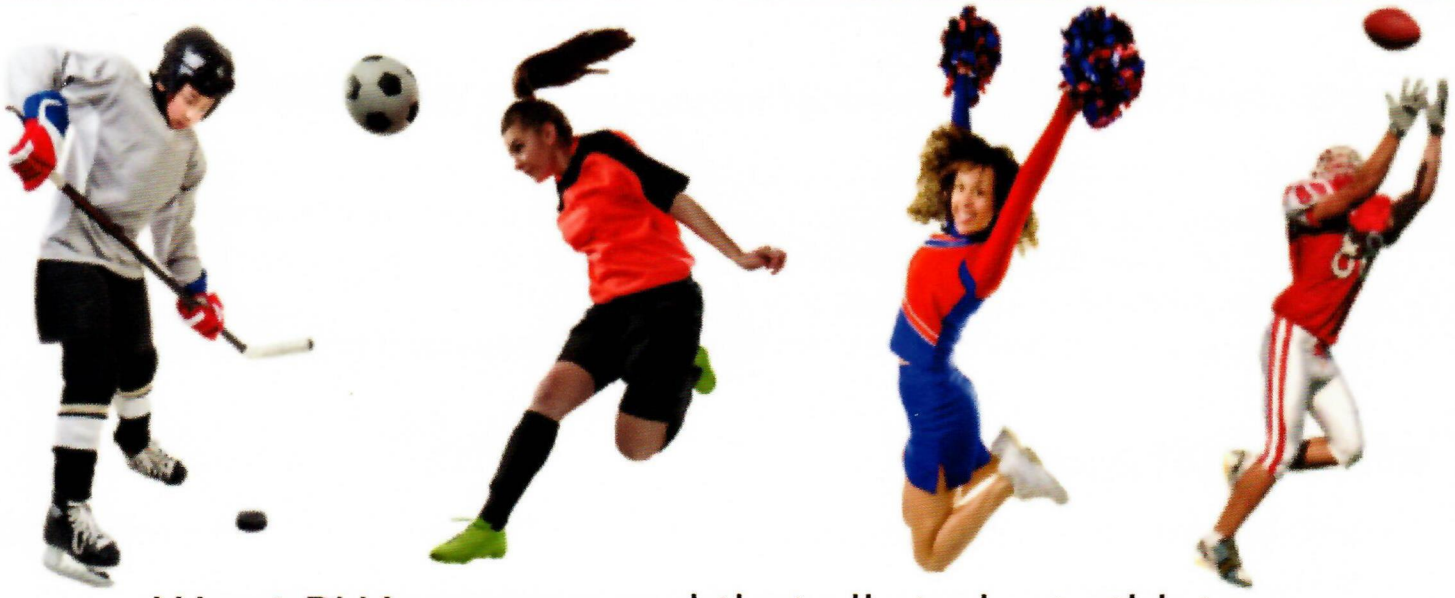
Date of Birth: _____ Date: _____

		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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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

Pediatric Healthcare Associates

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.