# Quincy Pediatric Associates Inc
## Registration Form
**(Please print clearly)**

| Today's Date: | PCP: | | | | |
|---|---|---|---|---|---|
| Childs Last Name | First | Middle | M | F | Date of Birth |
| Mother's Name | Father's Name | Partner's Name | Marital Status (circle one) Single/Mar/Div/Sep/Wid | | |
| Street Address | Home Phone | Cell Phone | Email Address | | |
| PO BOX | City | State | Zip Code | | |
| Other family members seen here: | | | | | |

### GUARANTOR (person responsible for the bill)

| Name | Date of Birth | Address If different | Cell phone |
|---|---|---|---|
| | | | |

### INSURANCE INFORMATION

| Please indicate Primary Insurance | | □ Blue Shield | □ Tufts Health | □ HPHC | □ United Health |
|---|---|---|---|---|---|
| □ Cigna Health | □ Aetna | □ Tricare | □ MassHealth | □ Allways | □ Unicare |
| □ Other-Please list: | | | | | |

| Subscribers Name | Subscribers SS# | Date of Birth | Policy Number |
|---|---|---|---|
| | | | |

| Patients relationship to subscriber | □ Self | □ Child | □ Other | |
|---|---|---|---|---|
| Secondary Insurance (if applicable) | Subscribers Name | Date of Birth | Policy Number | |
| Patients relationship to subscriber | □ Self | □ Child | □ Other | |

### IN CASE OF EMERGENCY

| Name of friend or relative (not living at the same address) | Relationship | Home Phone | Cell phone |
|---|---|---|---|
| | | | |

### AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benfits be paid Dlrectly to the physician. I understand that I am financially responsible for any balance, as stated in the financial policy, for whichI received a copy. I also authorize Quincy Pediatric Associates Inc. or insurance company to release any information required to process my claims.

Patient/Parent/Guardian Date

# Quincy Pediatric Associates Inc.
## Patient History Form

01/01/2015

| Name | Date of Birth | Parent E-mail Address |
|---|---|---|
| PCP | Todays Date | Telephone: Home ▫ Cell ▫ |

| Primary Language: | Secondary Language: |
|---|---|
| Race/Ethnicity: | ▫ White, Non-Hispanic ▫ Black, Non-Hispanic ▫ Hispanic ▫ Asian ▫ Native American ▫ Native Hawaiian and Other Pacific Islander ▫ Other |
| Current Health Concerns: | |

| BIRTH HISTORY (complete only if child is < than 3 years of age) | | | |
|---|---|---|---|
| Birth Hospital: | Pregnancy Problems: | ▫ Yes | ▫ No |
| Birth Weight: | Labor/Delivery Problems: | ▫ Yes | ▫ No |
| Discharge Weight: | Problems in the Nursery: | ▫ Yes | ▫ No |
| Discharge Date: | Breastfeeding | ▫ Yes | ▫ No |
| Pregnancy Duration: | Bottle Feeding | ▫ Yes | ▫ No |

| PAST MEDICAL HISTORY |
|---|
| Chronic Illness/Injuries? |
| Hospitalizations/Surgeries? |
| Behavior Issues? |
| School Issues? |

| ALLERGIES | | | |
|---|---|---|---|
| Allergic to any medications? | ▫ No | ▫ Yes | List: |
| Adverse Reaction to Medications | ▫ No | ▫ Yes | List: |
| Allergic to any foods? | ▫ No | ▫ Yes | List: |
| Other Allergies? | ▫ No | ▫ Yes | List: |

**MEDICATIONS**

List all medications you are currently taking including prescription medications, over the counter medications and herbal remedies

| SOCIAL HISTORY | | |
|---|---|---|
| Parent/Guardian#1: | DOB | Occupation: |
| Parent/Guardian#2: | DOB | Occupation: |
| Does child live with parents: ▫ Yes ▫ No | Parents Living together ▫ Yes ▫ No | Marital Status ▫ M ▫ S ▫ D |
| If parents are divorced or not living together, What is the custody status: | | |
| How often does child see parent not living in the home: | | |
| Is child adopted ▫ Yes ▫ No | | |
| Household (All those living in the child's home: names, gender and ages: | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Do you have any pets at home: ▫ Yes ▫ No | | |
| Does anyone smoke at home: ▫ Yes ▫ No | | |
| Do you have any firearms in the home: ▫ Yes ▫ No | | |

*PLEASE COMPLETE BOTH SIDES OF THIS FORM*

| FAMILY HISTORY<br>Please check if there is a family history of the medical problems noted below<br>(mother, father, siblings, grandparents, aunts and uncles) | | | | | |
|---|---|---|---|---|---|
| Problem | Relationship | Maternal/Paternal | Problem | Relationship | Maternal/Paternal |
| ▫ ADD | | ▫ M ▫ P | ▫ GERD (reflux) | | ▫ M ▫ P |
| ▫ AIDS | | ▫ M ▫ P | ▫ Heart Attack | | ▫ M ▫ P |
| ▫ Alcohol | | ▫ M ▫ P | ▫ Heart Murmur | | ▫ M ▫ P |
| ▫ Allergies | | ▫ M ▫ P | ▫ Hepatitis | | ▫ M ▫ P |
| ▫ Asthma | | ▫ M ▫ P | ▫ High Cholesterol | | ▫ M ▫ P |
| ▫ Autistic Disorder | | ▫ M ▫ P | ▫ Hypertension | | ▫ M ▫ P |
| ▫ Birth Defects | | ▫ M ▫ P | ▫ Hyperthyroidism | | ▫ M ▫ P |
| ▫ Cancer | | ▫ M ▫ P | ▫ Hypothyroidism | | ▫ M ▫ P |
| ▫ Colitis | | ▫ M ▫ P | ▫ Learning Problem | | ▫ M ▫ P |
| ▫ Cystic Fibrosis | | ▫ M ▫ P | ▫ Mental Retardation | | ▫ M ▫ P |
| ▫ Depression | | ▫ M ▫ P | ▫ Migraines | | ▫ M ▫ P |
| ▫ Diabetes | | ▫ M ▫ P | ▫ Rheumatoid Arthritis | | ▫ M ▫ P |
| ▫ Drug Abuse | | ▫ M ▫ P | ▫ SIDS | | ▫ M ▫ P |
| ▫ Eczema | | ▫ M ▫ P | ▫ Tuberculosis | | ▫ M ▫ P |
| ▫ Epilepsy | | ▫ M ▫ P | ▫ Urinary Problems | | ▫ M ▫ P |
| **Any other medical conditions "that run in the family"?** | | | | | |

| SAFETY/ENVIRONMENT | | | | | |
|---|---|---|---|---|---|
| Working Smoke Detectors in home | ▫ Yes | ▫ No | Does your child always wear a seat belt? | ▫ Yes | ▫ No |
| Carbon Monoxide Detectors in home | ▫ Yes | ▫ No | Does your child use sunscreen | ▫ Yes | ▫ No |
| Does your child use car seat/booster seat | ▫ Yes | ▫ No | Does your child use insect repellant | ▫ Yes | ▫ No |
| Does someone in your family know CPR | ▫ Yes | ▫ No | Does your home contain lead paint | ▫ Yes | ▫ No |

| TUBERCULOSIS SCREEN | | | |
|---|---|---|---|
| Has anyone in your household come to the United States from another country | ▫ Y ▫ N | What Country: | |
| Has your child lived with or spent time with anyone who was positive for tuberculosis | | ▫ Yes | ▫ No |
| Has your child lived or spent time with anyone who has a positive skin test for tuberculosis | | ▫ Yes | ▫ No |
| Has your child lived with or spent time with adults who have AIDS or are infected with HIV | | ▫ Yes | ▫ No |
| Has your child lived with or spent time with adults who use/used intravenous drugs or other street drugs | | ▫ Yes | ▫ No |
| Has your child lived with or spent time with adults who lived in a correctional facility, nursing home or mental institution | | ▫ Yes | ▫ No |
| If your child had a positive skin test for tuberculosis in the past and received treatment, inform your child's health care provider. Your child will not need another test | | | |

| VACCINES FOR CHILDREN PROGRAM |
|---|
| PATIENT ELIGIBILITY SCREENING QUESTIONS |
| Parents: This information is required by the state of Massachusetts<br>PLEASE CHECK ONE |
| |
| ▫ This child is enrolled in Medicaid (includes MassHealth and HMO's etc., if enrolled in Medicaid) |
| ▫ Does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan) |
| ▫ Is Native American (American Indian) of Alaskan Indian |
| ▫ Has health insurance and is not Native American (American Indian) or Alaskan Indian |

| Signature of Parent/Guardian: | Date: |
|---|---|
| Do you want electronic access to PHI (personal health information) via Patient Gateway? ▫ YES ▫ NO | |

## BILLING AND FINANCIAL POLICIES

We at Quincy Pediatric Associates are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

## COPAYMENTS

All co-payments required by your insurance carrier **MUST** be paid in full at the time of service. We accept cash, personal checks (in-state only), Visa, MasterCard, Discover, American Express and all debit cards. Failure to pay your co-pay at check in for *whatever* reason will result in an additional charge of $10.00 (Ten dollars). There is a service charge of $15.00 (Fifteen Dollars) for all returned checks. Please help keep costs down by being prepared to pay your co-pay on the day of your visit. The parent/legal guardian bringing the child (ren) in for the visit will be responsible for the payment.

We are not able to be involved in billing disputes in cases involving divorce or separation, and will not split bills among family members. It is the obligation of the parent, not our office, to collect medical bills from the other parent.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling routine appointments.

## INSURANCE

We bill **participating** insurance companies as a courtesy to you. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. If you receive a bill, it is because we believe we have collected everything we can from your insurance and the balance is your responsibility. If you receive a bill and think that your insurance should have paid, call your insurance carrier directly.

**If your insurance company is NOT participating, payment in full is expected at the time services are rendered**. Your time of service receipt includes all information necessary for submitting claims to your insurance carrier.

If you are a **"Self-Pay/ No Insurance"** patient, payment is requested at the time services are rendered. If you need assistance or have questions, please contact the Billing Coordinator between 10:00 a.m. and 4:00 p.m. Monday thru Friday. We must hear from you no later than 15 days after you receive you first statement. If we have sent you three (3) statements, and we have not received payment and have not heard from you, your physician will be notified. A decision will be made whether to send your account to collections. We also reserve the right to terminate you from our practice.

## MISSED APPOINTMENTS

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge for missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Quincy Pediatric Associates, Inc billing and financial policy. I agree to assigning benefits to Quincy Pediatric Associates, Inc whenever necessary.

Signature of insured/parent or authorized representative:

_____ Date: _____

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY**

In the material below, "you" and "your" are also used to mean and pertain to "you" or to "your child," or "your children" where appropriate. This notice is being given to you because federal law gives you a right to receive adequate notice of how our Practice handles medical information, our legal duties with regard to your medical information, and your rights with regard to your medical information.

## A. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

When you need health care, you give information about yourself to doctors, nurses, and other health care workers. This information, along with the record of the care you receive, is "protected health information." Our Practice uses your health information within the Practice and shares (or discloses) your health information outside the Practice in order to provide you with essential medical care and for other purposes. This Notice of Privacy Practices describes how we use and disclose your health information and when we will ask for specific permission to do so.

### 1. Treatment, Payment and Health Care Operations

Our Practice may legally use and disclose your health care information for treatment, payment and health care operations, and need not ask for your specific permission to do these things, as explained below.

#### Treatment

Our Practice may legally use and disclose your health information to provide, coordinate or manage your health care and related services by one or more health care providers. We will also share information with other third parties, such as home health agencies, visiting nurses, schools (immunization records, as required by education laws), and others who are involved in the care of your children. This helps to make certain that everyone caring for your child has the information needed.

#### Payment

Our Practice will use and disclose health information to bill and collect payment for health care services we provide. If you have health insurance, our providers bill those payers and will disclose information that the insurance companies or government agencies need in order to determine your child's eligibility for services or the medical necessity of the services you received. In those cases, we will provide the minimum health information necessary for payment. In most cases, this information consists of the diagnosis (medical reason for the visit or service) and the procedure(s) performed, such as an office visit, laboratory tests, or immunizations.

#### Health Care Operations

Our Practice may use and disclose your health information for activities that are necessary to operate the Practice and carry out its mission. Some disclosures are to outside parties, who must agree to protect the confidentiality of all health information they receive from us. Examples of "health care operations" include, but are not limited to, the following: Quality assessment; Auditing activities and Compliance programs; Using outside Legal, Auditing, or other Consulting services; Electronic data storage; and Medical information management and analysis.

### 2. Uses and Disclosures for other purposes

Federal privacy law also permits uses and/or disclosures of your child's health information in the following areas without your specific permission:

- As required by law
- For public health activities, including reports to the state public health and child protection authorities, and to the Food and Drug Administration
- For health oversight activities
- For legal and administrative proceedings
- For law enforcement purposes
- With regard to patients who have died, to coroners, medical examiners and funeral directors
- To avert a serious threat to health or safety

3. Uses and Disclosures That You May Limit or Request Not Be Made

Our Practice may disclose to a family member or other person close to you, or identified by you, the health information that is necessary for that person's involvement with your care.

4. Uses and Disclosures Requiring Your Written Authorization

- Disclosure of sensitive information to administrative and judicial proceedings (counseling, confidential communications between a parent and/or child and social worker or therapist, and the like)
- Disclosure of genetic testing (as defined by state law) or test results
- Disclosure of HIV testing or test results
- Disclosure of substance abuse treatment
- Disclosure of treatment for sexually transmitted diseases
- Research conducted by entities outside our Practice
- Marketing/Communication to you about products and services you might purchase
- Other uses not covered above that our Practice may describe when asking for your permission

Note: If you have given authorization, you may revoke it at any time, provided that the revocation is in writing, except to the extent that a use or disclosure has been made in reliance upon your prior authorization.

## B. YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION AND HOW TO EXERCISE THEM

The Right to Request Limits on Uses and Disclosures of Your Health Information

You have the right to request limitations on the uses and disclosures of your child's health information for treatment, payment or health care operations or for notification purposes. Our Practice is not obligated to agree to your request. If we agree, we must put the restriction in writing and abide by it, except if necessary to treat you in an emergency. You may not ask us to restrict uses and disclosures that we are legally required to make.

If you restrict disclosing information to your health insurance company for payment, we will ask you to sign an agreement indicating that you are originating the request, that you will be liable for payment for all such services requested at our full charge rate, and that you will not ask your insurance carrier to pay for such services or to appeal to our Practice. In the event that you contact your insurance carrier about such services, either to ask the carrier to pay or to complain that the Practice has asked for payment for a covered service (such as an office visit), we may disclose to the carrier the fact that you had agreed to a waiver to pay for services, that you had requested us not to bill or otherwise contact your carrier, and may have to disclose the reason for the visit, such as the diagnosis or procedure.

The Right to Receive Confidential Communication of Your Child's Health Information

You have the right to request to receive your child's health information by alternative means. For example, you might ask our Practice to send mail to an alternative address, or to contact you by telephone only at work. Your request must be in writing. Our Practice must agree with any reasonable request and cannot ask you to explain the basis for your request. We can require you to provide information as to how payment, if any, will be handled, and to specify an alternative address or other method of contact.

The Right to Look at and Get a Copy of Your or Your Child's Health Information

With very few exceptions, you have the right to look at and obtain a copy of you or your child's health information that our Practice maintains related to your treatment and bills. You must make your request in writing. We will respond within thirty (30) days from receipt of your request. If you ask for a copy, you will be charged a reasonable fee. If your request is denied, you will be given a written explanation of the reasons for the denial and the rights, if any, to a review of the denial. Instead of providing you with the information you requested, we may offer to provide a summary or explanation as long as you agree in advance to this and to any fees for such summary or explanation. If you ask for information we do not have, but we know where it is, we must tell you where to direct your request.

### The Right to Amend Your Health Information

You have the right to ask us to amend your health information related to your treatment and bills if you believe there are errors or missing information. You must make your request in writing and provide the reason. We have sixty (60) days to respond. If we have not been able to act on the request within sixty (60) days, we may notify you that we are extending the response time by thirty (30) days. If we do that, we will send you an explanation for the delay and state a date by which you will receive our decision. We may deny your request if we determine that the information you want amended is accurate and complete, is not part of our records or created by us, or is information to which you have no right of access. If we deny your request, we must give you a written statement with the reasons why and what other steps are available to you. If we grant the request, we will ask you to identify the persons you want to receive the amendment and agree to have us notify them along with any others who received the information before correction and who might rely on the incorrect information in providing treatment to you/your child.

### The Right to Receive An Accounting of Disclosures to Your/Your Child's Health Information

You have the right to receive a record of disclosures of your health information. You may request this for the six (6) years prior to the date of your request (but not prior to April 1, 2003) or for a shorter period. The listing you receive will include the date of each disclosure, the name (and address, if known) of the entity or person who received it, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure or a copy of the written request for information. The following exceptions apply:

- Disclosures made for purposes of treatment, payment or health care operations
- Disclosures made to you pursuant to your written authorization
- Disclosures to persons involved in your care or for notification purposes
- Disclosures for national security or intelligence purposes
- Disclosures to correctional institutions or law enforcement officials who have custody of you/your child
- Disclosures that occurred prior to the effective date shown on this Notice of Privacy Practices

We will respond to your request for an accounting within sixty (60) days, unless we need an extension of no more than thirty (30) days, in which case we will explain the reason for the delay and tell you the date by which you will receive the listing. Your first request for accounting in any twelve (12) month period is free, but we will make a reasonable charge for any other requests in that period. We will notify you of the charge before we carry out the accounting so that you have the chance to withdraw or modify the request to avoid or reduce the fee.

### *The Right to Receive a Copy of this Notice of Privacy Practices Upon Request*

***You may request a paper or email (if available) copy of this Notice of Privacy Practices from our Practice.***

## C. OUR DUTIES WITH RESPECT TO YOUR HEALTH INFORMATION

Our Practice is required by law to maintain the privacy of your/your child's health information and to provide individuals with notice of our legal duties and privacy practices with respect to your/your child's health information. Our Practice must abide by the terms of the Notice of privacy practices currently in effect. We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time and to make the new Notice of Privacy Practices effective for all protected health information that we maintain. If we do so, the updated Notice of Privacy Practices will be available in the registration area for public viewing. You may request a copy of the current Notice of Privacy Practices at any time from our Practice.

## D. HOW TO COMPLAIN IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

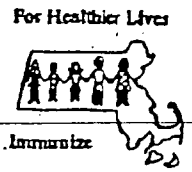
If you think that we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information, you may file a complaint with our Practice. You may also send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, or via e-mail to HHS.Mail@hhs.gov. We will take no retaliatory action against you if you file a complaint about our privacy practices.

## E. PERSON TO CONTACT FOR INFORMATION OR WITH A COMPLAINT

If you have any questions about this Notice of Privacy Practices or any complaints, please contact our Practice's Privacy Officer, or ask to speak to the Practice Administrator/Office Manager.

## F. EFFECTIVE DATE

This Notice of Privacy Practices is effective as of April 1, 2003.




MASSACHUSETTS IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

# Patient Eligibility Screening Form

Date _____

Child's full name _____

Date of birth _____

Parent, guardian, or legal representative's full name _____

Health care provider's full name _____

**This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes. Verification of responses is not required.**

## Check only one box below

**This child:**

- ☐ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- ☐ does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan)
- ☐ is Native American (American Indian) or Alaskan Native
- ☐ has health insurance and is not Native American (American Indian) or Alaskan Native

Please note that all children seen in Massachusetts practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program (first three boxes) and which get vaccines paid for by state and other federal funds (last box).

# The Mass HIway:

## Fact Sheet for Patients

The Mass HIway is a secure statewide Health Information Exchange that allows your healthcare providers to safely and quickly send your health information to where it is most needed. Doctors or nurses can care for you better when they have important information about your health. The Mass HIway is designed to make this safer and faster. The goal is better care coordination and quality for you and your family.

### What is the Mass HIway?

- Mass HIway is the statewide health information exchange (HIE). Healthcare providers can use the Mass HIway to quickly and securely send and receive your health information to better coordinate your care.
- The Mass HIway is managed by the Commonwealth of Massachusetts' Executive Office of Health and Human Services (EOHHS).

### How does the Mass HIway protect my information?

The Mass HIway has security measures in place to protect your information that aren't true of current methods, like fax, mail, or portable media like a CD or USB (flash drive), such as:

- Using a special code so that only authorized providers can read the information sent over the Mass HIway (this is known as encrypting data).
- Establishing policies and procedures that authorize the Mass HIway to suspend HIway participants as necessary to prevent unauthorized use of the Mass HIway.
- Overseeing who has access to the Mass HIway and who has used it for a patient's healthcare.

### How can the Mass HIway help me?

- If you were discharged from a hospital, the Mass HIway can be used by the hospital to send your doctor a note about your hospital stay so that he or she is up to date about healthcare that you have received.
- If you get tests done, the doctor can use the Mass HIway to send the results to other members of your healthcare team, like your specialist. This helps them coordinate your care. It can also save time and money by reducing the need for repeat tests.
- If you have a chronic condition your health insurer case manager can use the Mass HIway to communicate with your doctors to coordinate your care and help you stay healthy.
- Not all of your healthcare providers may be using the Mass HIway yet. There may be more benefits to you as more healthcare organizations use the Mass HIway.

### Who can use the Mass HIway and why?

- Currently the Mass HIway may only be used by healthcare organizations (like doctors' offices, hospitals, public health agencies, and health insurers).
- The Mass HIway can only be used for information sharing as allowed by federal and state privacy laws. You still need to give special permission for providers to request and receive certain sensitive information. You can speak to your healthcare provider about what information is sent over the Mass HIway.

### Can I request my medical record from the Mass HIway?

- No. A patient's medical record itself is not part of the Mass HIway system. Talk to your provider for information about how to obtain your medical records.

### Want more information?

- Talk with your doctor or their office staff about how they are using the Mass HIway.
- Visit www.masshiway.net, email us at masshiway@state.ma.us, or call us at 1-855-MA-HIway (624-4929) and press 3.

Original release April 2014. Updated February 2017.

Patient Consent/Opt-in to the Mass Hlway

I have been given information on the Massachusetts Health Information Highway ("Mass Hlway").

I give partners HealthCare System, Inc. (Partners HealthCare) and my health care providers permission to use the Mass Hlway to:

1) Send, request and receive my health information to and from the health care organizations that use Mass Hlway.

   This information may include information about HIV, alcohol and drug abuse treatment, mental health treatment sexually transmitted diseases, rape, sexual assault, domestic abuse, abortion and genetic testing.

2) Send my name, date of birth, gender, email home address, phone number and medical record number to Mass Hiway database. This allows providers treating me, who use the Mass Hiway, to know that I have received care with Partners associated providers and to ask for information when needed for my care.

I know that Partners HealthCare has developed an electronic health record for patient care. This electronic health record is used by:

- QUINCY PEDIATRIC ASSOCIATES INC
- Partners HealthCare, connected organizations and health care providers and
- Other non-Partners health care providers, such as Dana-Farber Cancer Institute
  (DFCI), Massachusetts Eye and Ear Infirmary (MEEI) and some community physicians and physician group.

I know that the terms "my health care providers" and "Partners associated providers" as used in this form includes all of the above users of the Partners HealthCare electronic health record.

I may take back my consent or opt-out of the Mass Hlway. To do so, I must

- Contact a Partners Health Care site privacy office. The privacy office will provide me with the opt-out form to complete.
- If I have a Partners Patient Gateway account, I can log into my account and update my Mass Hlway consent at any time.

Patient Signature: _____ Date: _____

Signature of Representative: _____ Date: _____

Relation to patient: _____

# ACKNOWLEDGMENT OF
## RECEIPT OF NOTICE OF PRIVACY PRACTICES

In this notice, "you" and "your" are also used to mean and pertain to "you" or to "your child" or "your children" where appropriate.

The providers (physician, nurse practitioners), nursing and administrative staff at our Practice, at the Directions of the physicians, may share your health information for treatment, payment and health care operations.

I understand that my health information may be used for treatment payment or healthcare operations purposes, such as:

1. Sharing my health information among providers (both inside and outside the practice), on a need-to-know basis, to give me treatment.
2. Using my health information for billing purposes, including giving referrals to specialists, when necessary and appropriate.
3. Sharing my health information with health insurance companies, government agencies, or other payers that request information related to benefits determinations, claims file for visits or admission, and other billing matters.
4. Using my health information for healthcare operations, including monitoring the quality of care, audits and surveys, and carrying out other business and administrative activities.

I understand that all reasonable efforts will be made to protect the privacy of my health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, email, and fax mail).

I have been given the opportunity to read the Notice of Privacy Practices that outlines in more detail how my health care information is used and shared with others. The Notice of Privacy Practices explains (1) When I need to give further approval for the providers to use my health information or share it outside the practice and (2) when my permission is not needed for the providers to use my health information or share it outside the practice (e.g. required by law, public health activities, etc.).

I understand that this Practice has reserved the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer or from the Practice's website.

My signature below constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

_____ _____

Signature of patient (if age 18 or older) or parent/guardian Date

_____

Name (Print)

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

# PATIENT CARE REPRESENTATIVE (PCR) ACCESS AUTHORIZATION TO PATIENT GATEWAY APPLICATION

PRACTICE/PROVIDER
(OR STAMP WITH PATIENT/PROVIDER INFORMATION)

STEP 1: (ONE PATIENT PER FORM)

**PATIENT INFORMATION (REQUIRED)**

PATIENT FULL LEGAL NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT MEDICAL RECORD #: _____ SEX: ☐F ☐M AGE: _____

PATIENT ADDRESS: STREET: _____ APT.#: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

FOR PATIENTS OVER THE AGE OF 13, CREATE A PG ACCOUNT FOR THE PATIENT ☐NO ☐YES
IF YES, PATIENT'S EMAIL ADDRESS: _____
*(Note: for patients 13 to 17, a PCR must exist in order for the patient to have a PG account)*

STEP 2: (ONE PCR PER FORM)

**PATIENT CARE REPRESENTATIVE - PCR INFORMATION (REQUIRED)**

PCR FULL LEGAL NAME: _____ PCR DATE OF BIRTH: _____

PCR EMAIL: _____ PHONE: _____

PCR ADDRESS IS *SAME AS PATIENT* YES NO (ADDRESS BELOW) SEX: ☐F ☐M

PCR ADDRESS: STREET: _____ APT. #: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

DOES PCR HAVE A PATIENT GATEWAY ACCOUNT? ☐ NO ☐ YES

IF YES, PATIENT GATEWAY USERNAME: _____

DOES PCR HAVE A MEDICAL RECORD NUMBER? ☐NO ☐YES (IF YES, MRN: _____)

For Internal Use Only (Rev 2.4 2011-04-13)

Authorization Received By: _____ Date: _____

Approved By: _____

Clinic/Office: _____

PCR Identification:

☐License ☐State ID ☐Passport ☐Other Photo ID

See Page 2 on Reverse

# AUTHORIZATION FOR PATIENT CARE REPRESENTATIVE ACCESS TO PATIENT GATEWAY APPLICATION

***Note: The information available in Patient Gateway is a subset of information contained in the legal health record. If at any time information is needed for legal or other purposes and/or a full copy of the Patient's Medical record is needed, please contact the patient's provider directly.***

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**I (THE PATIENT) UNDERSTAND THAT:**

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare
- I understand that this authorization will remain in effect until one of the following occurs:
  - A patient 12 years or younger reaches the age of 13 years; a new authorization form is required
  - A patient reaches the age of 18 years; a new authorization form is required
  - Closure of account is requested in writing by the patient, their Legal Guardian, or Patient Care Representative
  - In the event of death of the patient or Patient Care Representative
- Partners, the patient, their Legal Guardian, and/or the patient's Patient Care Representative may elect to suspend or terminate authorization to Patient Gateway access at any time, for any reason

## PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO PATIENT GATEWAY PATIENT CARE REPRESENTATIVE

I have carefully read and understand the above, and have had any questions explained to my satisfaction.

**Patient Care Representative Signature:** _____ **Date:** _____

**Print Name:** _____ **Relationship to patient:** _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to the person or agency listed above for the purposes of enrollment and utilization of the Patient Gateway application.

**Patient's Signature:** _____ **Date:** _____

**Print Patient's Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative:** _____ **Date:** _____

**Print Name:** _____ **Relationship to patient:** _____

# Authorization for Verbal Disclosure of Health Information

**Quincy Pediatric Associates, 191 Independence Ave, Quincy,MA 02169**
**Phone: 617-773-5070 Fax: 781-472-2380**

## Patient Information

**Important: Please initial each section as applicable**

**Patient Name:** _____ **Date of Birth:** _____
**(Please Print)**
**Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **Preferred Phone Number** _____

## Verbal Disclosures

**I Authorize staff of Quincy Pediatrics (QPA) to speak with the following individual(s) regarding my current care and treatment:**

Name: _____ Name: _____

Phone # _____ Phone# _____

Relationship to patient: _____ Relationship to patient: _____

❑ No restrictions to verbal disclosures. **Patient's Initials**: _____

❑ Verbal Disclosures restricted to dates of service and/or diagnoses as follows: _____

**Patient Initials**: _____

I authorize QPA to verbally disclose my protected health information (PHI) to the individual(s) noted above. I understand this authorization encompasses all PHI including, but not limited to sensitive information such as: HIV/AIDS, abortion, behavioral/mental health, alcohol/drug abuse rape/sexual assault, sexually transmitted disease, domestic violence and genetic testing unless otherwise excluded by initialing the statement below.

I do **NOT** authorize the disclosure of sensitive information as noted above. _____
**Patient Initials**

## Additional Authorizations Related to Verbal Disclosures

### Voice Messages Regarding Treatment or Test Results

**I Authorize staff of QPAto leave a detailed message on my preferred phone regarding my clinical treatment and/or non-sensitive test results with or without restrictions as indicated below:**

❑ No restrictions to information included in voice messages. **Patient Initials**: _____

❑ Restrictions to information included in voice messages as follows: _____ **Patient Initials**: _____

### Voice Messages for Prescriptions

**I Authorize staff of QPA to leave a message on my preferred phone indicating my prescription(s) is ready for pick-up. I understand the name(s) of the prescription(s) will not be disclosed in the message.**

Additional Instructions for Messages for Prescription Pick Up: _____**Patient's Initials:** _____

I understand:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at an QPA Facility unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to QPA. The revocation will be effective upon receipt of my written notice, except that it will not have any effect on any action already taken by qpa in reliance on this authorization.
- Once QPA has disclosed my health information to the recipient, QPA cannot guarantee that the recipient will not redisclose my health information to a third party.

### Select Authorization Timeframe:

❑ This authorization will remain valid as long as I am a patient of Quincy Pediatrics.

❑ This authorization will expire on: _____
(Specify expiration date)

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions. By my signature below, I hereby, knowingly and voluntarily, authorize QPA to verbally disclose my health information or fulfill specific instructions in the manner described above.

*Patient Signature:* _____ *Date:* _____

*Personal Representative Signature:* _____ *Relationship to patient:* _____