Notice of Privacy Practices

Glens Falls Pediatric Consultants, PC

Notice of Privacy Practices
Effective: April 14, 2003

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

If you have any questions about this Notice please contact: our Privacy Officer at (518) 798-9985.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice. We may change the terms of our privacy Notice, at any time. The new Notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. A copy of the current Notice will be prominently displayed in our office at all times.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We also will disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to an insurer or accreditation agency which performs chart audits. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We also may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the Practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We also may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing, except to the extent that Glens Falls Pediatric Consultants has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Permission or Opportunity to Object

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment.

Other Permitted and Required Uses and Disclosures that may be Made without your Consent or Authorization

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We also may disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your protected health information to a governmental agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, and biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or in connection with post-marketing surveillance, as required by law.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: We may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for authorized military purposes, as required by law.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy regulations.

2. YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a medical record maintained by the Practice, for as long as we maintain the protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You also may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction using the form "Request for Restrictions on Protected Health Information" from the Privacy Officer, or you may provide us your request, in writing. Your request must include (a) the information you wish restricted; (b) whether you are requesting to limit our Practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask us to contact you at home, rather than at work. You do not have to provide us a reason for this request. We will accommodate **reasonable** requests. We also may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you that we maintain. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, or in putting together a facility directory, or to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding other disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The first list you request within a 12-month period is free of charge, but there is a charge involved with any additional lists within the same 12-month period. We will inform you of any costs involved with additional requests, and you may withdraw your request before you incur any costs.

You have the right to obtain a paper copy of this Notice from us.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (518) 438-5538 for further information about the complaint process.

GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION

Date: _____

PATIENT NAME_____ **DOB:** _____
First Middle Initial Last

GENDER AT BIRTH Male Female **IDENTIFIES GENDER AS** Male Female Non-binary

Primary Doctor:_____ Primary Language:_____ Race :_____ Ethnic Origin:_____

Pharmacy of Choice:_____
Name Street City State Zip

Patient's Address**:**_____
Street City State Zip

Email Address:_____

Mother's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

Address:_____
Street City State Zip

Phone # (Home): _____ (Work): _____ (Cell): _____

Occupation: _____ Employer: _____
Maiden Name: _____

Father's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

Address:_____
Street City State Zip

Phone # (Home): _____ (Work): _____ (Cell): _____

Occupation: _____ Employer: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SS#_____
Address:_____

Name of Secondary Insurance:_____ ID number _____

<u>Responsible Party</u> (Person to Receive Billing Statements): _____

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I authorize Glens Falls Pediatric Consultants to use or disclose my personal health information (PHI) to treat my condition, obtain payment for that treatment and run the business operation. I also give my permission to disclose my personal health information (PHI) for payment activities and certain business operations of another healthcare provider or payer. In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.

Signature:_____**Date:**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Glens Falls Pediatric Consultants, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Glens Falls Pediatric Consultants, PC such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that as part of Glens Falls Pediatric Consultants, PC treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of how Glens Falls Pediatric Consultants, PC may use and disclosure my protected healthcare information. I further understand that Glens Falls Pediatric Consultants, PC reserves the right to change its ***Notice of Privacy Practices.*** Should Glens Falls Pediatric Consultants, PC change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Glens Falls Pediatric Consultants, PC may do the following unless I specifically give direction prohibiting such activity:

- ☐ Send visit reminders and test results to the address I have provided.
- ☐ Send routine correspondence, such as billing statements, to the address I have provided.
- ☐ Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

_____

Patient's Signature or Signature of Personal Representative

_____

Date

FOR OFFICE USE ONLY

[ ] Receipt received by _____ on _____.

[ ] Patient refused to sign receipt. _____ (Signature of Practice Representative)

Glens Falls Pediatric Consultants, P.C.

Pediatric & Adolescent Medicine

1 Lawrence Street, Glens Falls, NY 12801
Telephone (518) 798-9985

4 Carpenter Ln, Saratoga Springs NY 12866
Telephone (518) 587-3823

PATIENT INFORMATION FORM
FOR PATIENTS NEWBORN UP TO FOUR (4) WEEKS OF AGE

Date: _____

Patient Name _____DOB: _____ Age: _____Sex ___F ___M

BIRTH & DEVELOPMENT

Pregnancy # _____ Delivery Type: ____ vaginal _____ c-sec

Duration of Pregnancy _____ Birth Weight _____ Discharge Weight _____

Problems/Complications _____

____Jaundice ____Seizures ____Infection ____Birth defects ____Feeding

At birth did your child receive a Hep B immunization? ____YES ____ NO and Vitamin K ____YES ____ NO

At birth did your child pass the Newborn Hearing Screen? ____YES ____ NO ____UNKNOWN

FEEDING HISTORY

Breast _____ How long each breast at each feeding? _____
Formula _____ounces per bottle Bottles per day? _____
Stool frequency _____per day Feeding Problems? _____
Current Diet? _____

SOCIAL HISTORY

Who does the child live with/Primary Caregiver?_____ Relationship? _____

Highest grade level completed by parents? Mother _____ Father _____

Are parents/guardians employed? _____

Will the child be attending daycare? ____YES ____ NO Will be cared for in the home? ____YES ____ NO

Are there pets in the child's home? ____YES ____ NO If Yes, what type of pets? _____

FAMILY HISTORY – As the parent of the newborn child, are any of the following significant health issues?

Conditions	Mother	Father		Mother	Father		Mother	Father		Mother	Father
Allergies			Blindness			Developmental Disabilities			Kidney Disease		
Asthma			Cancer			Deafness			Lung (C/F)		
Birth Defects			Cardiac Issues			Juvenile Diabetes			Seizures		

RELATIONSHIP TO PATIENT	NAME	AGE	HEALTH CONDITION OR RELEVANT HEALTH CONCERNS
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Pat Grandfather			
Pat Grandmother			
Mat Grandfather			
Mat Grandmother			

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4 Carpenter Ln, Saratoga Springs NY 12866
Telephone (518) 587-3823

NEW PATIENT INFORMATION FORM
FOR PATIENT'S FOUR WEEKS AND OLDER

Date: _____

Patient Name _____DOB: _____ Age: _____Sex ___F ___M

SOCIAL HISTORY

Who does the child live with / Primary care giver to child? _____ Relationship? _____

Highest grade level completed by parents? Mother _____ Father _____

Are parents/guardians employed? _____

Will the child be attending daycare? ____YES ____ NO Will be cared for in the home? ____YES ____ NO

Are there pets in the child's home? ____YES ____ NO If yes, what type of pets? _____

PATIENT'S PAST MEDICAL HISTORY

Child's general health: _____ Concerns: _____Allergies_____

Child's Current Medications: _____

Does your child have any Development Delays? ____YES ____ NO Behavioral Concerns? ____YES ____ NO

If yes, please explain: _____

Are you aware of any Physical and/or Sexual abuse ____YES ____ NO

If yes, please explain: _____

Childhood Diseases: _____

Hospitalizations: Where? _____ When? _____ For What? _____

Where? _____ When? _____ For What? _____

Specialists: Who? _____ For What? _____

Who? _____ For What? _____

FAMILY HISTORY – As the parent of the newborn child, are any of the following significant health issues?

Conditions	Mother	Father		Mother	Father		Mother	Father		Mother	Father
Allergies			Blindness			Developmental Disabilities			Kidney Disease		
Asthma			Cancer			Deafness			Lung (C/F)		
Birth Defects			Cardiac Issues			Diabetes (Juv)			Seizures		

HEALTH CONDITION OR RELEVANT HEALTH CONCERNS

RELATIONSHIP TO PATIENT	NAME	AGE	HEALTH CONDITION OR RELEVANT HEALTH CONCERNS
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Pat Grandfather			
Pat Grandmother			
Mat Grandfather			
Mat Grandmother			

Glens Falls Pediatric Associates
Pediatric Associates of Saratoga
HIPAA Privacy Information
Authorization for Treatment of a Minor when a Parent is Not Present

Patient Name _____ DOB: _____

Parent/Guardian _____ Relationship_____

How may we communicate information to you (PLEASE CHECK ALL THAT APPLY).

Appointment Information			Medical Information		
On home phone	□	#_____	On home phone	□	#_____
On cell phone	□	#_____	On cell phone	□	#_____
Texting on cell	□	#_____	Texting on cell	□	#_____
On office phone	□	#_____	On office phone	□	#_____

I/We the undersigned parents(s)/legal guardian(s), authorize the following to bring the above listed patient to Glens Falls Pediatrics for healthcare in my absence.

****Not authorization to consent for vaccines at visit -- form available online at www.gfpeds.com.****

_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,

As a parent of the above named minor, I give permission for staff at Glens Falls Pediatrics Consultants/Pediatric Associates of Saratoga to discuss my child's medical care/treatment with any of the following:

_____ Relationship to patient _____ PH# _____,

_____ Relationship to patient _____ PH# _____,

_____ Relationship to patient _____ PH# _____,

Specific HIPPA Instructions:

This consent shall remain in effect until revoked, in writing, by parents(s) or legal guardian(s), or until the child may legally consent for him or herself.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of witness Date