Patient Information

Chart # **Location:**

Last Name			Gender
Date of Birth	Home Phone #	Allergy	
Home Address			
Clinician you see most often	Preferred pharmacy name	Pharmacy address	

Primary Insurance Plan / Policy Holder

Policy Holder Name		Date of Birth
Home Address		City
State	Zip	
Effective Date	PCP (if applicable)	
Insurance Plan Name	Patient's ID #	Patient's Group #

Secondary Insurance Plan / Policy Holder

Policy Holder Name	Date of Birth
Home Address	City
State	Zip
Effective Date	
Patient's ID #	Patient's Group #

Other Parent / Guardian

Name	Phone #

I certify that the above information is correct.

*****The Children's Medical Group, PLLC does not sell, give, transfer, or disclose any individuals information without prior consent.*****

Signature: ____ Date: ______________________

Print Name: __________________________________ Relationship to Child: __________________

Parent / Guardian Information (Who the child lives with)

Name			Date of Birth
Home Address		City State Zip	
Home Phone #	Work Phone #	Social Security # **XXX-XXX-XXX**	Marital Status

What is your highest level of education? (please check one)

☐ High School Attendance ☐ High School / GED ☐ College Attendance

☐ College Degree ☐ Other

What is the primary language spoken in your home? (please check one)

☐ English ☐ Spanish ☐ Other

What is your child's race? (please check one)

☐ Asian / Oriental ☐ Black ☐ Hispanic ☐ Other Pacific Islander

☐ Native Hawaiian ☐ White ☐ Alaskan Native/Native American ☐ Other race

What is your child's ethnicity? (please check)

Hispanic Non-Hispanic

Mother's First Name and Maiden Name (please provide us with the Patients Mother's first name and maiden name for the NYS Immunization registry)

Mother's First Name:
Mother's Maiden Name:

Email Address: Please provide us with your email address so in the future CMG may provide pertinent information to you regarding your child's healthcare.

Email Address:

I certify that the above information is correct.

*****The Children's Medical Group, PLLC does not sell, give, transfer or disclose any individuals information without prior consent.*****

Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Relationship to Child: ____________________

CONSENT FORM
The Children's Medical Group, PLLC

- In this Consent Form, you can choose whether to allow The Children's Medical Group, PLLC to obtain access to your medical records through Surescripts, a provider of electronic prescribing services. Surescripts, which is a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies.
  This program allows The Children's Medical Group, PLLC to electronically transmit prescriptions to pharmacies.

  You may use this Consent Form to decide whether or not to allow The Children's Medical Group, PLLC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

  If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, The Children's Medical Group, PLLC's staff involved in my care may see and get access to all of my medical records through Surescripts."

  If you check the **"I DENY CONSENT"** box below, you are saying "No, The Children's Medical Group, PLLC may not be given access to my medical records through Surescripts for any purpose."

  Please carefully read the information on the back of this form before making your decision.

  Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT for The Children's Medical Group, PLLC to access ALL of** my electronic health information through Surescripts in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for The Children's Medical Group, PLLC to access** my electronic health information through Surescripts for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Surescripts.

______________________________ Print Name of Patient

______________________________ Patient Date of Birth

______________________________ Signature of Patient or Patient's Legal Representative

______________________________ Date

______________________________ Print Name of Legal Representative (if applicable)

______________________________ Relationship of Legal Representative to Patient (if applicable)

THE CHILDREN'S MEDICAL GROUP
PATIENT PORTAL AUTHORIZATION AGREEMENT

Patient Name:
Date of Birth:

□ Patient Portal Status Please Choose:

□ Yes, please activate the patient portal.
(Email & Photo ID needed)

Patient/Parent Email: ___________________________

□ I am currently enrolled.

□ Not interested at this time.
Reason: □ Do not have email
□ Will not disclose email

____

Parent/Patient Signature (18 years or older) Date

CMG Staff
Patient Account #:
Has parent/patient signature been verified? ❒Yes ❒No

Patient's Account has been enabled? ❒Yes ❒No

Initials of Staff Member Accepting Authorization Form: __

THE CHILDREN’S MEDICAL GROUP, PLLC
PATIENT FINANCIAL POLICY

Insurance Card:
You must present a current valid participating insurance card at each visit.

Copays/Coinsurance/Deductibles/Past due balances are payable at time of service. A service charge will be applied to your account if payment is not made at time of service.

Returned check:
There will be a service charge applied to your account for a returned check. The full amount of check plus the service charge must be paid immediately. If there are 2 returned checks on your account, we will require services to be paid in CASH/CREDIT CARD/MONEY ORDER.

Primary Care Physician (PCP):
If you have an insurance that The Children’s Medical Group participates with that requires a Primary Care Physician, a provider from our group must be chosen prior to your visit. If we are notified that we are not the listed PCP for date of service, you will be responsible for all services rendered. Payment in full is expected immediately upon notification.

Self-Pay Accounts:
Self pay accounts are:

Patients who are covered by a non participating insurance company.
Patients who have no insurance coverage.
Patients who do not present a valid participating insurance ID card at time of service and we are unable to verify coverage either by phone or internet.

Payment in full is expected at time of service.
A finance charge will be applied to all account balances not paid at time of service.

Non participating Insurance Plan:
If The Children’s Medical Group has no participating agreement with an insurance plan, payment in full is expected at time of service and you are responsible to submit charges to your insurance company.

Payment Arrangements:
Under certain circumstances, payment arrangements may be made with our Finance Dept. An agreement must be signed. If terms of agreement are not followed, your account will be referred to our collection agency and possible further action may be taken.

Patient Refunds:
The following criteria must be met before The Children’s Medical Group will issue a patient refund. There is no outstanding balance on your account. There is no collection balance due with our collection agency. If there is a balance, the refund will go towards your collection balance.

Divorce Cases:
In the case of divorce, the parent/guardian bringing the patient into our office will be responsible for all payments due. We will not bill a divorced spouse for the patient’s services. We do not get involved with any specific arrangements i.e. one parent pays 80% and the other parent pays 20%. It is the parent’s responsibility to work out any financial agreements themselves or through the legal system.

Custody Cases:
If custodial parent/non custodial parent carries an insurance that The Children’s Medical Group participates with, we will bill directly to the insurance company. Any copays/co-insurance/deductibles must be paid at time of service. If the custodial parent/non custodial parent has an insurance company that The Children’s Medical Group does not participate with or has no insurance, payment in full is expected at time of service.

Authorization for Payment:
This form authorizes the release of protected health information that may include treatment pertaining to psychiatric conditions, alcohol or substance abuse, acquired immunodeficiency syndrome (AIDS) or test for infection with HIV to process any insurance claims. If any services are not covered by my insurance company or if my coverage is not in effect at time of service, I agree to pay The Children’s Medical Group for these services.

SIGNED : ____ **DATE:**
Signature of Parent/Legal Guardian or patient over 18 years old

A/C #: PATIENT NAME:

Patient Name: Date of Birth:

Date:

I have read the Notice of Privacy Practices of **The Children's Medical Group PLLC** (CMG).
I authorize the release of pertinent information to complete forms for schools, camps, day care centers, home health agencies, places of employment, WIC and other related facilities.

Parent/Guardian Signature: _______________________________

Relationship to child: ____________________________________

Child's Name: ____

The Children's Medical Group firmly believes that vaccinating children & young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers.

This is to certify that I have received the American Academy of Pediatrics handouts regarding vaccines for my child.

Date:
Parent Signature: ___________________________________

Mother's Information

Maiden Last Name: ___________________

First Name: _____________________

The Children's Medical Group Vaccine Policy Statement

■ We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

■ We firmly believe in the safety of our vaccines.

■ We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

■ We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

■ We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox…I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of underimmunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at The Children's Medical Group.** Such additional visits may require additional co-pays on your part.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Infants, Children & Adolescents

Diplomates of the American Board of Pediatrics

www.childrensmedgroup.com

LOCATIONS:

104 Fulton Ave.
Poughkeepsie, NY 12603
(845) 452-1700
FAX (845) 452-1752

FISHKILL
HOPEWELL JUNCTION
HYDE PARK
KINGSTON
MODENA
NEWBURGH
RHINEBECK

Herschel R. Lessin, M.D.
David L. Fenner, M.D.
Adrian Gruszko, M.D.
Marc Habert, M.D.
Dominique Aristide, M.D.
Vandana Bacon, D.O.
Sejal Dalwadi, M.D.
Robert Felix, M.D.
Celeste Grosso, M.D.
Carolyn Hirschmann, D.O.
Michael Kirpan, M.D
Kira Lawton, M.D.
Christine Lee, M.D
Oluchi Nwahiwe, M.D.
Puja Singh, M.D.
Arlene Solomon, M.D.
James Sulzer, M.D.
Natasha Tzagoloff, M.D.
Christine Verna, M.D.
Dana Mitchell, PNP
Michelle Patrick, PNP
Lisa Ryan, DNP FNP-C
Caitlin Smart, PNP
.
Kim Mayhew
CEO

PERSONAL REPRESENTATIVE DESIGNATION

Account #:

Patient Name: Date of Birth:

Address:

Phone Number (including Area Code):

❑ I **authorize** consent to the persons listed below (complete form and sign)

❑ I **deny** consent (please sign bottom of form)

I, ______________________________ designate the person(s) listed below as my personal representative(s). I understand and acknowledge this designation gives the personal representative(s) the same power over my protected health information as I have, including the right to inspect my records, authorize disclosures and request restrictions and amendments. I hereby waive any restrictions on my personal representative(s)' access to my protected health information, except transferring of my medical records. I understand that I am not obligated to list anyone. I also understand this designation shall remain in place until such time as I revoke it in writing to The Children's Medical Group.

Print Name: ____

Relationship to Patient: ___________________________________
(Must provide Photo ID when picking up records)

Print Name: ____

Relationship to Patient: ___________________________________
(Must provide Photo ID when picking up records)

Is this a change of a previous designation? ❑ Yes ❑ No

____
Signature of Patient/Parent/Guardian Date

Please return to staff member

CMG staff must complete below

Staff Initials accepting this form ___________

Site: ❑ FS ❑ HJ ❑ HP ❑ KG ❑ MN ❑ NB ❑ PW ❑ PK ❑ RB

12/17/2018 jd

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Christine Verna, M.D.
Dana Mitchell, PNP
Michelle Patrick, PNP
Lisa Ryan, DNP FNP-C
Caitlin Smart, PNP
.
Kim Mayhew
CEO

Patients' Bill of Rights

- **The Right to Information.** Patients have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities and professionals.

- **The Right to Choose.** Patients have the right to a choice of health care providers that is sufficient to assure access to appropriate high-quality health care including giving women access to qualified specialists such as obstetrician-gynecologists and giving patients with serious medical conditions and chronic illnesses access to specialists.

- **Access to Emergency Services.** Patients have the right to access emergency health services when and where the need arises. Health plans should provide payment when a patient presents himself/herself to any emergency department with acute symptoms of sufficient severity "including severe pain" that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- **Being a Full Partner in Health Care Decisions.** Patients have the right to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators. Additionally, provider contracts should not contain any so-called "gag clauses" that restrict health professionals' ability to discuss and advise patients on medically necessary treatment options.

- **Care Without Discrimination.** Patients have the right to considerate, respectful care from all members of the health care industry at all times and under all circumstances. Patients must not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

- **The Right to Privacy**. Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Patients also have the right to review and obtain a copy of their own medical records and request amendments to their records.

- **The Right to Speedy Complaint Resolution.** Patients have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

- **Taking on New Responsibilities.** In a health care system that affords patients rights and protections, patients must also take greater responsibility for maintaining good health

Infants, Children And Adolescents

104 Fulton Ave. • Poughkeepsie, N.Y. 12603 • (845) 452-1700 • Fax (845) 452-1752

MONDAY – FRIDAY 9AM-9PM SATURDAY – SUNDAY 9AM-5PM

❋ FISHKILL ❋ HOPEWELL JUNCTION ❋ POUGHKEEPSIE ❋ HYDE PARK ❋ RHINEBECK ❋ NEWBURGH ❋ MODENA ❋ KINGSTON ❋

HIPAA AUTHORIZATION FORM TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR

Patient Name: Date of Birth: Phone Number:

□ Description of information The Children's Medical Group is to obtain :_______________________________________

□ Medical Records from date: _________________ to ________________

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults and records sent to you by other healthcare providers

I authorize THE CHILDREN'S MEDICAL GROUP to OBTAIN protected health information from:

Doctor/Group Name: ____

Address
Street, City & Zip Code: ____

Area Code & Phone Number: (   ) __________________________________

Reason for authorization:

□ Transferring from another doctor/group

□ Returning to The Children's Medical Group

□ Other (please explain) ____

I understand the following:

a. This authorization shall be in force and effect for 1 year from the below date at which time it will expire.
b. I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.
c. I am signing this authorization freely and under no pressure from any individual to do so.
d. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use. My questions regarding this form have been answered to my satisfaction.
e. This authorization includes the disclosure of information related to ALCOHOL and DRUG ABUSE, CONFIDENTIAL HIV RELATED INFORMATION, MENTAL HEALTH TREATMENT (except psychotherapy notes) and GENETIC INFORMATION including test results.
f. The recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand I have a right to request a list of people who may receive or use my HIV-related information without authorization.

I hereby declare that I am the patient over 18 years of age or the natural/adoptive/legal guardian for person listed above and there is no court order restricting or prohibiting my authorization for The Children's Medical Group to obtain medical records on my behalf:

Signature of Patient or Patient's Representative: ________________________________ Date: ________________