Patient Information

Chart # **Location:**

Last Name			Gender
Date of Birth	Home Phone #	Allergy	
Home Address			
Provider 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 #	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 computer networks operated by THINC and MedAllies, which are part of a statewide computer network, and by Surescripts, a provider of electronic prescribing services. These computer networks can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

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 THINC, MedAllies and 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 THINC, MedAllies and Surescripts for any purpose."

This kind of sharing of medical records is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask [Name of Provider] for it, or go to the website www.ehealth4ny.org. The three types of computer networks that [Name of Provider Organization] would access based upon this consent are:

- THINC, which is a not-for-profit organization that involves physician practices, community health centers, hospitals, laboratories and other health care organizations in the Hudson Valley. It shares information about people's health electronically and securely to improve the quality of health care services.
- Surescripts, which is a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies.
- MedAllies, which is a provider of information technology services that hosts a service that enables hospitals to share patient information with physicians that care for their shared patients.

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 THINC, MedAllies and 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 THINC, MedAllies and 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 THINC, MedAllies and 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)

Details about patient information and the consent process:

1. **How Your Information Will be Used**.
   Your electronic health information will be used by The Children's Medical Group, PLLC **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

   NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, The Children's Medical Group, PLLC may access ALL of your electronic health information available through THINC, MedAllies and Surescripts. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from THINC. You can obtain an updated list of Information Sources at any time by checking the THINC website at www.thinc.org or by calling 845-896-4726.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on The Children's Medical Group's medical staff who are involved in your medical care; health care providers who are covering or on call for The Children's Medical Group's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call The Children's Medical Group, PLLC at: (845) 452-1700; or visit THINC's website: www.thinc.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by The Children's Medical Group to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Persons who access this information through THINC, MedAllies and Surescripts must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to The Children's Medical Group, PLLC You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on THINC's website at www.thinc.org, or by calling 845-896-4726. **Note: Organizations that access your health information while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

YOUR CHILD'S MEDICAL HISTORY

Date: _____ Child's Name:_____ Date of Birth:_____

If you are new to our Practice, please take a moment to answer all the questions listed below for us to get to know your child better. Existing Patients, please take a moment to update QUESTIONS 8-24 since your previous visit.

Yes No

1. Where was your child born? (Name of Hospital and State) _____
   Weight at birth_____
2. Was your pregnancy less than 37 or more than 41 weeks? If so, how long was it? _____ weeks
3. Were there any problems with your pregnancy? (e.g. hospitalization, infection, early labor)
   If yes, please explain _____
4. Was your delivery Vaginal_____ Forceps_____ Vacuum_____ Ceasarian _____
5. Any problems with your delivery?
   If yes, please explain _____
6. Did your baby have any problems in the nursery? (e.g. fever, breathing problems, NICU stay)
   If yes, please explain _____
   _____
7. Has your child had any problems with physical growth?
   If yes, please explain _____
8. Has your child had any delays in talking or walking? Receive(d) speech, occupational or physical therapy?
   If yes, please explain _____
9. Has your child ever been hospitalized overnight?
   If yes, please explain _____
   _____
10. Has your child ever had any operations or surgery?
    If yes, please explain _____
11. Has your child ever had any blood transfusions? (Date) _____
12. Has your child had any serious infections? (e.g. pneumonia, meningitis, urine infection, Lyme, etc)
    If yes, please explain _____
13. Has your child had any other type of serious illness? (medical or traumatic)
    If yes, please explain _____
14. Does your child have any chronic illnesses? (e.g. asthma, diabetes, heart, arthiritis, sickle cell, etc.)
    If yes, please explain _____
    _____
15. Does your child have any recurring illness? (e.g. bronchitis, ear or bladder infections, etc.)
    If yes, please explain _____
16. Is your child allergic to any medications, foods, animals, or other things?
    If yes, please explain _____
17. Does your child take medication for any problem? (other than pain relievers and cold remedies)
    If yes, please explain _____
18. Has your child had any problems with: (If yes, please explain.)

Head, Eyes, Ears, Nose, Throat_____
Heart_____
Lungs_____
Thyroid_____
Stomach or Bowel_____
Kidney or Bladder_____
Muscles, Nerves or Brain_____
Bones/Joints/Hip Disorders_____
Excessive Bleeding_____
Hearing or Vision_____
School Problems_____
Emotional or Behavioral Problems_____

(Please Complete Other Side)

19.Does the child's Mother, Father, Siblings, Grandparents, Aunts or Uncles have a history of:(Please ✓if applicable)	Mother	Father	Siblings	Grandmother	Grandfather	Aunt/Uncle	Other
Asthma							
Diabetes Type I							
Diabetes Type II							
Thyroid Disease							
Seasonal Allergies							
Eczema							
Heart Attack (What Age)							
Abnormal Heart Rhythym							
Sudden Death Before Age 40							
Fainting							
High Blood Pressure							
Stroke							
Seizures or Epilepsy							
Cancer							
High Cholesterol							
Kidney Problems							
Alcoholism/Substance Abuse							
Psychiatric Illness (eg. Bipolar, Depression, Schizophrenia)							
Smokes Cigarettes							

20. Has your child had chickenpox disease (date: _____)?

21. What is the current marital status of parents?

Married ____ Single ____ Separated ____Divorced ____ Re-Married _____Widowed_____ Domestic Partnership ____ Other ____

22. Who currently lives in your home?

_____

23. Father's Occupation_____

Mother's Occupation_____

24. Please list names and birthdates of siblings:

Name **Birthdate**

_____

_____

_____

_____

_____

Please explain any other medical history that you consider important:

_____

_____

_____

REVIEWED BY CMG PROVIDER:

SIG: _____ **DATE:**_____

07/28/2014 mmp

THE CHILDREN'S MEDICAL GROUP
PATIENT PORTAL AUTHORIZATION AGREEMENT

Patient Name: _____

Date of Birth: _____

Patient/Parent Email: _____

I authorize The Children's Medical Group to web enable my child/self for the Patient Portal.
By signing this agreement I have furnished my e-mail address that will receive e-mail messages from The Children's Medical Group for the Patient Portal.

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_____ D.O.B. _____

Rev 3/1/06

The Children's MEDICAL GROUP

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
PAWLING
RHINEBECK

Carl D. Sorgen, M.D.
Herschel R. Lessin, M.D.
David L. Fenner, M.D.
Adrian Gruszko, M.D.
Marc Habert, M.D.
Fe Aplasca, M.D.
Dominique Aristide, M.D.
Aaron M. Blum, M.D.
Sejal Dalwadi, M.D.
Robert Felix, M.D.
Bobby Gearing, M.D.
Celeste Grosso, M.D.
Oluchi Nwahiwe, M.D.
Jaime Rivera, M.D.
John Sieverding, M.D.
Puja Singh, M.D.
Arlene Solomon, M.D.
James Sulzer, M.D.
Natasha Tzagoloff, M.D.
Chika Ugorji, M.D.
Christine Verna, M.D.
Nancy Laterra-Ferraro, PNP
Dana Mitchell, PNP
Michelle Patrick, PNP
Margaret Serino, PNP

Joseph F. Heavey
CEO

HIPAA AUTHORIZATION FORM TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

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

Doctor: _____

Address: _____

City: _____

State / Zip code: _____

Area Code & Phone Number: ( ) _____

Reasons for receiving information:
□ transferring from another doctor
□ returning to The Children's Medical Group
□ other (please explain) _____

Specific dates of service we are to receive: _____

This authorization shall be in force and effect for 1 year from the above date at which time it will expire. I understand that I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.

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.

_____ _____
Signature of Parent / Guardian / Patient over 18 Daytime Phone

_____ □ FS □ HJ □ HP □ KG □ MN □ NB □ PK □ PW □ RB
Staff Initials & Staff Location

09/20/2012MP

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 PLLC

Notice of Privacy Practices

Effective September 22, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED BY THE CHILDREN'S MEDICAL GROUP AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the HIPAA Privacy regulations, The Children's Medical Group and all similar health care providers are required by federal law to maintain the privacy of your child's protected health information (PHI) and will abide by the terms in the Privacy Notice.

This notice of Privacy Practices describes how we may use and disclose your child's 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 child's protected health information. "Protected health information" is information about your child, including demographic information, that may identify you or your child (children) and that relates to you or your child's 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 of Privacy Practices. We may change the terms of our 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. You may call the office and request that a revised copy be sent to you in the mail, ask for one at the time of your next appointment, or access our website at www.childrensmedgroup.com.

1. Uses and Disclosures of Protected Health Information

The following categories describe different ways that we use and disclose medical information, which do not require your written authorization. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways are permitted to use and disclose information will fall within one of the following categories:

Treatment: We will use and disclose your child's protected health information to provide, coordinate, or manage your child's health care and any related services. For example, your child's health information will be disclosed to the Children's Medical Group nurses who participate in your child's care. We may disclose your child's health information to another physician for the purpose of a consultation. We may also disclose your child's health information to your child's primary care physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat your child.

Payment: Your child's protected health information will be used, as needed, to obtain payment for your child's 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 your child such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to your child for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your child's relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. With your permission, we may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

Healthcare Operations: We may use or disclose, as-needed, your child's protected health information in order to support the business activities of your child's providers' practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your child's protected health information to medical school students that see patients at our office. We may also call your child by name in the waiting room when the provider is ready to see your child. We may use or disclose your child's protected health information, as necessary, to contact you to remind you of your child's appointment.

Business Associates: We will share your child's protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. For example, we may use another company to perform medical billing services.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your child's protected health information, we will have a written contract that contains terms that will protect the privacy of your child's protected health information. In addition, at the request of your other health care providers or health plan, we may disclose your child's protected health information to their authorized business associates for purposes of performing certain business functions or health care services on their behalf. For example, we may disclose your child's protected health information to a business associate of Medicaid for purposes of medical necessity review and audit

Appointment Reminders: We may use and disclose your child's protected health information to contact you as a reminder that your child has appointments with our office or to discuss treatment alternatives.

Health-related Benefits and Services: We may use and disclose your child's protected health information to inform you of health-related benefits or services that may be of interest to you.

Others Involved in Your Child's Healthcare: If you agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your child's health information. We may disclose to a family member, close personal friend, or anyone else whom you identify who is involved in your child's medical care or who helps pay for your child's care health information relevant to that person's involvement in your child's care or paying for your child's care. ***If you would like us to refrain from releasing your health information to a family member or friend, please notify the Children's Medical Group Privacy Officer at 845-452-1700***. We may also make these disclosures after your child's death, unless doing so is inconsistent with any prior expressed preference made by you that is known to us.

We may use or disclose your child's health information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your general condition or death. We may also disclose your child's health information to disaster relief organizations so that your family or other persons responsible for your child's care can be notified about your child's condition, status and location.

Research: As authorized by applicable state and federal law, we may use and disclose your child's health information for certain limited research purposes without your authorization. For example, we might use some of your child's health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your child's health information without your authorization. We may disclose your child's health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the Children's Medical Group..

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your child's protected health information in the following situations, to the extent permitted by applicable state and federal law, without your authorization. These situations include:

Required By Law: We may use or disclose your child's protected health information for public health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your child's protected health information for public health activities and purposes 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. Other public health information activities in which we may disclose your child's health information include the following:

- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- Activities related to the quality, safety or effectiveness of FDA-regulated products; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

We may also disclose your child's protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Data Breach Notification Purposes: We may disclose protected health information to provide legally required notices of unauthorized access to or disclosure of your child's health information. We will notify you in writing if we discover a breach of your child's unsecured health information, unless we determine that notification is not required by applicable law. You will be notified without unreasonable delay. Such notification will include information about what happened and what has been done or can be done to mitigate any harm to your child as a result of such breach.

Abuse or Neglect: We may disclose your child's 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 child's protected health information if we believe that your child has been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, that disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose your child's health information in response to a court or administrative order. We may also release your child's health information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested, and only if authorized by applicable state and federal law.

Law Enforcement: We may also disclose protected health information, within limitations, and only when authorized by state and federal law, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity/Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your child's protected health information, if we believe that the use or disclosure in necessary to prevent or lessen serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual, as authorized by applicable state and federal law.

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 (1) for the activities deemed necessary by appropriate military command authorities; (2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your child's protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your child's protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related injuries or illness.

Inmates: We may use or disclose your child's protected health information if your child is an inmate of a correctional facility and your child's provider created or received your child's protected health information in the course of providing care to your child.

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 Section 164.500et.seq.

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

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

Marketing: Your written authorization is required for us to use or disclose your child's medical information for marketing purposes, except if we communicate personally with you face-to-face or if we provide you with prescription refill reminders or otherwise communicate with you about a drug or biologic that your child is currently prescribed and we do not in exchange receive any payment that is unreasonable related to our cost of making such communication to you. It is not considered marketing, and therefore your written authorization is not required, if we communicate with you related to your child's treatment, case management, or care coordination, or if we direct or recommend alternative treatment, therapies, healthcare providers or settings of care, unless we receive payment from a third-party in exchange for making such communication to you. If marketing activities are to result in payment to us from a third-party we will state this on our authorization.

Sale of Medical Information: Your written authorization is required for any use or disclosure which is considered a sale of your child's medical information. Any authorization for the sale of medical information will state that the disclosure will result in payment to us.

Psychotherapy Notes: We usually do not maintain psychotherapy notes about your child. If we do, we will only use and disclose them with your written authorization except in limited situations.

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HIV-Related Information: We will not disclose your child's HIV-related information without your written authorization.

Genetic Information: We will not disclose your child's genetic information without your written authorization.

Substance Abuse Information: We will not disclose your child's alcohol and other drug abuse information without your written authorization.

Mental Health Information: We will not disclose any of your child's information relating to mental health treatment without your written authorization.

If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

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

We may use and disclose your child's protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your child's protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your child's provider may, using professional judgment, determine whether the disclosure is in your child's best interest. In this case, only the protected health information that is relevant to your child's health care will be disclosed.

Emergencies: We may use or disclose your child's protected health information in an emergency treatment situation.

Communication Barriers: We may use and disclose your child's protected health information if your child's provider or another provider in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment that you intend to consent to use or disclosure under the circumstances.

2. Your Rights

Following is a statement of your rights with respect to your child's protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and obtain a copy of your child's protected health information ("PHI"). This means you may inspect and obtain a copy of protected health information about your child that is contained in a designated record set for as long as we maintain the protected health information, except in limited circumstances. To inspect and copy your health information, you must make your request in writing. You may request access to your health information in a certain electronic form and format and access may be granted in that requested form and format if it is readily producible, or, if not readily producible, in a mutually agreeable form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your child's health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request. We may deny your request to inspect and copy in certain very limited circumstances. Under state and 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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed by a licensed health care professional chosen by us. Please Contact our Manager of Medical Records Department if you have any questions about access to your child's medical record.

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

In most circumstances, your child's provider is not required to agree to a restriction that you may request. If the provider believes it is in your child's best interest to permit use and disclosure of your child's protected health information, your child's protected health information will not be restricted. If your child's provider does agree to the requested restriction, we may not use or disclose your child's 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 child's provider. You may request a restriction by writing to one of our managers.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also 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. We will not request an explanation from you as to the basis for the request. Please make this request in writing to one of our managers.

You may have the right to have your provider amend your child's protected health information. This means you may request an amendment of protected health information about your child in a designated record set for as long as we maintain this information. 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 one of our managers to determine if you have questions about amending your child's medical report.

You have the right to receive an accounting of certain disclosures we have made, if any, of your child's protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your child's care, or for notification purposes. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to request a specific item or service not be disclosed to a health plan for purposes of payment or health care operations. If you have paid out-of-pocket (or in other words, you have requested that we not bill your child's health plan) in full for a specific item or service, you have the right to ask that your child's PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. The Children's Medical Group may not use or disclose your child's PHI in violation of that restriction unless it is necessary for treatment purposes or in the event the disclosure is required by law.

You have the right to request an electronic copy of your child's electronic medical record. This means you may request an electronic copy of your child's electronic medical record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your child's PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you requested, your child's record will be provided in a readable hard copy form. We may charge you a reasonable fee for the labor associated with transmitting the electronic medical record.

You have the right to obtain a paper copy of this notice form us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

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

You may contact our Privacy Officer, Melissa Peters, Health Information Manager at (845)-452-1700 ext. 1140 or mpeters@cmgkids.org for further information about the complaint process.

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in ***all Waiting Areas***. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website www.childrensmedgroup.com.

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.

The Children's MEDICAL GROUP

Diplomates of American Board of Pediatrics

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

✳ PAWLING ✳ FISHKILL ✳ HOPEWELL JUNCTION ✳ POUGHKEEPSIE ✳ HYDE PARK ✳ RHINEBECK ✳ ✳ NEWBURGH ✳ MODENA ✳ KINGSTON ✳

RETURN TO PRACTICE

ACCOUNT NUMBER: _____

PATIENTS NAME: _____ D.O.B.: _____

My child is returning to The Children's Medical Group as of: _____

I have notified my insurance company that a provider at The Children's Medical Group will be my child's Primary Care Physician.

I agree to pay any bills that are incurred in the event that I have not notified my insurance company. This will be for all visits until we have confirmed coverage.

I will request that my child's records be transferred back to The Children's Medical Group. (Please fill out a separate form).

_____ _____

Parent's/Patient 18 years or older Signature Date

PERSONAL REPRESENTATIVE DESIGNATION

The Children's MEDICAL GROUP

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
PAWLING
RHINEBECK

Carl D. Sorgen, M.D.
Herschel R. Lessin, M.D.
David L. Fenner, M.D.
Adrian Gruszko, M.D.
Marc Habert, M.D.
Fe Aplasca, M.D.
Dominique Aristide, M.D.
Aaron M. Blum, M.D.
Sejal Dalwadi, M.D.
Robert Felix, M.D.
Bobby Gearing, M.D.
Celeste Grosso, M.D.
Oluchi Nwahiwe, M.D.
Jaime Rivera, M.D.
John Sieverding, M.D.
Puja Singh, M.D.
Arlene Solomon, M.D.
James Sulzer, M.D.
Natasha Tzagoloff, M.D.
Chika Ugorji, M.D.
Christine Verna, M.D.
Nancy Laterra-Ferraro, PNP
Dana Mitchell, PNP
Michelle Patrick, PNP
Margaret Serino, PNP

Joseph F. Heavey
CEO

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, **«Ptname»** 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

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Dana Mitchell, PNP
Michelle Patrick, PNP
Margaret Serino, PNP

Joseph F. Heavey
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