**WELCOME TO OUR PRACTICE !**

**Carlisle Pediatric Associates** welcomes you to our practice. Our four pediatricians and one physician assistant provide primary care for children and specialty care for more complex medical and developmental problems encountered with children. We have been trained at some of the premier pediatric hospitals in the country. Our participation in numerous continuing education programs throughout the year allows us to remain on the forefront of pediatric care.

**Our providers are dedicated to providing excellent health care** to your children. We will act as advocates for your child’s health and wellness based on current scientific knowledge, nationally accepted recommendations, as well as our experience. We will be consultants to you as parents in the care and rearing of your child.

**As a parent**, you are a critically important part of your child’s health care team. You are the one who will be reporting concerns, soliciting medical advice, and following through with your child’s doctor’s recommendation. A partnership between you and your child’s pediatrician will provide your child with the best, most optimal care. Realizing this, we do expect you to ask questions, understand our recommendations, and leave our office comfortable with the plan developed to provide evaluation, care, and treatment of your child.

**Saturday morning and Sunday afternoon** appointment times are provided for emergencies and illnesses that come up over the weekend that cannot wait until regular hours. Our practice has office hours every day of the year except Christmas Day. “Walk-in” times are also provided on all other major holidays and the timing of those hours will be stated on the office telephone recording when you call. We try to make our schedules as accommodating as possible. Our office has expanded its Monday-Friday hours to 8am-7pm. We ask for your help in making sure that our time is used wisely during our schedules. To help ensure this we require a 2 hours’ notice to reschedule or cancel any scheduled appointment. Canceling an appointment with less than 2 hours’ notice will be considered a “No Show”.

**Newborn Inpatient Care** is provided at Carlisle Regional Medical Center along with emergency room consultations. Inpatient pediatric care for our patients is now provided by Harrisburg Hospital, York Hospital or Hershey Medical Center. Although the distance to these hospitals does not permit us to personally admit to the hospital, we do have a close relationship with the doctors and specialist who will provide inpatient care for our patients at the Medical Center.

**Our physicians are participating with many insurance companies**.

Please check with your insurance company or your employer to verify if your coverage is restricted on whom your child may see in order for them to pay your claims. This will ensure that your claims will be processed and paid correctly. If we are not considered “Participating” with your insurance, there will be out-of-pocket expenses that you will be responsible for at the time-of-service.

**We see children in our practice from their newborn period** until completion of their schooling. If your child continues their formal education beyond high school, we will continue to provide medical care until the advanced schooling is completed.

**Our staff is dedicated to your child**. We will work hard to provide the care, time, supplies, and facilities needed for your child’s health care. We appreciate your respect for the dedication of our staff and their efforts to help you. Mutual respect is necessary for the relationship necessary to provide optimal care for your child.

**Our practice is a PCMH (patient-centered medical home).** This concept is a model of health care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term health-care relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient’s health care needs and arranging for appropriate care with other qualified clinicians. You will choose a primary physician, who will be your child's caregiver whenever they are available in the office. The medical home is intended to result in more personalized, coordinated, effective and efficient care by providing patients and families access to evidence-based care and self-management support.

**PCMH** works by delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.

**PCMH** coordinates patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions.

**Our office telephone number is (717) 243-1943**. Upon answering, a list of options is given. Although this may seem impersonal, we have found that it allows for more efficient communication. You may leave non-acute messages and requests for medication refills on an answering system. This allows the staff answering the phones more availability to talk with you when you need to schedule an appointment or to talk with us regarding an acute situation. This number is used to access your pediatricians during office hours as well as outside of regular hours.

**Our Practice website is** [**www.carlislepediatric.com**](http://www.carlislepediatric.com/). This website has many helpful links to resources. You can find links to general health information, common dosage charts, links for vaccine information, and links to local hospitals. You can obtain our Office Policies and download Forms to be filled out.

**Our Patient Portal is accessed through our website.** This iswhere is can send us messages, print off vaccine records, request school forms and appointments, self-confirm upcoming appointments, update your personal demographic information, and you will soon be able to pay your balance. Parents of teenagers please understand that, due to the physicians’ strong convictions in building a trusting relationship with your adolescents and teenagers, the providers may not be able to discuss all of the content of their appointments with the parents, unless the physician feels that your teen is a danger to themselves or has been abused. Due to the medical need for these issues to be discussed confidentially with our teens - parental access to their portal account will be discontinued at age 13.

**Outside of regular office hours**, we do have a pediatrician on call to answer questions and to help you deal with problems that cannot wait until regular hours. Although we are happy to help you work through problems during these times, we do ask you to use this service for problems that need more immediate attention and cannot wait until regular office hours. Matters such as prescription refills and problems of a more chronic nature should wait until the office is open when the physician has access to your child’s chart.

**Please read over the attached:**

Insurance Guidelines, Financial Policy, No Show Policy, Parents Responsibilities,

Referral Process Policy and Notice of Privacy Practices.

**We look forward to being your child’s pediatricians, getting to know**

**you and your family and partnering with you in caring for your child.**

**Dr. Holly C. Hoffman**

**Dr. Deborah Raubenstine**

**Dr. Stephanie R. Waters**

**Dr. Teresa J. Frank**

**Dianna Rudy PA-C**

**NEW PATIENT MEDICAL HISTORY**

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1 ST VISIT

**\* WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES**

\*

The followinq is **very important** to your child's health. Please complete it **accurately and completely**



**Child's name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth date**:



Where was your child born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is child adopted or fostered? Y \_\_\_ N



|  |  |  |  |
| --- | --- | --- | --- |
| **Has your child ever been seen by anyone in this practice in the past?** | | |  |
| **BIRTH HISTORY** | | | |
| Birth Weight: lbs. oz. Vaginal birth? C-section? | | | |
| Was the baby : circle one Full term Early Late | | | |
| If early, how many weeks? |  | | |
| Did the baby have any problems right after birth? |  | | |
| Were there any problems with the pregnancy? |  | | |
|  | | | |
| **DEVELOPMENTAL HISTORY** | No | Yes | If Yes - explain |
| Are you concerned about your child's physical development? |  |  |  |
| Are you concerned about your child's attention span? |  |  |  |
| Has he/she failed or repeated a grade? |  |  |  |
| How is our child's behavior in school? | | | |
| What kind of grades does he/she make in academic subjects? | | | |
| Is he/she in a special or resource classes? | | | |
| When did your child: Sit Up? \_\_\_\_\_Crawl? \_\_\_ Walk? \_\_\_\_ |  | | |
| First sentence (age) Toilet trained (age) | | | |
|  | | | |
| **PATIENT ALLERGIES** | No | Yes | If YES - explain |
| Does this child have any known Drug Allergies ? |  |  |  |
| If you answered YES - Is your child allergic to: |  |  |  |
| Penicillin (Amoxicillin, Augmentin) |  |  |  |
| Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax) |  |  |  |
| Sulfa (Septra/Bactrim) |  |  |  |
| Zithromax/erythromycin |  |  |  |
| Other Antibiotics or medications? Give name: |  |  | Reaction: |
| Peanuts or other nuts — Give name or Group: |  |  | Reaction: |
| Milk |  |  |  |
| Eggs |  |  |  |
| Seafood |  |  |  |
| Other Foods — give name here: |  |  | Reaction: |
| Bees / Wasps |  |  |  |
| Indoor Allergens (pets, molds, dust) |  |  |  |
| Outdoor Allergens (trees, weeds, pollens) |  |  |  |
| Latex |  |  |  |
| Other Allergies: |  |  | Name: |
|  |  |  |  |
| **PATIENT SOCIAL HISTORY** | No | Yes |  |
| Does patient live with both mother and father in same house? |  |  |  |
| Non-intact home - explain custody status. |  |  | Lives with: |
| Does non-custodial parent have visitation rights? |  |  |  |
| Are there Siblings? |  |  | Live in same house? |
| Are there pets in the home? |  |  |  |
| Are there smokers in the home? |  |  |  |
| Are there guns in the home? |  |  |  |
| Are guns locked and kept separate from ammunition? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT - PAST MEDICAL HISTORY** | No | Yes | If Yes —explain |
| Serious accidents or injuries |  |  |  |
| Surgeries |  |  |  |
| Hospitalizations |  |  |  |
| Chicken Pox Disease |  |  | What age: |
| Frequent ear infections or sinus infections |  |  |  |
| Frequent sore throats or tonsillitis |  |  |  |
| Other infection illnesses |  |  |  |
| Allergic rhinitis or other allergy |  |  |  |
| Asthma, bronchitis, bronchiolitis, pneumonia or croup |  |  |  |
| Heart problems or heart murmur |  |  |  |
| Abdominal pain/reflux |  |  |  |
| Constipation requiring doctor visits |  |  |  |
| Bladder or kidney infection or other urologic problem |  |  |  |
| Bed-wetting (after age 5) |  |  |  |
| Eye conditions / wear corrective lenses |  |  |  |
| Problems with ears or hearing |  |  |  |
| Chronic or recurrent skin problems/ acne |  |  |  |
| Anemia or bleeding problem |  |  |  |
| Past blood transfusion |  |  |  |
| Frequent headaches |  |  |  |
| Convulsions, seizures, or past concussions? |  |  |  |
| Mental health concerns |  |  |  |
| Seizures, developmental delays, ADD/ADHD or other neurolo ical disorders |  |  |  |
| Orthopedic problems |  |  |  |
| Diabetes |  |  |  |
| Thyroid, diabetes or other endocrine problems |  |  |  |
| If female, have menstrual periods started? |  |  |  |
| If female, any problems with periods? |  |  |  |
| Use of alcohol or drugs |  |  |  |
| Emotional or mental health problems |  |  |  |
| Other significant issues: |  |  |  |
|  |  |  |  |
| Current Medications and Dosage: (include any over the counter, herbal, or supplements)  Does your child see any specialists? If so, who and where? | | | |

In this FAMILY medical history - if you answer YES - please check off which BIOLOGICAL RELATIVE has the condition

Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather

List or explain condition if possible.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY- PAST MEDICAL HISTORY** | NO | YES | **If YES - Please check which biological relative** | | | | | | |
|  |  |  | Mom | Dad | Sib | Maternal Gr Mth | Maternal Gr Fth | Paternal Gr Mth | aternal Gr Fth |
|  |  |  |
| Nasal allergies or other allergies |  |  |  |  |  |  |  |  |  |
| Asthma/lung disease |  |  |  |  |  |  |  |  |  |
| Heart disease or heart condition |  |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |  |
| Diabetes or other endocrine problem |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |  |  |
| Bleeding disorders |  |  |  |  |  |  |  |  |  |
| Epilepsy or convulsions |  |  |  |  |  |  |  |  |  |
| Mental retardation or developmental disorders |  |  |  |  |  |  |  |  |  |
| Neurological disorder including ADHD/ADD |  |  |  |  |  |  |  |  |  |
| Liver disease |  |  |  |  |  |  |  |  |  |
| Other Gl disease / disorder |  |  |  |  |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |  |  |  |  |
| Bed-wetting (after age 10) |  |  |  |  |  |  |  |  |  |
| Hearing impairment |  |  |  |  |  |  |  |  |  |
| Vision impairment or eye disorder |  |  |  |  |  |  |  |  |  |
| Immune problems, recurrent infections or HIV-AIDS |  |  |  |  |  |  |  |  |  |
| Alcohol Abuse |  |  |  |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |  |  |
| Other issues: |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

Is there anything else regarding your child's health that you think we should know that has not already been asked?

**WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT**

I understand that providing correct and complete information is essential to my child's health, and that **incomplete or incorrect information can be dangerous**. It is my responsibility to inform the office of any changes in my child's family or medical history after I have submitted this form.



Signature Relationship to patient Date

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**It's very important we have your Patient/Family Information correct –** PLEASE PRINT CLEARLY

PRIMARY PARENTAL CONTACT PERSON FOR FAMILY (this contact will be the **preferred contact person** for Reminder calls)

Check one: \_\_\_ Biological-Mother \_\_\_ Step-Mother \_\_\_ Adoptive-Mother \_\_\_ Foster-Mother \_\_\_ Legal Guardian Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Biological-Father \_\_\_ Step-Father \_\_\_ Adoptive-Father \_\_\_ Foster-Father \_\_\_ Legal Guardian Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Do youlive with patient? \_\_\_Yes \_\_\_No Name of Employer **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_

Check preferred means of contact for messages: \_\_\_Home \_\_\_Cell \_\_\_Work

Check preferred means of contact for Appt. Reminders: \_\_\_Home \_\_\_Cell \_\_\_Work

SECONDARY PARENTAL CONTACT PERSON FOR FAMILY

Check one: \_\_\_ Biological-Mother \_\_\_ Step-Mother \_\_\_ Adoptive-Mother \_\_\_ Foster-Mother \_\_\_ Legal Guardian Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Biological-Father \_\_\_ Step-Father \_\_\_ Adoptive-Father \_\_\_ Foster-Father \_\_\_ Legal Guardian Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Do youlive with patient? \_\_\_Yes \_\_\_No Name of Employer **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to obtain more accurate Family Medical History requirements, if contacts listed above are NOT the BIOLOGICAL PARENTS, we now necessitate BOTH BIOLOGICAL PARENTS (if known) to be listed **(fill in any and all information if known):**

Biological Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Biological Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

If either biological parent listed above has NO parental rights per a SIGNED COURT ORDER a copy of that COURT ORDER is required to be on file.

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ONLY CHILDREN IN FAMILY THAT THE ABOVE PARENTAL INFORMATION APPLIES TO

(If children have a different family dynamic then above - they must be on a different sheet)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **First Child** | **Second Child** | **Third Child** | **Fourth Child** |
| **First Name** |  |  |  |  |
| **Mid. Initial** |  |  |  |  |
| **Last Name** |  |  |  |  |
| **Sex** | \_\_\_ Male \_\_\_ Female | \_\_\_ Male \_\_\_ Female | \_\_\_ Male \_\_\_ Female | \_\_\_ Male \_\_\_ Female |
| **Birth Date** | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |
| **Primary Language Spoken** | \_\_\_ English  \_\_\_ Spanish  List other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ English  \_\_\_ Spanish  List other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ English  \_\_\_ Spanish  List other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ English  \_\_\_ Spanish  List other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ethnicity** | \_\_\_ Not Hispanic  \_\_\_ Hispanic \_\_\_ Unknown | \_\_\_ Not Hispanic  \_\_\_ Hispanic \_\_\_ Unknown | \_\_\_ Not Hispanic  \_\_\_ Hispanic \_\_\_ Unknown | \_\_\_ Not Hispanic  \_\_\_ Hispanic \_\_\_ Unknown |
| **Race**  **(Check all that apply)** | \_\_\_ Native American  \_\_\_ Black  \_\_\_ Asian  \_\_\_ White  \_\_\_ Pacific Islander | \_\_\_ Native American  \_\_\_ Black  \_\_\_ Asian  \_\_\_ White  \_\_\_ Pacific Islander | \_\_\_ Native American  \_\_\_ Black  \_\_\_ Asian  \_\_\_ White  \_\_\_ Pacific Islander | \_\_\_ Native American  \_\_\_ Black  \_\_\_ Asian  \_\_\_ White  \_\_\_ Pacific Islander |
| **Who do you consider your Primary Care**  **Physician ?** | \_\_\_ L Hoffman \_\_\_ Waters  \_\_\_ H Hoffman \_\_\_ E. Man  \_\_\_ Raubentsine \_\_\_ Rosario  \_\_\_ Frank | \_\_\_ L Hoffman \_\_\_ Waters  \_\_\_ H Hoffman \_\_\_ E. Man  \_\_\_ Raubentsine \_\_\_ Rosario  \_\_\_ Frank | \_\_\_ L Hoffman \_\_\_ Waters  \_\_\_ H Hoffman \_\_\_ E. Man  \_\_\_ Raubentsine \_\_\_ Rosario  \_\_\_ Frank | \_\_\_ L Hoffman \_\_\_ Waters  \_\_\_ H Hoffman \_\_\_ E. Man  \_\_\_ Raubentsine \_\_\_ Rosario  \_\_\_ Frank |

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU MAY BE CONSIDERED SELF-PAY

Medical Assistance Coverage: Name of Plan (example Gateway or Amerihealth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have medical assistance you must complete yearly DPW forms to maintain your coverage. If not completed you may be responsible for your bills.

CHIP Coverage: Name of CHIP plan (example Aetna, Keystone, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO CARRIES PRIMARY COMMERCIAL INSURANCE?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ Best Phone # to contact you: (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Name of Ins. Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do youlive with patient? \_\_\_Yes \_\_\_No Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO CARRIES SECONDARY COMMERCIAL INSURANCE?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ Best Phone # to contact you: (\_\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Name of Ins. Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do youlive with patient? \_\_\_Yes \_\_\_No Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO IS THE FINANICAL GUARANTOR – If Financial Guarantor is a Contact on previous page only complete first line.

**This is the person that will receive Billing Statements in the mail.**

**(Parents must agree on this and work arrangements out among themselves for payment issues.**

**Carlisle Pediatrics cannot become involved with domestic arguments over who receives Billing Statements.**

**If this becomes a recurring problem, you may be asked to find another practice that better suits your needs)**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Do youlive with patient? \_\_\_Yes \_\_\_No Name of Employer **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand copies of the FinancialPolicy, No Show Policy, Billing Fee Policy, Referral Policy, Collection Policy, Portal Policy, Consent to Treat Policy, and Notice of Privacy Practices are posted in the office and on our website. I understand copies are available upon request. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.

**I understand** the office requires all parents to leave a credit card on file with our office. The card number will not be stored in our computer servers, rather encrypted off site of Instamed Secure Data Center. The card may be used as a convenient solution for me to pay my balance and if no payments have been made will be used for those accounts that become delinquent.

I understandboth biological parents have access to full disclosure of their child's medical information (even if they are not the custodial parent) and can authorize someone to bring their child to their appointments in their absence.

I understand the Patient Portal is in place for my benefit and if it is misused my access can be terminated by the practice.

I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the physician feels the patient is a danger to themselves or has been abused. This confidential information will also not be accessible on the portal.

I authorizeCarlisle Pediatric Associates, upon my request, to fax any forms or immunizations records to my child’s school.

I understand that Carlisle Pediatric Associates provides immunization information to the Pennsylvania State Immunization Information System, and I may opt out of having my child’s information sent by notifying Carlisle Pediatric Associates writing.

I understand that I am personally responsible for being aware of dates and times of my scheduled appointments.

I understand that I am responsible for all charges whether or not covered by insurance and that all co-pays are due at the time of service.

**I understand** that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at out of network benefits. Any questions about reimbursement for care (medical, lab, x-ray, etc) should be directed to our insurance carrier prior to services.

I agree to keep laboratory testing and referral appointments as ordered by the doctors.

I understand the office requires 24 hours’ notice for prescription refill requests.

I understand if there are Custody Orders in place I must present **current copies** for my child’s file. If custody issues interfere with our physicians providing proper medical care you may be asked to find a facility that better suits your needs.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners.

I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Carlisle Pediatric Associates.

**SIGNATURE:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Relationship to patient Date

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* CREDIT CARD ON FILE POLICY \*\***

**Authorization for Credit Card on File Program:**

We are excited to offer an innovative program to help manage your health care dollars. With the changes in healthcare, many families have chosen individual high deductible health plans to help lower their monthly insurance premiums. With the Credit Card on File program we will process any amounts that your insurance carrier deems as your responsibility. Your credit card information is not stored in this office. We use a secure clearinghouse that meets the industry standards set forth from the Payment Card Industry Data Security Standard (PCI-DSS). Once we enter your information through this gateway, we do not have access to view or edit the information.

**TERMS OF CREDIT CARD ON FILE**:

**Your credit card information is not kept on file in this office. It is kept securely offsite by our Payment Gateway and our office does not have access to the full credit card number once it is scanned into our system.** Be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment. If you have any questions about this payment method, do not hesitate to ask.

**I understand** I must keep this card information current in this office. Cards denying could incur additional fees.

**I understand** that once my insurance has paid their portion for the medical care we received at CARLISLE PEDIATRIC ASSOCIATES, the remaining balance is my responsibility as shown on my Explanation of Benefits (EOB) from my insurance company.

**I authorize** CARLISLE PEDIATRIC ASSOCIATES to charge my payment card on file for the balance due if I do not make a payment or respond to my courtesy statement resulting in the balance being 30 days past due.

If I have more than one type of payment card on file CARLISLE PEDIATRIC ASSOCIATES will process my Health Savings card before charging my credit card for the remaining balance.

If I am self-pay my payment card will be charged at the time of service.

If the payment card is declined for any reason an additional fee of $25.00 will be applied to my account (same as a bad check fee).

If your HSA card declines, you will receive a phone call and be given the opportunity to give us another card to use.

If the amount billed to my credit / debit / HSA card will be over $100 you will receive a courtesy notification 48 hours prior to it being charged.

**\* \* Carlisle Pediatric Associates Financial Policy – revised 1/1/18 \* \***

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy

is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility in regard to your services.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

Please be advised that you are initiating services to be rendered and ultimately you are financially responsible for all charges incurred whether paid by your insurance or not.

**Patients are expected to:**

1. Bring and present their insurance card to every visit. We must have a copy of insurance card to submit

claims. We must have accurate personal and insurance information or patient may be given a 30 day

notice of dismissal from the practice.

1. Give the office current insurance plan information within 45 days of the date of service or we cannot file

a claim to your insurance and you will be responsible for payment.

1. Have our name listed on their insurance card as PCP if they have an HMO plan. If another doctor or

facility is listed we cannot see the patient. Newborns have 30 days to have us added as PCP.

1. Review our Referral and Authorization Policy attached.
2. Pay co-payments assigned by your insurance, IN FULL, on the date of service. If not, you will be

charged a billing fee and may be required in the future to pay before services are rendered.

1. Pay personal balance due on account that is over 30 days old before next visit.
2. Means of Payments include: Cash, Checks, Visa, Discover and Master Card.
3. Understand there will be a $25.00 fee assessed for any returned personal check or credit card that denies.
4. Keep appointments and arrive promptly. Notify office of any need to cancel or reschedule. If

appointments are “no shows” or canceled with less than 2 hours notice there will be a charge

assessed. A courtesy reminder call is made, when possible, but it is your responsibility to know the

date and time of your appointment.

1. Understand your insurance policy and its benefits. Understand there may be things your insurance

plan does NOT cover. Every plan is different, and it is your responsibility to know your specific

coverage. This is a contract between you and your plan.

1. Verify with your employer or insurance company if we are participating with your specific plan BEFORE

scheduling appointments.

1. Understand if you will be responsible for the full charge if you choose to use our services and

we are non-participating with your insurance. This payment is due on the date of service. We

will with documentation to file a claim for your visit to your insurance company. They will reimburse you.

1. Provide coordination of benefits information to your insurance. If not, claims will be denied and will be

your responsibility to pay.

1. Work with YOUR insurance to get prompt payment of claims. We will handle your claims according to

our claims agreement with that insurance company.

1. Call us if you have any questions regarding the payment by your insurance company, our insurance

department will try to assist you. Please have the “Explanation of Benefits” you received from your

insurance on hand when you call our office.

1. Understand we will not become involved in disputes between you and your insurance company regarding

deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc.,

other than to supply factual information as necessary. You will need to resolve these with your insurance.

17. Understand we cannot become involved in domestic disputes over who is responsible for the bill.

1. Understand once your account if 90 days delinquent and you have not made any attempt to make a

payment or set up a payment schedule you may be sent to a collection agency and you may be

discharged from the practice.

1. If you have a previous balance that has been turned over to the Collection Agency, you must to be

prepared to pay for your co-pays, etc. at the time of your future appointments.

\*\* NO SHOW POLICY \*\*

The relationship between doctor and patient is a two-way street. There are rights and responsibilities on both sides. When you make an appointment to see one of our doctors or our physician’s assistant, that time is set-aside just for you. We attempt to confirm appointments a day in advance but **ultimately you are responsible to mark your calendar to assure you are available to keep the appointment.** If you miss your appointment it creates several problems:

1. Lost time that could have been used by another patient;

2. It demonstrates a lack of basic courtesy and respect for our Physicians and our practice.

We do understand there could be a circumstance when you are unable to arrive for appointments. However, if this becomes a pattern for your family’s appointments, there will be consequences involved. If you have missed an appointment in our office in the past we ask you to be sure to keep future appointments. Last minute cancellations still result in lost appointment times.

* + - * **Appointments must be** **canceled with at least a two-hour advanced notice** **to avoid further consequences**.
* **If you do not keep an expanded visit, such as a Consultation or Complex Check-up there will be a $50.00 fee for the lost visit.**
* **If you miss more than one standard appointment within 12 months you will incur a fee.**
* **If you have missed several appointments within the past 12 months you may be billed for**

**the full amount of an office visit and your family may be discharged from the practice.**

* **If your family has had 3 no show appointments within a year, or an excessive amount**

**compounding over the years, you may be asked to find another practice that better meets**

the needs of your schedule.

\*\* PARENTS RESPONSBILITIES \*\*

I will review the No Show Policy and understand we expect you to keep all of your appointments,

except in emergency situations.

I am responsible for being aware of dates and times of my scheduled appointments.

Give at least 2 hours notice to avoid a missed appointment feeif you need to reschedule your

appointment.

Keep laboratory testing and referral appointments as instructed by your physician.

Your right to continue care with Carlisle Pediatric Associates may be terminatedif a pattern of

failure to keep scheduled appointments occurs.

Review the Financial Policy and understand your financial responsibilities.

All co-pays and other financial responsibilities are due at check in on the day of service.

**I am initiating services to be rendered to my family and ultimately I am financially**

**responsible for all charges incurred.**

\*\* INSURANCE GUIDELINES \*\*

Please bring your insurance card to every visit. You will need to present your card at every visit. Our contracts with insurance companies require us to validate your coverage each time we see you.

WE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD ON FILE IN ORDER TO SUBMIT CLAIMS. If we are not given a valid insurance card, you will be considered “Self Pay”.

**CURRENT INSURANCES WE ARE PARTICIPATING WITH:**

**(this list can change due to contract negotiations)**

#### CAPITAL BLUE CROSS KEYSTONE

### HIGHMARK BLUE SHIELD P.H.C.S.

## HEALTH AMERICA HEALTH ASSURANCE

## TEAMSTERS PRIME SOURCE

AETNA CIGNA

ACCESS GATEWAY

GEISINGER

**\*\*Any patients with an HMO PLAN (including Gateway)\*\***

Our name must be on your card to receive care. You MUST call your insurance and

add us as your child’s Primary Care Physician prior to being seen.

**Newborns have 30 days to have us added as PCP**.

**If your insurance is not on this list – YOU NEED TO CALL YOUR INSURANCE to see if they consider us participating with your plan. If we are NOT participating with your insurance you will be responsible to pay for your visits at the time of service.**

## 

\*\* NEW BABY INSURANCE COVERAGE \*\*

If you have recently given birth to a new baby - CONGRATULATIONS ON YOUR NEW ARRIVAL !!!

If you have not already notified your Insurance company (including Gateway) of your new family member,

it is necessary that you do so immediately. Insurance coverage is determined by which plan or plans

your employer offers and you enroll in. We encourage you to contact your human resource department or employer about the specifics of your plan, including what your coverage is for well-baby exams and immunization coverage. Just because our physicians (or the American Academy of Pediatrics) recommends certain physicals or immunizations does not mean they are automatically covered by your insurance plan.

Failure to add your child to your insurance in a timely manner will

result in claim denials.

**Carlisle Pediatric Associates, P.C.**

**If your child is under 18 years of age and is coming to an appointment alone or with someone other than a parent or legal guardian, WE MUST HAVE an authorization to treat your child or they cannot be seen.**

1. **I am the child’s biological or adoptive parent** and I hereby authorize the person(s) listed below to initiate and approve medical care for my child/children in my absence. This person will be authorized to: discuss my child’s medical information, authorize medical decisions on my part, give consent for tests, age appropriate vaccines, and/or treatments.

PRINT name of authorized person: Relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT name of authorized person: Relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all patients’ names and birthdates to which this applies:

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_\_/ \_\_\_\_\_

# PRINTED name of parent filling out form:

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Parent Signature: Todays Date:

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

1. **List the contact phone number you can be reached at during the appointment: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**

**\*\*** REFERRAL PROCESS POLICY **\*\***

Many insurance plans, especially capitated plans such as **Aetna HMO, Keystone Health Plan Central, and Gateway** have complicated rules regarding specialist visits and referrals. Even within the same insurance company, policies and procedures may vary from one employer to the next. As a result, it is impossible for Carlisle Pediatric Associates to know the details of every patient’s insurance plan.

When you need to visit another doctor or facility, **it is your responsibility to know your specific benefits**. **YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY**. If you are unsure, you can get more information by calling the member services number on the back of your insurance card**. We recommend that you know the answers to the following common questions before you need them:**

* Where should I get blood work and other lab work done?
* Where should I get x-rays and other imaging studies done?
* Do I need a referral to see a specialist?
* What do I do if the specialist wants me to have additional lab work or x-rays or therapy?
* If I choose to see a specialist who is “out of network,” how much of the bill will I be responsible for?

**If your insurance plan does need referrals, our office policy requires a minimum of two (2) business days to process a routine referral.** We recommend that you contact us as soon as you make an appointment with a specialist.

**We cannot “back date” a referral.** **If you are seen by a specialist without a referral, we will not be able to process one after the fact**. If you call us on the way to the specialist, we will not be able to process your request in time for your scheduled visit. You may be asked to reschedule the appointment if the specialist cannot verify that you have a referral in the system. If you need to see a specialist for a follow-up appointment, inquire if you will need an additional referral or if the original referral included a certain number of follow-up visits within a defined period of time.

**If you would like a “non-par” referral (to visit a specialist or facility that is out-of-network), we require 5 business days to handle such requests.** This process often requires additional documentation and multiple contacts with your insurance company. Before contacting us, we ask that you call your insurance company to confirm whether your policy covers such services, and if so, to get the details on what information we will need to process the request.

If your child needs a referral for therapies including physical therapy, occupational therapy or speech therapy, it is likely that there will be limits to how many visits your plan will cover and specific locations that you must use for care.

Please remember the above information is for your benefit so that your insurance company will pay for services. If you do not comply with the rules that are outlined by your specific insurance policy, you may be responsible for all or a portion of your bill.

**POLICY ON TRANSITION TO ADULT HEALTH CARE**

Patients 13-17 years old: beginning at age 13 years, at least part of a patient’s medical visit will generally be in private, and the parent/guardian may be asked to step out of the exam room if the adolescent requests. The patient may ask for the parent/guardian or nurse to be present in the exam room. Discussions of certain sensitive issues, such as sexual and mental health and substance use, will remain confidential and will not be shared with the parent/guardian unless the adolescent consents. Medical records documenting the corresponding portions of the medical exam and discussion also will be treated as confidential, to the extent required by law, and will be released to a parent/guardian or other person only with the patient’s written authorization.

For adolescent patients who have developmental disabilities or other special health needs, it may be necessary and appropriate to modify these policies to accommodate their needs. We welcome patients and parent/guardians to discuss social needs with us, so that we may plan reasonable accommodations together.

In addition, CPA will inform the parent/guardian of any life-threatening situation or behavior involving any patient younger than age 18 years, whether disclosed by the patient or becoming evident through medical examination. In this case, we will inform the patient that we have a legal obligation to disclose this information to the parent/guardian.

Patient 18 years and older: Patients 18 years and older are adults under the law. Patients under age 18 who have been emancipated (through marriage, pregnancy, etc.) are also considered adults under the law.

CPA will respect these patients right to make their own health care decisions and manage their own health care, unless a court has determined that they are not able to do so and has appointed a legal guardian. Please provide us a copy of the court’s decree or equivalent documentation, if you have been appointed the legal guardian. Please provide us a copy of the court’s decree or equivalent documentation if you have been appointed the legal guardian of your adult child, so that we may conform to the terms of you guardianship.

CPA will respect the right of patients age 18 years and older to privacy regarding their health information and records. Providers will meet with and examine these patents privately unless the patient requests that the parent or other person be present. A young adult patient may authorize a parent or other person to receive medical information or records by signing a release of information. A release form is available at [www.carlislepdiatric.com](http://www.carlislepdiatric.com/) (on the Office Policies and Forms page; Downloadable forms; then click on Release for records transferring FROM us) or you may ask your CPA doctor or office personnel for the form.

\*\*Understanding your insurer’s privacy policies: Please be aware that young adults and children who are insured under a parent’s family policy might receive statements from the insurer at the parent’s address. CPA has no control over insurers’ procedures and is not responsible for any resulting disclosure of health information. Please contact your insurer about any questions regarding its privacy procedures and policies.

Transitioning from pediatric to adult health care is a partnership: CPA serves patients from birth to adult status. If you are 18, graduate high school, enter the workforce and get a job with your own insurance, we ask that you find your own adult physician by the September following graduation. We welcome our young adult patients who remain in school and on their parents’ insurance to continue in our care until they are 22 years old. By that age, patients should transition to an adult primary care provider. Most specialists require you to transition at age 18. We encourage you to start collecting information about adult health care providers well before the actual need arises. Remember to check with your insurer or ask the adult provider which insurances are accepted.

Once you select your adult provider, please remember to sign a release promptly so we may send your medical records to this provider. You may use CPA’s release form the [www.carlislepediatric.com](http://www.carlislepediatric.com/) (on the Office Policies and Forms page; Downloadable forms; then click on Release for records transferring FROM us) or the form from the adult provider’s office. Please be aware that CPA disposes of medical records according to state law. This generally means that we retain records for seven years after the last date of service or until age 18 years, whichever is longer.

If you have questions or concerns, please feel free to speak with your Carlisle Pediatric Associates provider or one of our office staff at 717-243-1943.

**NOTICE OF PRIVACY PRACTICES FOR CARLISLE PEDIATRIC ASSOCIATES**

804 BELVEDERE STREET, CARLISLE, PA 17013

717-243-1943

Effective Date: 4 - 14 - 03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND

DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have questions regarding this notice, you may contact our privacy officer at the above address,

# OUR COMMITMENT TO YOUR PRIVACY

Carlisle Pediatric Associates understands the importance of maintaining the privacy of your individually identifiable health information (IIHI). The federal privacy rule mandates that we provide you with notice of our legal duties and privacy practices with respect to your protected health information (PHI). By federal and state law we must follow the terms of the notice currently in effect. We may at times update this notice. Changes to this notice will apply to present or future information we may receive or create.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of healthcare to you, or payment for healthcare provided to you, and individually identifies you or reasonably can be used to identify you. Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

## WE MAY USE AND DISCLOSE YOUR (IIHI) IN THE FOLLOWING WAYS

The following categories describe the various ways in which we may use and disclose your IIHI.

**HEALTH CARE OPERATIONS:** Our practice may use and disclose your IIHI to operate our business, some examples of health care operations purposes include:

* Quality assessment and improvement activities.
* Cost management and business planning activities.

**TREATMENT:** Our practice may use and disclose your IIHI for our treatment purposes as well as the treatment purposes of other healthcare providers. Some examples of treatment uses and discloses include:

* We may contact you to provide appointment reminders
* We may use sign-in sheets and call you by your name in the waiting room.
* We may ask you to have laboratory tests and use the results to help us reach a diagnosis.
* We may write a prescription for you and disclose information to a pharmacist.
* We may use your answering machine to leave appointment reminders or to disclose results of laboratory or x-ray results.
* We may disclose IIHI to grandparents, older responsible children or babysitters who assist in caring for your child.

**PAYMENT:** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. Some examples of payment uses and disclosures include:

* We may contact your health insurer to certify that you are eligible for benefits.
* We may provide your health insurer with details regarding your treatment to determine if your insurer will cover

or pay for your treatment.

* We may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs.
* We may use your IIHI to bill you directly.

**OTHER USES AND DISCLOSURES FOR OTHER PURPOSES**

We may use and disclose your IIHI for other purposes. This section generally describes those purposes by category.

**PUBLIC HEALTH RISKS:** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect such information for recording, prevention or notification purposes.

**HEALTH OVERSIGHT:** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law such as investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**LAWSUITS:** Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. This would include a response to a discovery request, subpoena or other lawful process by another party involved in the dispute.

**LAW ENFORCEMENT:** Our practice may use and disclose your IIHI when required by federal, state or local law.

**BUSINESS ASSOCIATES:** Our practice may disclose your IIHI to our business associates and allow them to create and receive protected health information on our behalf. Business associates would include a consulting firm, and accounting firm or a law firm. For example, we may share with our attorney information regarding your care in the event a legal situation should occur.

**USES AND DISCLOSES WITH AUTHORIZATIONS**

For all other purposes that do not fall under a category listed under above categories we will seek to obtain your written authorization to sue or disclose your IIHI. This would include contact with teachers and school personnel who will be unable to receive information or discuss a child’s status without such authorization.

**PATIENT PRIVACY RIGHTS**

**CONFIDENTAIL COMMUNICATIONS:**

You have the right to request that our practice communicate your protected health information to you by a certain means (eg. Phone, mail) or at a specific location (eg. home, work). We will accommodate reasonable requests. To make a request for confidential communications, you must submit a written request for our privacy officer. You must state how or where you want to be contacted. You do not need to give a reason for your request.

**REQUESTING RESTRICTIONS:** You have a right to request further restrictions on our use and disclosure of your IIHI for treatment, payment or healthcare operations. You also have the right to request us to restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care such as family member and friends. We are not required to agree to your request. To request a further restriction, you must submit a written request to our privacy officer stating: a) what information you want restricted; b) how the information is to be restricted; c) to whom you want the restriction to apply,

**INSPECTION AND COPIES:** You have the right to inspect and obtain a copy of the IIHI that we maintain in a designated record set. This right is subject to limitation and a predisclosed fee will be imposed. To exercise your right of access you must submit a written request to our privacy officer stating: a) the health care information to which access is requested; b) how you wish to access the information, such as inspection, pick up copy, mailing of copy; c) mailing address if applicable.

**RIGHT TO AMENDMENT:** You may ask us to amend your health information if you consider it incorrect or incomplete. You must provide us with a reason that supports your request. To request an amendment your request must be made in writing and submitted to our privacy officer. We may deny your request if you ask us to amend information that is in our opinion; a) accurate and complete; b) not part of the IIHI kept by or for the practice; c) not part of the IIHI which you would be permitted to inspect or copy; or d) not created by our practice.

**ACCOUNTING OF DISCOLUSRES:** You have a right to obtain an accounting of non-routine disclosures of your IIHI by us (or a business associates for us) made for non-treatment or operations purposes. All requests must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. A predisclosed fee may be imposed.

**PRIVACY VIOLATION COMPLAINTS**

If you believe your privacy rights have been violated, you may submit a complaint to the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, submit the complaint in writing to our privacy officer. You will not be penalized for filing a complaint.

**Introduction to our new Patient Portal**

Call our office to get set up for our patient portal. Simply provide us with your email address. You will be assigned a temporary password. Simply log onto our website **at www.carlislepediatric.com and click on the PORTAL button.**

**Log on with your email and this password \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Please keep in mind the patient portal is to be used for NON-URGENT issues only.

Urgent matters still require a phone call to the office.

1. This will give you access to your vaccine records, growth charts, medications, and allergies.
2. You will be able to access records of your office visits.
3. You will be able to place a request for NON-emergent appointments and our staff will call you back to schedule the appointment. **(cannot be used to make same day sick calls)**
4. You will be able to place a request for a prescription refill (on-going medications).
5. You will be able to place a request for a Referral to be processed (please allow 72 hours).
6. You will be able to place a request for a Form to be ready for pick-up.

(some restrictions will apply depending on the date of your child's last physical)

1. You will be able to pay any outstanding balance on the portal with your credit card.
2. You will be able to send a message to our office staff that can be addressed within 2 business days. (anything requiring same day response you will need call the office)
3. You will be able to update your contact / personal information.
4. You will be able to self-confirm upcoming appointments within 4 days of appointment date.
5. You will be able to receive age driven “tasks” and “surveys” prior to well-child appointments to fill out at your convenience at home.
6. You will be able to make your flu vaccine appointments on the portal during Flu Vaccine Clinics.

Please understand due to the physicians’ strong convictions in building a trusting relationship with

our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the physician feels the patient is a danger to

themselves or has been abused.

**Due to the medical need for these issues to be discussed confidentially with our teens parental access to their portal account will be discontinued at age 13. If your child is 13 or older and you try to log on portal for them they will see:** **You are not authorized to view medical information for any patients. If your child is age 13 or over you may not be able to access their records on this portal. If you are a New Patient to our practice, please call our office to register. If you are an established patient and feel you have received this message in error, please call our office. 243-1943**

**CARLISLE PEDIATRIC ASSOCIATES - PATIENT PORTAL TERMS AND CONDITIONS**

CARLISLE PEDIATRIC ASSOCIATES, PC is pleased to provide you with the ability to access different parts of your child's medical record by using our Patient Portal. By requesting to set up such access and an account with the Patient Portal, you agree to the following terms and conditions. Please note that your failure to follow these terms and conditions can result in the termination of your account with Patient Portal.

**ELIGIBILITY**

Your child must also be an active patient of Carlisle Pediatric Associates. If your child is 13 years of age, or over, they must sign a release for the parent to continue to be able to access their information on the portal.

**USE OF PATIENT PORTAL**

By your request to participate in Patient Portal, you understand and agree to the following:

(a) Patient Portal is intended as a secure online means for you to access your child's confidential medical record information. Please note that if you share your Patient Portal user name and password with another person, this will allow that person to see your confidential medical record information. Carlisle Pediatric Associates has no responsibility concerning any breach of your confidential medical record information due to your sharing or losing your user name and password.

(b) The Patient Portal gives you access to your child’s Electronic Medical Record. If both parents in a non-intact home have separate access to their child (children’s) portal account, please understand that there is only ONE medical record account per child. Both parents will have access to all information and communications placed on the portal. We cannot set up separate accounts for parents who do not live in the same household.

(c) You must select a confidential password and maintain that password in a confidential and secure manner. If you believe that the confidentiality of your password has been compromised, you should call our office to have it reset.

(d) Patient Portal is not meant to be used in any manner in the case of an emergency. If you should experience an emergency, you should immediately seek appropriate emergency care.

(e) You will use Patient Portal only as permitted and not attempt to harm or circumvent any of its security features or use Patient Portal for any purpose other than as described in this Agreement.

(f) Patient Portal is being provided to you as a convenience. Carlisle Pediatric Associates has the right to terminate your Patient Portal access at any time for any reason. This can include cases where Carlisle Pediatric Associates determines that it is not in your best interest to continue to have Patient Portal access.

(g) Participation in Patient Portal is entirely voluntary and you are not required to use Patient Portal to receive care from Carlisle Pediatric Associates. Carlisle Pediatric Associates will not condition its treatment of you on any requirement to participate in Patient Portal.

(h) Patient Portal provides access to different parts of your child's medical record, but not the complete medical record.

**PROVISION OF SERVICES**

(a) Patient Portal is presently provided free of charge, but Carlisle Pediatric Associates reserves the right to charge for Patient Portal services in the future. Should such a charge ever be introduced, anyone with a Patient Portal account would have the option to discontinue the service.

(b) Carlisle Pediatric Associates will use all efforts to keep Patient Portal free from error, but Carlisle Pediatric Associates cannot guarantee the completeness, accuracy, or adequacy of Patient Portal information. Carlisle Pediatric Associates cannot guarantee Patient Portal itself will be fault-free, but Carlisle Pediatric Associates will attempt to correct reported faults in a reasonable time frame.

(c) Carlisle Pediatric Associates reserves the right to change Patient Portal from time to time. Carlisle Pediatric Associates may also suspend or terminate Patient Portal at any time.

**PRIVACY POLICY**

Carlisle Pediatric Associates is fully committed to complying with all federal and state laws and regulations concerning the confidentiality of medical record information. Our HIPAA Notice of Privacy Practices can be found at our office and on our web site.

**SECURITY**

Patient Portal is protected using industry standard security measures. While the security measures will reasonably protect your information and use of Patient Portal, if you have any concerns regarding the security of your child's information or the use of the Internet to access your child's medical record information through Patient Portal, you should consider not creating a Patient Portal account.

**DISCLAIMER**

Carlisle Pediatric Associates will attempt to provide patient portal without interruption, but access is provided on an "as is available" basis. Carlisle Pediatric Associates does not guarantee that you will be able to access patient portal at any time of your choosing.

Carlisle Pediatric Associates cannot guarantee that patient portal will be error-free.

SHOULD YOU HAVE CAUSE TO BELIEVE THAT YOUR INFORMATION ON PATIENT PORTAL IS NOT ACCURATE OR THAT THERE IS AN ERROR WITH PATIENT PORTAL, PLEASE CONTACT CARLISLE PEDIATRIC ASSOCIATES IMMEDIATELY.

Carlisle Pediatric Associates reserves the right to terminate your access to patient portal at any time without cause or notice.

You agree that Carlisle Pediatric Associates takes no responsibility for and disclaims any and all liability arising from any inaccuracies or defects in the information, software, communication lines, internet or your internet service provider ("isp"), computer hardware or software, or any other service or device that you use to access patient portal. additionally, you are responsible for printing copies of your information if you want to have the information available in the event that patient portal is unavailable.

Carlisle Pediatric Associates may modify these terms and conditions, other terms and materials referenced in this document, Patient Portal, or the content of the Patient Portal website at any time. For this reason, you should review these terms and conditions on the website periodically. The services and the content of Patient Portal are provided solely for your personal use. Re-publication, distribution, or use of Patient Portal that is inconsistent with the terms

and conditions described herein is strictly prohibited.

These terms and conditions are governed by and will be interpreted in accordance with the laws of the Commonwealth of Pennsylvania.

**CARLISLE PEDIATRIC ASSOCIATES \*\* VACCINE POLICY**

CARLISLE PEDIATRIC ASSOCIATES has carefully reviewed our approach to vaccinations in our practice. There are several factors that we feel have a bearing on this vaccine policy. Our practice wants to ensure all of our patients, as well as the community at large, are as healthy as possible. One of the most important public health advancements has been the development of vaccinations, so we strongly believe that all children should be immunized. Because of vaccines, many diseases have been eliminated or have become uncommon. Scientific research has consistently and overwhelmingly shown that vaccines are not only effective but also safe. To not have a child vaccinated not only puts that child at risk, but everyone with whom he or she comes into contact. That includes family members, classmates, and other children in our waiting room. Alternative or limited vaccination schedules have no benefits and can cause harm by leaving children vulnerable to deadly diseases.

With these issues in mind, the following reflects our vaccine policy:

CARLISLE PEDIATRIC ASSOCIATES follows the recommended schedule of the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC). We look forward to providing the best care possible for our patients and their families. We respect the rights of all parents/guardians to make decisions and understand that you also want what is best for your children. We firmly believe in the effectiveness of vaccines to prevent illness and to save lives. Based on all available literature, evidence and current studies, we do not believe that vaccines cause autism or other developmental disabilities. Furthermore, the thimerosal preservative, which has been removed from almost all vaccines, has never been shown to cause autism or other developmental disabilities.

We want to assure you that vaccines are safer today than they have ever been and that it is safe to give multiple or combination vaccines at the same office visit. This is because the reactivity of the individual vaccines is a tiny fraction of what a child’s immune system would be faced with if it were exposed to the actual diseases.

We firmly believe that much of the protection of vaccines comes from mass immunity. Most vaccines produce immunity in 90-95% of children. The remaining 5-10% who do not produce immunity are protected from mass immunity, meaning that a highly vaccinated population limits the spread of most infections. As more people choose not to vaccinate, mass immunity will become absent. Now more than ever, it is important to protect those who choose to vaccinate their children from those who elect not to vaccinate.

Our policy is written to emphasize the importance of vaccinating children. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to provide education and information that vaccinating according to the schedule is the appropriate thing to do. Please be advised, however, that delaying or splitting 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 CARLISLE PEDIATRIC ASSOCIATES. We follow the recommendations of the AAP and CDC and as such do not recommend that parents pick their own schedule.

**If despite our recommendations, you feel you cannot follow the AAP and CDC recommendations for these vaccines, 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 providers. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness and disability, 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 adolescents. We want your trust and will work to earn it. 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. By signing below, you agree and acknowledge compliance with this policy.

Print Patient Name: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Print Parent/Guardian Name: Signature: \_\_\_\_\_