Kiddie West Pediatric Center

Dear Parents,

Welcome to Kiddie West Pediatric Center.

We are looking forward to your first visit with us and we would like to thank you for choosing our office to care for your child(ren)'s healthcare needs.

Your appointment time has been reserved for you and your child(ren) so that we may get to know you, provide a thorough medical examination and answer any questions that you may have.

We understand the importance of following your child(ren)'s growth and development, and will schedule periodic well-child screening visits to monitor your child(ren)'s progress.

Our website is a great online healthcare resource and provides useful information for healthcare questions you may have. Our website includes information on:

- How to reach us
- Office hours
- After hours care
- Our location
- Dosage charts
- Well child and immunization schedules
- Medical questionnaires and evaluations

The forms in this packet are necessary for us to provide healthcare services for your child, please do the following:

- Download, print, review and complete these forms as thoroughly as possible. Please bring all completed forms to your first appointment.
- Be sure to bring your insurance card, insurance co-payment, photo ID, and any custody paperwork.
- Any medical records from a previous physician, or any discharge information regarding your newborn from the hospital.

Again, thank you for choosing us to provide for your child(ren)'s healthcare needs. We are looking forward to meeting you and your child.

Sincerely,
Kiddie West Pediatric Center
The Physicians and Staff

*4766 W. Broad Street Columbus, OH 43228*
*614-851-7337 (PEDS)*

*www.KiddieWest.com*

# KIDDIE WEST PEDIATRIC CENTER
## Patient Registration Form

**Please circle: Mother / Guardian/ Stepmother/ Foster Mother/Grandmother** Home Phone:_____

Name: _____Work Phone: _____

Address: _____ Cell Phone:_____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#:_____

**Mother's Email Address**: _____

Employer:_____

**Please Circle**: **Father / Guardian/ Stepfather/ Foster Father/Grandfather** Home Phone: _____

Name: _____ Work Phone: _____

Address: _____ Cell Phone:_____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#: _____

**Father's Email Address**: _____

Employer: _____

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**PHARMACY Name, Address & Phone Number: _____**

**I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: Yes No**

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**CHILDREN:** **Please circle:**

Name:_____ M/F Date of Birth:_____

Name: _____ M/F Date of Birth:_____

Name: _____ M/F Date of Birth:_____

Name: _____ M/F Date of Birth:_____

Name: _____ M/F Date of Birth:_____

**In order to assist us in meeting Meaningful Use Measures with the U.S. Government, please answer the following questions below regarding your children**:

**Race: (Please circle one)**

American Indian or Alaskian Asian Black or African American Native Hawaiian or Other

Refuse to Report/Unreportable White

**Ethnicity: (Please circle one)** Hispanic or Latino NonHispanic or Latino Refuse to Report

**Primary Language:** (Please circle one) English Spanish Somali Sign Other _____

**PRIVATE PRIMARY INSURANCE (Please present insurance card upon check-in)**

Name of Insurance Company:_____

Name of person who carries the insurance: _____

Relationship to Patient:_____SSN#:_____

**SECONDARY INSURANCE**

Name of Insurance Company:_____

Name of person who carries the insurance: :_____

Relationship to Patient:_____ SSN#:_____

**Assignment And Release**

**Payment and/or copayment is required at the time the service is rendered.** I hereby authorize my insurance benefits be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature:_____Printed Name:_____Date:_____

**Kiddie West Pediatric Center**
**Patient Medical History Form**

**Child's Name** _____
**Date of Birth** _____
**Drug Allergies** _____

**Current Medications** **Dosage** **Times/Day**

_____
_____
_____

**Social History (circle all that apply)**

Child lives with: Both parents Mom Dad Step Mom Step Dad Adoptive Parents
Foster Family Maternal Grandparents Paternal Grandparents Guardian
Other (specify) _____

Smoking in house Y N Guns in house Y N
Pets in house Y N What kind of pet(s) _____

**Birth History**

Term or Preterm (<37 weeks) Type of Delivery (vaginal or c-section)
Complications at delivery or shortly after birth:

_____
_____

**Hospitalizations**: If your child has been in the hospital overnight – state the year- illness/operation
**Year/Illness/Operation**

_____
_____

**Past Medical History**

Has your child ever had the following (circle yes or no, leave blank if uncertain)

| | | | | | |
|---|---|---|---|---|---|
| ADD/ADHD | Y | N | Intestinal Disease | Y | N |
| AIDS or HIV | Y | N | Jaundice | Y | N |
| Anemia | Y | N | Kidney Disease | Y | N |
| Asthma | Y | N | Learning Disability | Y | N |
| Allergies | Y | N | Liver Disease | Y | N |
| Apnea | Y | N | Mental Retardation | Y | N |
| Arthritis | Y | N | Mental Illness | Y | N |
| Bladder infections | Y | N | Menstrual Abnormalities | Y | N |
| Bleeding Tendency | Y | N | Pneumonia | Y | N |
| Bone or Joint Disease | Y | N | Rheumatic Fever | Y | N |
| Bronchitis | Y | N | Seizure Disorder | Y | N |
| Bronchiolitis | Y | N | Sleep Disturbance | Y | N |
| Cancer | Y | N | STD | Y | N |
| Cerebral Palsy | Y | N | Thyroid Disease | Y | N |
| Chicken Pox | Y | N | Transfusions | Y | N |
| Constipation | Y | N | Tuberculosis | Y | N |
| Developmental delay | Y | N | Ulcer | Y | N |
| Diabetes | Y | N | Whooping Cough | Y | N |
| Gastroespheal Reflux | Y | N | | | |
| Genetic Disease | Y | N | | | |
| Heart Murmur | Y | N | | | |
| Headaches | Y | N | | | |
| Hypertension | Y | N | | | |

Comments (please give details of your child's medical condition such as onset of illness, treatment and outcomes)

_____
_____

**Family History**

This includes the child here today, parents, brothers and sisters

| | Relative | Explain |
|---|---|---|
| Alcohol-drug abuse | | |
| Allergies (hay fever, asthma) | | |
| Anemia (low blood, blood disease, sickle cell) | | |
| Bone or joint disease (arthritis) | | |
| Congenital anomalies (birth defects) | | |
| Cystic fibrosis | | |
| Heart Disease or Stroke (before age 50, high cholesterol) | | |
| Hypertension (high blood pressure) | | |
| Inborn errors of metabolism (PKU, thyroid) | | |
| Infectious disease including (TB) | | |
| Intestinal disease (ulcer, ulcerative colitis, Crohn's Disease) | | |
| Juvenile diabetes (onset less than 18 years) | | |
| Kidney Disease including (urinary tract infection) | | |
| Mental retardation | | |
| Seizures | | |
| Other | | |

_____ **No significant history**

_____

Signature of Parent/Guardian Date

_____

**Office Use Only**

_____

Reviewed by:

_____

Physician/Nurse Practitioner Signature Date

**KIDDIE WEST PEDIATRIC CENTER**
**4766 West Broad Street**
**Columbus, OH 43228**
**614-851-7337**
**HIPAA NOTICE OF PRIVACY PRACTICES**

*This notice describes how medical information about you, your child, or any patient for whom you are responsible, may be used and disclosed and how you can get access to this information. Please review it carefully.*

This is a formal notice, as required by law, explaining how we may use and disclose your PROTECTED HEALTH INFORMATION to carry out treatment, payment, or healthcare operations, and for other purposes permitted by law. It also describes your rights to access and control your PROTECTED HEALTH INFORMATION ("PHI").

**Protected Health Information**, hereafter noted as "**PHI**" or "**your PHI**", is information about you or a patient for whom you are responsible, including demographic and/or billing information, that may individually identify you or the patient, and that relates to past present or future health conditions and related health care services and payment.
**Kiddie West Pediatric Center**, hereafter noted as **"KWP"**.

This serves as notice of our intent to maintain all medical records and information in the strictest of confidence.

**HOW WE MAY USE AND DISCLOSE YOUR PHI**

**FOR TREATMENT.** We will use PHI to provide, coordinate or manage health care and any related services. This includes communication with other physicians, nurses, technicians, office staff, or providers of services (specialists, laboratories, orthotists, prosthetists, facilities, pharmacies, etc.) who provide care or services requested by your physician. For example, your doctor, nurse or social worker may provide medical information to your other doctors or health care providers to coordinate your care.

**FOR PAYMENT.** We will use PHI to obtain payment for services you receive from KWP from another provider who has treated you, an insurance company or a third party. This may include pre-treatment reviews or authorizations, determinations of eligibility and coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may contact your insurance company before an office or home visit, surgery, or testing, to determine the need for precertification or to determine whether your plan will cover the services.

**BUSINESS OPERATIONS.** We may use or disclose PHI in order to support our business activities. These include, but are not limited to, professional peer review, employee review activities, clinical improvement, training or education of students or residents, continuation of medical education, accrediting, insurance and licensing activities, and conducting or arranging for other business activities. For example, we may use your PHI to train medical residents or students who see our patients. We may also disclose your PHI to another healthcare facility, professional or plan for such purposes as quality assurance, if that entity has a healthcare relationship with you.

**APPOINTMENTS AND SERVICES.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office. We may also contact you with test results. You have the right to request and we will attempt to accommodate reasonable requests by you to receive communications regarding your PHI from us by alternative means or at alternative locations (see "Your Rights"). We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**BUSINESS ASSOCIATES.** We will share your PHI with third party 'business associates' who perform various activities (e.g., billing, transcription) for us. Whenever an arrangement with a business associate involves the use or disclosure of PHI,

we will have a written contract that contains terms that will protect the privacy of this PHI.

**OTHERS INVOLVED IN YOUR HEALTH CARE.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or health. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**TO YOUR FAMILY AND·FRIENDS.** We must disclose your PHI to you as described in the Patient Rights section of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**COMMUNICATION BARRIERS.** We may use and disclose your PHI if we, your physician or another physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

**EMERGENCIES.** *Your consent is not required before using or disclosing PHI in an emergency treatment situation.* We will attempt to obtain consent, but will proceed with treatment and use and disclose your PHI as needed. If this happens, we will try to obtain your consent or objections as soon as reasonably possible.

**GOODS AND SERVICES.** Unless you object, we may use and disclose your PHI to provide you with information about treatment alternatives or other health related benefits and services we offer. For example, your name and address may be used to send you a newsletter about a product or service that may be beneficial to you.

**REVOKING CONSENT.** You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses or disclosures that occurred before that time. If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations. Therefore we may choose to discontinue providing you with healthcare treatment and services. Other uses and disclosure of PHI will be made only with your written authorization, unless otherwise permitted or required by law as described herein. You may revoke an authorization at any time, in writing..

***WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING SITUATIONS WITHOUT YOUR CONSENT OR AUTHORIZATION:***

**AS REQUIRED BY LAW.** We may disclose your PHI when required to do so by federal, state or local law. In some cases, you will be notified of such disclosures. Some areas that require release include gunshot wounds, domestic violence. and victims of abuse and neglect. We may disclose your PHI to your employer if we have provided healthcare to you for a work-place injury or illness.

**PUBLIC HEALTH.** We may disclose your PHI for public health reasons in order to prevent or control disease, injury or disability: report births, deaths. non-accidental physical injuries, reactions to medications (for example, in cooperation with the FDA), problems with products, or if we suspect a serious risk to public safety.

**HEALTH OVERSIGHT.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care

system, government programs, and compliance with civil rights laws.

**LEGAL PROCEEDINGS.** We may disclose your PHI in the course of any judicial or administrative proceedings, in response to an order of a court. subpoena, discovery request or other lawful process, subject to all applicable legal requirements. ·

**LAW ENFORCEMENT.** We may release your PHI if asked to do so by a law enforcement official in response to a subpoena, warrant, summons, or similar process, subject to all applicable legal requirements. We may also provide limited information for identification, locations, or apprehension purposes, information pertaining to victims of crime, suspicion that death has occurred as a result of criminal conduct, in the event that a crime occurs on our premises, or regarding a medical emergency (not on our premises) where it is likely that a crime has occurred.

**CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS.** We may disclose your PHI, for identification purposes determining cause of death or for these persons to perform their duties as authorized by law.

**HEALTH AND SAFETY.** We may disclose your PHI, if pem1itted by federal and state laws, if we believe that this information is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

**WORKER'S COMPENSATION.** We may disclose your PHI as authorized to comply with worker's compensation laws and other similar legally established programs.

**INMATES.** We may disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

**RESEARCH.** We may use or disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of this PHI.

**OHIO LAW.** Ohio law requires we obtain a consent from you before disclosing the performance or results of an HIV test or diagnoses of AIDS or related conditions.

***YOUR RIGHTS. The following is a statement of your rights with respect to your PHI.***

*You have the right to inspect and copy your PHI.* You may inspect and obtain a copy of PHI about you or your child. All requests must be in writing to the entity or location providing your care and signed by the patient or the parent or legal guardian, if a minor. We will charge for all copies and postage, if mailed. However, under federal law, you may not have a right to 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. Please contact our Privacy Contact if you have questions about access to your medical record.

*You have the right to request limits on the use and disclosure of your PHI.* You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also ask that your PHI not be disclosed to family members or friends who may be involved in your care or for payment. Your request must state the specific restrictions requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your, or your child's best interest to permit use of PHI, the PHI use will not be restricted. If your physician agrees to the requested restriction, we may not use PHI in violation of that restriction unless it is needed to provide emergency treatment.

*You have the right to request to receive confidential communications from us by alternative means or at an alternative*

*location.* You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. This request must be made in writing.

*You may have the right to amend your PHI.* If you believe that your PHI that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. You must complete and submit a Medical Record Amendment/Correction Form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that we did not create, is not part of your PHI that we keep, or medical record that is accurate and complete.

*You have the right to receive an accounting of certain disclosures we have made.* This right applies to disclosures for purposes other than treatment, payment and healthcare operations. You have the right to receive specific information regarding many disclosures that occurred after April 14, 2003. You must submit this request in writing and we may charge you for the costs of providing the list.

*You have the right to obtain a paper copy of this notice from us, upon request, at any time.* You will be asked to sign an acknowledgment that you received this notice.

**CHANGES TO THIS NOTICE.** KWP, or any of its voluntary participants, reserves the right to withdraw from, modify or change this Notice at any time effective for medical information we already have about you as well as any information we receive in the future. A Revision Notice will be available upon request by contacting this office. An updated KWP Privacy Notice, or a separate corporate Notice, in the event of a withdraw from this notice, will be posted for all affected participants \within 60 days of the revision.

**COMPLAINTS.** If you believe your privacy rights have been violated, you can file a written complaint by requesting a complaint form from KWP. You may also file a complaint with the Secretary of Health and Human Services in Washington DC in writing within 180 days of the violation. There will be no retaliation for filing a complaint.

This Notice was published and becomes effective April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy· practices with respect to protected health information.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (614) 851-7337.

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature:_____ Date:_____

# Kiddie West Pediatric Center

4766 West Broad St. Columbus, OH 43228
Phone: 614-851-7337 Fax: 614-851-0080

## AUTHORIZATION TO OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Address: _____Phone:_____

**I hereby authorize Kiddie West Pediatric Center to obtain healthcare information of the patient named above from:**

Name: _____

Address: _____ Phone: _____

City: _____State:_____ Zip: _____

This request and authorization applies to:

☐ All healthcare information

☐ All healthcare information excluding: _____

☐ Other: _____

☐ Shared

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Signature of Patient_____
(if 18 years of age OR is an emancipated minor)

Signature of ☐ Parent/ ☐ Guardian Signature (check one):_____Date _____
Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

Address: _____ Phone: _____

City_____ State: _____ Zip: _____

THIS AUTHORIZATION EXPIRES AFTER NINETY DAYS FROM SIGNATURE

Per Ohio Revised Code 3701.741 the following fees for providing medical records applies to all records forwarded from Kiddie West Pediatric Center:

$2.74 per page for first 10 pages
$.57 per page for pages 11-50
$.23 per page for pages 51 and higher

An invoice will be provided and payment for records must be paid in full prior to the records being mailed.

This form authorizes Kiddie West Pediatric Center to use and/or disclose protected health information in the manner described above and is voluntary. Kiddie West Pediatric Center will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no long protected by the federal privacy regulations.

cs 6-29-10

# EFFECTIVE IMMEDIATELY

**IF YOU ARRIVE MORE THAN 15 MINUTES LATE FOR YOUR SCHEDULED APPOINTMENT, YOU WILL BE REQUIRED TO RESCHEDULE.**

**IF YOU ARRIVE MORE THAN 15 MINUTES EARLY FOR YOUR SCHEDULED APPOINTMENT, YOU WILL BE ASKED TO WAIT UNTIL YOUR APPOINTMENT TIME.**

**WALK IN APPOINTMENTS ARE NOT ACCEPTED. YOU MUST SCHEDULE AN APPOINTMENT**

**ADD ON PATIENTS ARE NOT ACCEPTED. YOU MUST SCHEDULE AN APPOINTMENT.**

**WE ARE HOPING TO DECREASE YOUR WAIT TIME BY KEEPING TO A TIGHTER SCHEDULE.**

**THANK YOU**

**KWP STAFF**

# Kiddie West Pediatric Center
# 4766 West Broad St.
# Columbus, OH 43228
# 614-851-7337

# CONTROLLED MEDICATION POLICY
## All ADHD medication as well as antipsychotics

1. All patients currently on these medications must be seen every 1 to 3 months as directed by the physician.
2. Appointments must be made 30 days in advance to keep the medication schedule. There will be no exception!
3. The following is REQUIRED in order to receive any monthly refills:
    a. Only the parent/guardian is able to pick up the prescription.
    b. A photo ID.
    c. The last prescription bottles (including school and/or daycare bottles)
    d. Any notes or letters from the school and/or daycare.
4. Account balances must be current prior to the receipt of any new prescriptions, unless prior arrangements have been made through our billing department.
5. Medication(s) may be discontinued or discharged from the practice if there are any discrepancies.
6. The controlled medication(s) may be discontinued during the summer months at the discretion of the physician.
7. During the months that patients are not required to be seen by the physician to refill medication, all requests require a 72 hour notice and are available for pick-up Monday thru Friday from 9-6. No pick up or requests can be made on the weekends.
8. Parents must notify the physician if any other physicians are prescribing similar medications. Failure to do so will result in prosecution and immediate discharge from Kiddie West Pediatric Center.
9. All pharmacy information including telephone numbers are required below.
10. Random monitoring of remaining dosages may be enforced by having the medication (in the bottle) brought to our office on the same day as notified to be accounted for.
11. Kiddie West Pediatric Center is a member of OARRS (Ohio Automated Rx Reporting System) and will take all necessary means in order to protect our patients and office.

I have read and will abide by the above guidelines.

_____

Parent(s) or Guardian(s) Date

_____

KWP Representative Date

_____
_____
_____
_____

Pharmacy Name Phone Number

cs 9-4-12