Pediatrics Associates of Plainview
400 South Oyster Bay Road, Suite 207
Hicksville, NY 11801

Please print and complete all information where applicable.

Patient's Last Name_____ **First Name** _____
Address _____ **Home Phone** _____
City _____ **State**_____ **Zip**_____ **Birth date** _____
Male_____ **Female** _____

Responsible Party (Insured) Information. If same, write "same".

Last Name _____ First Name_____
Address _____ Home Phone_____
(if different from above) Birth Date_____
City_____ State_____ Zip____ Social Security #_____
Patient
Employer _____ Relation_____
Employer's Address _____
City_____State_____ Zip_____
Work Phone_____

Insurance Information (Please show us your insurance card)

Primary:
Insurance Name _____
Address _____
City_____ State_____Zip_____
Insured Party_____
Insurance ID#_____
Effective Date of
Insurance_____

Secondary:
Insurance Name _____
Address_____
City_____State_____Zip_____
Insured Party_____
Insurance ID#_____
Effective Date of
Insurance_____

I hereby authorize the above named physician to furnish any and all records pertaining to medical history, services rendered or treatment given to me, or my dependents for purposes of review, investigation or evaluation of claims. I authorize payment of medical benefits to the above named physician.

Patient's or Authorized Signature: _____ Date:_____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Male ____ Female ____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Mother's Name: _____Occupation: _____Work Phone: _____

Father's Name: _____ Occupation: _____ Work Phone: _____

MEDICAL HISTORY

Birth Weight: _____ Type of Delivery: _____ Apgar Score: _____

List any problems while in the newborn nursery: _____

Allergies: _____

Current Medications: _____

Surgeries/Operations: _____

Hospitalizations: _____

Serious or Chronic Illnesses: _____

FAMILY HISTORY

Please circle if the listed condition has occurred in a family member.

Asthma, seizures, diabetes, heart disease, stroke, sudden death before age 50,
high blood pressure, high cholesterol, kidney failure/dialysis,
cancer (type)_____, anemia/blood disorder, colitis/Crohn's ileitis,
mental retardation, connective tissue disease (Lupus. Rheumatoid arthritis, etc.),
genetic or inherited conditions (specify:_____), deafness,
severe allergic reactions (specify:_____), other _____

Please note any other medical information you feel is important: _____

_____

Pediatric Associates of Plainview, LLP
Gail Kaden, MD, FAAP Ilyse Nayor, DO, FAAP
Brian Rabinowitz, MD, FAAP
400 South Oyster Bay Rd, Suite 207 Hicksville, NY 11801
Phone (516) 822-1400 Fax (516) 822-5602

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

ONE TIME USE BASIS

By signing this authorization, I authorize Pediatric Associates of Plainview, LLP to use and/or disclose certain protected health information (PHI) about me (if >18 yrs. of age) or my child to or for the party or parties listed below.

This authorization allows for provision at any time of my PHI back to me if >18 yrs. old or provision of my child's PHI back to me (or other legal guardian) if minor or dependent.

This authorization permits Pediatric Associates of Plainview, LLP to use or disclose my/my child's PHI to the following other party or parties:

_____

Specifically the following information such as date(s) of service, level of detail to be released (ie. a summary or actual copy of chart information), etc.:

_____

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing sent to the practice at 400 South Oyster Bay Rd., Suite 207 Hicksville, NY 11801 except to the extent that Pediatric Associates of Plainview, LLP has acted in reliance upon this authorization.

Signed by: _____ _____
Signature of Legal Guardian (or patient if >18 yrs. old) Date

_____ _____
Print Name of Legal Guardian Relationship to Patient

_____
Full Name of Patient

Pediatric Associates of Plainview, LLP

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of Plainview, LLP may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of Plainview, LLP's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I am aware that the Notice of Privacy Practices is available for my review and that upon request I may be furnished with my own copy prior to signing this consent. I am aware that this practice reserves the right to revise its Notice of Privacy Practices at any time and I may review and /or request my own copy of any revised notices. By signing this form, I am consenting to Pediatric Associates of Plainview's use and disclosure of my PHI to carry out TPO.

By signing this form, I also authorize Pediatric Associates of Plainview, LLP to disclose at any time certain PHI about me (if >18 yrs. old) or my child back to me (or other legal guardian) if minor or dependent.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, I understand that Pediatric Associates of Plainview, LLP may decline to provide treatment to me.

_____ _____

Signature of Legal Guardian (or Patient if >18yrs old) Date

_____ _____

Print Name of Legal Guardian Relationship to Patient

Full Name of Patient(s)

_____

Pediatric Associates of Plainview, LLP

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

(YEARLY BASIS FOR SCHOOL, CAMP, OR SIMILAR)

By signing this authorization, I authorize Pediatric Associates of Plainview, LLP to use and/or disclose certain protected health information (PHI) about me (if >18 yrs. of age) or my child to or for the party or parties listed below.

This authorization allows for provision at any time of my PHI back to me if >18 yrs. old or provision of my child's PHI back to me (or other legal guardian) if minor or dependent.

This authorization permits Pediatric Associates of Plainview, LLP to use or disclose my/my child's PHI for the following school year/calendar year _____
in the format of a required school physical or sports participation physical or camp physical, or other group extracurricular physical if requested by me to the following entity/entities:

School: _____

Camp: _____

Other: _____

_____

This authorization will expire on _____ if not a specified year as above.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing sent to the practice at 400 South Oyster Bay Rd., Suite 207 Hicksville, NY 11801 except to the extent that Pediatric Associates of Plainview, LLP has acted in reliance upon this authorization.

Signed by:

_____ _____
Signature of Legal Guardian (or patient if >18 yrs. old) Date

_____ _____
Print Name of Legal Guardian Relationship to Patient

_____
Full Name of Patient

Pediatric Associates of Plainview, L.L.P.
Gail Kaden, M.D. F.A.A.P.
Ilyse Nayor, D.O., F.A.A.P.
Brian Rabinowitz, M.D., F.A.A.P.
400 South Oyster Bay Road Ste 207
Hicksville, New York 11801
Phone: (516) 822-1400
Fax: (516) 822-5602

Re: Fees & Payments

I understand that it is my responsibility to confirm that at least one of the following providers, Gail Kaden, M.D., Ilyse Nayor, D.O., or Brian Rabinowitz, M.D., is a participating provider and is listed as my PCP (if necessary under my policy). Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due.

I understand that it is my responsibility to provide Pediatric Associates of Plainview with appropriate and current insurance information- and to notify the office immediately upon any change in my insurance coverage- to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company (ies) may deny payment of claims relating to services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that I will be responsible for paying co-payments, deductibles, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company (ies), including administrative fees.

_____ _____

Signature Date

_____ _____

Print Name Print Child's Name

Pediatric Associates of Plainview, L.L.P.
400 South Oyster Bay Road, Suite 207
Hicksville, New York 11801 Phone (516) 822-1400 FAX: (516) 822-5602

AUTHORIZATION FOR RELEASE/PATIENT ACCESS OF MEDICAL INFORMATION

Patient Name_____ D.O.B.____/_____/____

Address _____State_____ZIP_____

Phone # _____

1. I hereby authorize the Medical Records Dept staff at _____ to release information from my medical record to (if self please indicate below):

2. Pediatric Associates of Plainview
   400 S. Oyster Bay Road Suite 207
   Hicksville NY 11801 (516) 822-1400

3. For the purpose of: Continued Treatment
   I request the information released to include the following items:
   Outpatient / Office Record including immunizations, growth charts, lab work, well check-ups, problem list, and specialists' letters.
   Any exclusions, please specify: _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

   _____ I understand that if my record concerns information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

   _____ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

5. I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. If I experience discrimination because of release of HIV confidential information I can call the NYS Division of Human Rights at (212) 480-2493 and/or the NYC Commission of Human Rights at (212) 306-7450

6. This authorization will automatically expire within 6 months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Pediatric Associates of Plainview. I understand that the revocation will not apply to information that has already been released in response to this authorization

7. I also understand that in an effort to prevent unauthorized re-disclosure, Pediatric Associates of Plainview attaches a notice when sending out records that states " re-disclosure is prohibited." However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

8. I also understand that in order to process this request to reproduce medical record information on a timely basis, Pediatric Associates of Plainview, from whom I am requesting information, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

Signature_____ Date_____

Print Name_____Relationship to patient_____