



# Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Highway, Suite 201

Cohasset, MA 02025

T. 781.383.8380

F. 781.383.8382

**PLEASE CHECK YOUR CHILD'S PRIMARY CARE PHYSICIAN:**

- Jocelyn R. Healey, MD, FAAP
- Nicola J. Smith, MD, FAAP
- Katherine A. Trier, MD, FAAP
- Kayla M. Cochran, CPNP-PC

**GENERAL PEDIATRICS  
PATIENT REGISTRATION FORM**

Child's First	Middle	Last Name	Date of Birth	Age	Sex
Street Address		City	State	Zip	
Preferred Phone # (for office to contact you)		How did you hear about us? <input type="checkbox"/> Mailing <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Physician _____ <input type="checkbox"/> Family/Friend _____			
Ok to leave messages Voice <input type="checkbox"/> or Text <input type="checkbox"/>		Email address for Office News and Updates and other correspondence			
Parent A. Mother's Name (Father if 2 dad family)		Parent B. Father's Name (Mother if 2 mom family)		Parent's Marital Status	
				S M D W	
Legal Guardian (if different from above) or if divorced, who has legal and physical custody (Legal documentation required if not joint custody)					
Parent/Guardian Street Address (if different from above)		City	State	Zip	
Parent/Guardian Home Phone # if applicable		Parent A's Cell Phone #	Parent B's Cell Phone #	Work Phone # if ok to call	
Next of Kin/Emergency Contact Name			Relationship	Telephone #	

**PRIMARY INSURANCE COMPANY – EFFECTIVE DATE \_\_\_\_\_**

Name of Insurance Company		Policy ID #		Group #	
Claims Address		City	State	Zip	Telephone #
Name of Policy Holder		Date of Birth	Relationship to Insured		Effective Date
Employer Name and Address					

**SECONDARY INSURANCE COMPANY – EFFECTIVE DATE \_\_\_\_\_**

Name of Insurance Company		Policy ID #		Group #	
Claims Address		City	State	Zip	Telephone #
Name of Policy Holder		Date of Birth	Relationship to Insured		Effective Date
Employer Name and Address					

**ASSIGNMENT OF BENEFITS**

**I understand that I am responsible for payment in full of all charges.** I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to my health insurance carrier(s), its agents or any other insurance company to determine the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PATIENT HISTORY FORM**

**GENERAL PEDIATRICS**

Child's Name	Date of Birth	Today's Date
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Child lives with: (check one)  <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	Language (s) Spoken at Home: _____ Ethnicity: _____ Religious Preference: _____ Race: _____	Please Rate this Child's Health: (check one)  <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
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Names of Siblings	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check any conditions that this child or any blood relative has:

	Child	Relative	Comments		Child	Relative	Comments
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature birth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Growth problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poor nutrition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema / skin problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning disability / ADD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Socialization problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia / blood problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	School problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name of Previous Physician \_\_\_\_\_

Name of Person Completing this Form	Relationship to Child
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CONSENT FORM

GENERAL PEDIATRICS

**CONSENT TO TREAT A CHILD  
IN THE ABSENCE OF A PARENT OR LEGAL GUARDIAN**

We encourage and prefer that you, the parent or legal guardian, bring your child to all appointments with the pediatrician. You know the most about your child and this knowledge may be crucial for the pediatrician to deliver the best care possible.

Unfortunately, you may not always be able to bring your child for an urgent appointment. So that we may treat your child when she/he is accompanied by someone other than you, the parent or legal guardian, please complete the consent form below. Without your consent, we may refuse to treat your child for anything less than a very serious, life-threatening emergency.

If the pediatrician feels that your child's life is in danger, he or she will provide the necessary care without this consent.

**\* PLEASE NOTE: A PARENT OR GUARDIAN MUST ACCOMPANY CHILDREN UNDER 18 YEARS OF AGE TO ALL HEALTH SUPERVISION VISITS, DEVELOPMENTAL APPOINTMENTS AND IMMUNIZATION ADMINISTRATIONS.**

Thank you for your understanding and cooperation.

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I, \_\_\_\_\_, give my permission to Child and Adolescent Health Specialists, PC to treat my child in the event that I am unable to be present.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Mother/Parent A's Name

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Cell/Work Phone #

\_\_\_\_\_  
Father/Parent B's Name

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Cell/Work Phone #

# Patient Eligibility Screening Form

Date \_\_\_\_\_

Child's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent, Guardian, or Legal Representative's Full Name \_\_\_\_\_

Health Care Provider: Child and Adolescent Health Specialists, PC

**This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office for (3) years. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes.**

**Verification of responses is not required.**

## Check only one box below

This child:

- is enrolled in Medicaid (includes Mass Health)
- does not have health insurance or is enrolled in the Children's Medical Security Plan
- is Native American (American Indian) or Alaskan Native
- has health insurance (paid for by parents, employers, or both)

Please note that all children seen in Massachusetts's practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program (first three boxes) and which get vaccines paid for by state and other federal funds (last box).

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NOTICE OF PRIVACY PRACTICES

GENERAL PEDIATRICS

## HIPAA PRIVACY PRACTICES

*This is a summary of how we use and disclose your Protected Health Information. Please read the full Notice of Privacy Practices available on our web site or at our front desk or request a copy to be mailed to you, prior to signing this form.*

- A. We have a legal duty to protect health information about you.
- B. We may use and disclose Protected Health Information or “PHI” about you in the following circumstances: *see full Notice of Privacy Practices for examples*
  - 1. We may use and disclose PHI about you to provide health care treatment to you.
  - 2. We may use and disclose PHI about you to obtain payment for services.
  - 3. We may use and disclose your PHI for health care operations.
  - 4. We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
  - 5. You can object to certain uses and disclosures.
  - 6. We may contact you to provide appointment reminders by voice message, text or email.
  - 7. We may contact you with information about treatment, services, products or health care providers.
  - 8. We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

- C. You have several rights regarding PHI about you.
  - 1. You have the right to request restrictions on uses and disclosures of PHI about you.
  - 2. You have the right to request different ways to communicate with you.
  - 3. You have the right to see and copy PHI about you.
  - 4. You have the right to request amendment of PHI about you.
  - 5. You have the right to a listing of disclosures we have made.
  - 6. You have a right to a copy of this notice.
- D. You may file a complaint about our privacy practices.
- E. A copy of the full description of Child and Adolescent Health Specialists, PC privacy practices has been made available to me. I understand my rights and how my protected health information can be used by Child and Adolescent Health Specialists, PC.
- F. For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today’s date: \_\_\_\_\_

Patient’s Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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NOTICE OF OFFICE CODES

GENERAL PEDIATRICS

## Billing for General Pediatrics

Our office will submit claims to the insurances with which we are contracted, which includes most major health insurances. **We are not contracted with all insurances and we are not providers in limited network plans.** You can verify we are in your specific plan network on your insurance website ("Find a Doctor") or by calling your member services department.

The following is a list of our most commonly applied insurance codes for General Pediatric office visits, which we use to bill your insurance. This list is provided to assist you if you have questions about what is covered by your insurance. **Please note this is not an inclusive list.** Codes may change yearly. Reimbursement for any code is at the discretion of each individual insurance carrier, and can vary within plans based on employer choice.

**If you have a deductible, please be aware of what is covered.** Deductibles may apply to all charges or only to certain types, e.g. labs, diagnostics, procedures, hospitalizations. If you have any questions or concerns please contact your insurance provider **prior to your appointment.** Your insurance company is required to inform you of your financial responsibility within 2 business days of your request.

### General Pediatric Codes:

If your child is seen for a "sick visit" (illness, injury, health concern,), or in follow-up for treatment, the following codes would apply:

**Evaluation and Management**, new patient (99201-99205) established patient (99211-99215)

**Telehealth calls Provider: 99441,99442,99443, Telehealth Nurse 98966,98967,98968**

General Pediatric **Health Supervision Visits** (HSV) are performed within the first week of newborn nursery discharge, and then at the following ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and then annually until age 22.

HSV, new patient (99381-99385) HSV, established patient (99391-99395)

\*Vision screening (99713) hearing screening (92587) will be performed at most HSVs beginning at age 3 yrs. in addition to the examination. (92587 may apply to deductible). Multiple units of screenings (96110,96127) for developmental/emotional/behavioral issues will be administered at certain ages. Some insurances only pay for 1-additional fee is patient responsibility. Urine and blood tests are ordered routinely at certain ages and may apply to your deductible. **If an issue or concern is addressed by the provider at your/your child's well visit, billing guidelines require it to be billed as a "sick visit" and your copay and deductible rules will apply.**

### Immunization Codes:

Certain immunizations are supplied by the state of Massachusetts at no cost to the patient or insurance provider. Other vaccines are purchased by this practice and will need to be reimbursed by your insurance provider. Fees to administer immunizations are in addition to the cost of the immunizations (90471-90474, 90460,90461)

**Other General Pediatric Codes:** Laceration Repair (11201-12011) Rapid Strep Test (87880) Wart Removal (17110) Mental health screenings (96127)

I understand that these or other applicable codes may not be covered by my insurance or may be subject to my deductible/coinsurance and if not paid by my insurance, I am responsible for payment in full. A copy of the *Office Financial Policies* has been made available to me via the website. I understand that Balances are due upon receipt and are subject to a \$10 billing fee if payment or a payment plan is not addressed within 30 days; Returned checks/charges incur a \$25 fee; Appointments not cancelled with 24 hours' notice during business hours, are subject to a \$50 fee, \$15 for Immunization appointments not canceled with 24 hours' notice during business hours. Divorce has no bearing the responsibility for medical care for your child. Whoever schedules or brings the child is responsible for payment of any balance for that appointment.

Child's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL  
AND MASSACHUSETTS GENERAL HOSPITAL

## STEP 1: (ONE PATIENT PER FORM)

PATIENT INFORMATION	PATIENT FULL LEGAL NAME: _____		PATIENT DATE OF BIRTH: _____	
	PATIENT MEDICAL RECORD #: _____		SEX: <input type="checkbox"/> F <input type="checkbox"/> M	AGE: _____
	PATIENT ADDRESS: STREET: _____		APT. #: _____	
	CITY: _____		STATE: _____	ZIP CODE: _____
	FOR PATIENTS OVER THE AGE OF 13, CREATE A PG ACCOUNT FOR THE PATIENT <input type="checkbox"/> NO <input type="checkbox"/> YES			
	IF YES, PATIENT'S EMAIL ADDRESS: _____			
	<i>(Note: for patients 13 to 17, a PCR must exist in order for the patient to have a PG account)</i>			

## STEP 2: (ONE PCR PER FORM)

PATIENT CARE REPRESENTATIVE - PCR INFORMATION (REQUIRED)	PCR FULL LEGAL NAME: _____		PCR DATE OF BIRTH: _____	
	PCR EMAIL: _____		PHONE: _____	
	PCR ADDRESS IS <b>SAME AS PATIENT</b> Yes No (ADDRESS BELOW)		SEX: <input type="checkbox"/> F <input type="checkbox"/> M	
	PCR ADDRESS: STREET: _____		APT. #: _____	
	CITY: _____		STATE: _____	ZIP CODE: _____
	DOES PCR HAVE A <b>PATIENT GATEWAY ACCOUNT</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes			
	IF YES, PATIENT GATEWAY USERNAME: _____			
	DOES PCR HAVE A <b>MEDICAL RECORD NUMBER</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes (IF YES, MRN: _____)			
	Authorization Received By: _____		Date: _____	
	Approved By: _____			
Clinic/Office: _____				

PCR Identification:

License

State ID

Passport

Other Photo ID

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## Authorization for Patient Care Representative Access to Patient Gateway application

Note: The information available in Patient Gateway is a subset of information contained in the legal health record. If at any time information is needed for legal or other purposes and/or a full copy of the Patient's Medical record is needed, please contact the patient's provider directly.

### I (the Patient) understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare
- I understand that this authorization will remain in effect until one of the following occurs:
  - A patient 12 years or younger reaches the age of 13 years; a new authorization form is required
  - A patient reaches the age of 18 years; a new authorization form is required
  - Closure of account is requested in writing by the patient, their Legal Guardian, or Patient Care Representative
  - In the event of death of the patient or Patient Care Representative
- Partners, the patient, their Legal Guardian, and/or the patient's Patient Care Representative may elect to suspend or terminate authorization to Patient Gateway access at any time, for any reason

### Patient Authorization for Release of Health Information to Patient Gateway Patient Care Representative

I have carefully read and understand the above, and have had any questions explained to my satisfaction.

**Patient Care Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to the person or agency listed above for the purposes of enrollment and utilization of the Patient Gateway application.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Patient's Name:** \_\_\_\_\_

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_



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**Permission to share information with your child's school or daycare**

**Any communication between our providers and school/daycare personnel requires your consent, including faxing a copy of your child's well visit form to school/daycare. At each visit our office will provide you with copies of your child's forms which the school needs to have on file. Occasionally, you may need us to send a form directly to their school/daycare. Your written consent is needed to allow us to do this.**

I hereby give permission to the providers at Child and Adolescent Health Specialists, PC to share information about my child \_\_\_\_\_, with his/her school/daycare personnel, for the purposes of documentation or treatment by school/daycare personnel, to include copies of annual physical exam, vaccination history, medication forms (if administered at school/daycare), consents or excused absences for school or sports activities.

This form will remain in effect until it is rescinded in writing or until your child turns 18 years of age. Child and Adolescent Health Specialists has the right to deny the sharing of information if in their opinion it is not in the best interest of the child and/or providing this information would compromise their relationship with the child.

**EXCLUSION** of any reference to: drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment or specific learning issues will require a separate release to communicate with specific individuals.

Please list any personnel you wish to exclude from this list.

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\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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Dear Patient or Parent of a Patient,

We are pleased to inform you that our office is now participating in the Massachusetts Immunization Information System (MIIS). The MIIS is the new statewide, electronic record-keeping system (or registry) that keeps track of your and your children's immunizations (shots). This new system will help us keep complete and accurate records of the shots that you/your children get from any doctor or healthcare provider in Massachusetts, who has also completed the registration. It was developed by the Immunization Program at the Massachusetts Department of Public Health. We are beginning the registration and patient information process in August and hope to be live by the fall 2018.

The MIIS will allow us to:

- keep all of your/your children's important immunization information together in one place for you and all of your healthcare providers
- know which shots you/your children are due for and when
- easily send reminders to you about your upcoming immunizations to help you in scheduling your next visit
- quickly print out the forms you/ your children need for school and camp to save you time each fall and summer

Immunization registries like the MIIS help healthcare providers make sure that everyone is up-to-date on their immunizations to keep us all healthy and prevent the spread of harmful disease. The system has been created according to state law, which requires that healthcare providers who give immunizations, report them to the MIIS. All information in the MIIS is kept confidential. You may choose to limit the providers who may see your/your child's shot records in the MIIS. However, if you do choose to limit who can view your/your child's shot records in the MIIS, we may be unable to give you a complete and accurate record of your/your child's shots (if you/your child receives any shots outside of our practice eg. ED, school or specialist office that we are not affiliated with). This means you must continue to keep track of this information on your own.

If you have any questions please call our office at 781-383-8380 and speak to one of our nurses. You can also visit the MIIS website at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis), or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

We look forward to seeing you at your next appointment.