PEDIATRIC ASSOCIATES OF KINGSTON
Taking Exceptional Care of the Next Generation since 1867

Jeffery R. Kile, MD, MHA
John C. Gaudio, MD
Michelle K. Sudo, DO
Steven J. Leung, MD
Alvaro G. Reymunde, MD
Aimee M. Johnson, MD

Amy Flaherty, PA-C
Darnetta Yusko, CRNP, IBCLC
Allen Sabatino, CRNP

NEPA BREASTFEEDING CENTER

425 Tioga Ave, Kingston, PA 18704 | O: 570-288-6543 | F: 570-288-7130 | kingstonpeds.com

Dear Young Adult,

(for young adults)

When you turn 18, seeking medical care is a new responsibility. Your parents can help guide you in seeking medical care, however, as an adult you have the right and responsibility for your medical care. This means that you may now seek medical care without your parents consent and call for your own appointments as needed.

In this packet you will find our forms that you will need to fill out and also a few things you will need to know about being responsible for your own medical care.

FORMS AND DESCRIPTIONS

The following forms can be found in this packet and will need to be filled out by you and returned to our office .

PATIENT INFORMATION :

- Please fill out this form so we can create your own patient account. While you may still be on your parent or guardian's insurance policy, any statement will be mailed under your name.

CONSENT TO USE & DISCLOSE HEALTH INFORMATION (HIPPA)

- This form needs to be filled out only if you want your parents or any other individual access to your medical records. If we do not have this signed form on file, Pediatric Associate **WILL NOT** be able to give any of your medical information out, even an immunization letter.

FINANCIAL AGREEMENT:

- This form outlines our financial policies. By signing this form , you acknowledge that YOU, as an adult, are responsible for any payment that needs to be made to our office.

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THINGS TO KNOW:

- Under the Federal Health Information Portability and Accountability Act or HIPAA, medical records are now records between you and your health care provider, Access to your medical records and any discussion about your health is only provided to people that you consent to, including your parents. If you wish your parents to discuss your health on your behalf, you must provide written consent to your health care provider by completing a form. This form is called a **CONSENT to USE DISCLOSE HEALTH INFORMATION** form and is within the packet of information.
- **Pediatric Associates will continue to provide medical care for you until 22 years of age**. At that time, PAK will help you make a smooth transition from pediatric to adult health care.
- When calling for an appointment, you will need to let the receptionist/nurse know who your doctor is, why you need to see the doctor (provide the most honest description of why you need to be seen so that appropriate time is scheduled), and when you need the appointment.
- Your parents may come to the appointment with you but you will need to check in and sign forms yourself. Some of the forms you may be asked to complete and sign are contact information (called demographics) financial responsibility and medical treatment consent forms.
- You will need to pay for any co-payments or billing portions required.
- You will need to sign for any vaccinations. Your mom, dad, or guardian can no longer sign for you.
- Unless specific consent is given, we are not permitted to talk with your parents about your health care. You will need to have the discussion with your doctor. Your parents may only be involved if you provide consent to do so.
- You have the right to be informed of your medical care and treatment. You also have the right to refuse medical treatment if you so wish.

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Dear Parent or Guardian:

(advice for **Teen** to **Adult**)

Turning 18 years old is an exciting time in your child's life and you have spent rewarding time preparing your child for this moment- becoming an adult. Because your child has turned 18 years old, many things are changing rapidly and one of those things is healthcare. We would like to share some tips in hope that the information provided helps you to understand what it now means to be an adult and what that means for your child's healthcare. In order to help you through this process, we are providing you with information as well.

Upon turning 18, your child is now considered to be an adult and is responsible for their own healthcare, among other things. Because of this, we asked your child to complete a new patient registration form and packet.

What you need to know as a parent:

In the past we were able to talk with you about your child's health. Now that your child is 18, your child is considered an adult and as such we are not able to discuss anything with you without your child's consent. Due to Federal laws, we are required to talk to your child regarding these issues. We can talk to you if your child completes the **Consent to Use and Disclose Health Information** or **HIPAA** form. Your child was given this consent form to complete. This needs to be received and on file for us to discuss any health issues with you. Please note that your child does not have to complete the consent form, but if it is not completed, we will only be able to talk with your child about care, even if they are away in college.

If you need access to your child's records, your child must consent in writing to provide you access by signing the **Consent to Use and Disclose Health Information** or **HIPAA** form. Under **HIPAA**, **medical providers are no longer permitted to discuss health issues with you without express consent from your now young adult.** This is important to keep in mind when trying to call for health questions when your young adult is away at college. They will need to call themselves.

Due to Federal Laws, as an adult, your child is the only one that can access their medical records. Any requests for medical records must be made in writing by your child. Your child can call our office to request a medical release form. Your child may request that the information be released to you, but again, we must have written authorization for this by having them sign the **Consent to Use and Disclosed Health Information.**

Your child has their own patient account. The bills may come to your address, but will be under their name. If this causes concern, please talk to your child about this. You may request that the bills come to you at your address but this must be a mutual request from your child as well.

We can still bill your insurance for your child as long as your child is eligible. Even though the Explanation of Benefits (EOB) comes to you , the bill is still your child's responsibility and we are not able to discuss billing unless the previously discussed consent form has been completed.

These changes are not intended to cause difficulty, however, due to Federal Law, when your child turned 18, they became a legal adult. All of these changes are designed to appropriately treat your child as an adult. We understand that this time can be challenging and is changing fast. We recommend you take the time to talk to your child about what it means to be responsible for their health care, offer help if they need it, and discuss what they would like for their care.

Please feel free to discuss these changes with our front desk or business office as we are here to help and would like to offer assistance if you need it.

PEDIATRIC ASSOCIATES OF KINGSTON

PATIENT IDENTIFICATION DATA-18 YEARS AND OLDER

Patient's name _____ Sex M/F DOB___/__/___

Address_____
Street

_____
City Sate Zip

Your Home Phone: (__)_____Your Cell: (__)_____Email _____

Parent #1 Name_____

Address_____
Street

_____
City State Zip

Home number (__)_____ Cell: (___) _____

Parent #2 Name_____

Address_____
Street

_____
City State Zip

Home number (__)_____ Cell: (___) _____

Authorization for Treatment and Release of Information

I authorize Pediatric Associates, LLC to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment,and to receive all payments for such examination or treatment, Pediatric Associates has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care. _____INITIAL

Acknowledge of Receipt of Consent to Use and Disclose Health Information

I acknowledge that I have received the Consent to Use & Disclose Health Information, which explains how my health information will be handled be various situations. _____**INITIAL**

ATTENTION

Though you may still be covered under your parent's insurance, you , as an adult, are solely financially responsible for any and all payments: copay, coinsurance or deductible that your insurance deems as your responsibility.

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the the provision above.

_____ _____

Patient Signature **Date**

PEDIATRIC ASSOCIATES OF KINGSTON

FINANCIAL AGREEMENT AND CONSENT

18 YEARS OF AGE AND OVER

We are committed to provide you with the best possible medical care. Your signature at the end of this document will indicate that you have read, understand and agree to the polices outlined below.

BILLING YOUR INSURANCE:

- Please present your current health insurance card . We will scan your insurance card at your visit. Please inform upon your arrival if your insurance has changed since your last visit.
- If you have NO INSURANCE, then payment in FULL is required at the time of service.

PAYMENT FOR SERVICES

- Co-pays must be made at time of service. If your copay is not paid on the day of your appointment, there will be a **$5.00** fee _____please initial
- We accept cash, checks, money orders, Visa and Master Cards and debit cards.

RETURNED CHECKS:

- The charge for a non-sufficient funds (NSF) check is $25.00. You must pay in full for the NSF check and NSF fee. For the next 12 months, cash or equivalent payment at time of service is required.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days, we reserve the option to refer the account to an outside collection agency. Pediatric Associates reserves the right to reschedule or deny future appointment for delinquent accounts. If your account is sent to a collection agency you may be asked to find a new provider.

LATE ARRIVALS. CANCELLATION AND NO SHOWS:

- We required a 24-hour notice to cancel or to reschedule an appointment. As a courtesy a reminder of your appointment time will go out to you 2 days prior to your appointment. You will be asked at check in how you would prefer to have communication between you and our office. You may choose home number, cell number or text. If you choose text, the receptionist can provide you instructions how to opt in.
- Failure to give proper notice for cancellation will result in:
  - We will courtesy the charge of $25.00 for the first missed appointment.
  - $25.00 charge for missed appointment after the first
  - After 3 missed appointments within a 3 year time frame, could lead up to dismissal from the practice.

please initial that you understand the above._____

I acknowledge and understand the office policies and procedures explained above and have receive a copy. I hereby authorize to pay Pediatric Associates directly. A copy of this authorization can be considered an original for insurance.

I do hereby consent to and authorized the performance of all examinations , treatment and medical services by Pediatric Associates and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to policies outlined in this document.

_____ _____

Signature Date

_____

Print Name

July 2015

PAK
PEDIATRIC ASSOCIATES OF KINGSTON

CONSENT TO USE & DISCLOSE HEALTH INFORMATION (2015)

18 Years of Age or Older

This office is required by Federal Regulations to inform our Patients to the use of your health information accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

I understand that as part of my health care, Pediatric Associates of Kingston originates and maintains paper and or /electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatments, and any plans for future care or treatment. I understand that this is information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and treatments information to my bill
- A means by which a third-party can verify the services billed to me actually took place

I understand and have been provided access to a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. This notice is located on our website www.kingstonpeds.com and in the sick waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent, allowing treatment, or making payment for services rendered and the right to a paper copy of the Notice of Privacy Practices.
- The right to object to the use of my health information for directory purposes
- The right to request confidential communications
- The right to inspect and copy
- The right to amend or supplement
- The right to an accounting of disclosures

I AUTHORIZE PEDIATRIC ASSOCIATES OF KINGSTON, LLC AND ITS STAFF TO DISCUSS MY MEDICAL INFORMATION AS FOLLOWS (INITIAL BELOW ALL THT APPLY)

- For financial purposes, I allow my parent(s) to access my diagnosis and treatment information and to discuss my account. _____
- I allow my immunizations records to be released by fax or mail to:
_____Parents _____School _____Self
- I allow my treatment plans (i.e.: medication, asthma, epi-pens, etc) to be disclosed
_____Parents _____School _____Self
- I allow my office visits to be accessed by : _____Parents _____School
- I allow my labs to be released to: _____Parents _____School _____Self
- With my consent, I allow any "confidential information" including results of STD testing, HIV, AIDS, and Pregnancy testing to be shared with _____Parents _____School _____Self Only

_____

Parent /Guardian 1 **relationship**

_____

Parent /Guardian 2 **relationship**

_____

Other **relationship**

I understand that as part of PAK treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

_____ _____

Signature of Patient **DATE**

****

REVOKE CONSENT (DO NOT SIGN BELOW UNLESS REVOKING THE ABOVE CONSENT)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this change.

_____ _____

Signature of Patient Date signed

_____

PRINT NAME OF SIGNATURE ABOVE