Valley Medical Group
Valley Health System

# PEDIATRIC PATIENT REGISTRATION

*Thank you for choosing the Kireker Center for Child Development* **Date: _____**

**PLEASE PRESENT YOUR DRIVER'S LICENSE AND INSURANCE CARDS TO RECEPTION DESK.**

**PATIENT GENERAL INFORMATION:**

Last Name: _____

First Name: _____ MI ___

Sex: ☐ M ☐ F Date of Birth: _____

S.S. # _____

Address: _____

_____

_____

City ST Zip Code

_____

**PARENT INFORMATION:**

Last Name: _____

First Name: _____ MI ___

Home Phone: _____ Cell Phone: _____

Work Phone: _____

May we call you at work? ☐ Yes ☐ No

Email: _____

☐ No email

Preferred Contact # ☐ Home ☐ Work ☐ Cell ☐ Email

Language:_____ Race: _____

Ethnicity: _____ ☐ Decline to Answer

_____

**Marital Status:** ☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed ☐ Partner

**Pediatrician:**_____

**How did you hear about us?** ☐ Advertising ☐ Physician

Referring Physician's Name: _____

☐ Word of Mouth ☐ Patient in the Practice ☐ Hospital

☐ Insurance Company ☐ Other: _____

Please specify

**EMERGENCY CONTACT INFORMATION**:

Contact Name: _____

Contact Relation: _____

Contact Phone: _____

Contact Cell Phone: _____

_____

**PARENT'S EMPLOYER INFORMATION:**

Name: _____

Address: _____

_____

City ST Zip Code

Phone: _____

Occupation: _____

_____

**GUARANTOR INFORMATION:**

Patient's Relationship to Guarantor: _____

GUARANTOR (*name to whom statements are sent*)

Last Name: _____

First Name: _____ MI ___

Guarantor Date of Birth: _____

Mailing Address ☐ Same as patient's?

Address: _____

_____

_____

City ST Zip Code

*Optional Guarantor Information:*

S.S.#:_____ Phone:_____

Email: _____

**CONTACT INFORMATION FOR APPOINTMENT REMINDERS:**

Phone #: _____

**INSURANCE INFORMATION:** Policy Holder's Name: _____
Last Name First Name MI

Sex: ☐ M ☐ F Relationship to Patient: ☐ Mother ☐ Father ☐ Other: _____

Date of Birth: _____ S.S. # _____

Address: _____

_____

City ST Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Policy Holder's Employer: _____

Employer's Address: _____

_____

City ST Zip Code

**Primary Insurance Company:** _____

Policy Holder's ID: _____ Group #: _____

Insurance Company Address: _____

_____

City ST Zip Code

**Secondary Insurance Company:** _____

Policy Holder's ID: _____ Group #: _____

Insurance Company Address: _____

_____

City ST Zip Code

**PHARMACY INFORMATION:**

Local Pharmacy Name: _____ Phone: _____

Address: _____

Mail Order Pharmacy Name: _____ Phone: _____

Address: _____

**PREFERRED LABORATORY:** Name: _____ Phone: _____

Address: _____ Fax: _____

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, Inc.., and Valley Physician Services, NY, PC

# GENERAL CONSENT FOR TREATMENT

Name of Procedure:_____

1. I hereby consent to treatment, including local anesthesia and diagnostic or therapeutic procedures.

2. The nature and effect of the procedure to be performed, the risks involved, as well as possible alternative methods of treatment, and the prognosis if no treatment is rendered, have been explained to me. I am aware that the practice of medicine is not an exact science, there are risks associated generally and that no guarantees about the outcome of this care have been made to me as a result of examinations and `treatment.

3. I authorize my doctor and staff to take any photographs required for the completion of documentation.

4. I understand and agree that Valley Medical Group (VMG)* may disclose any or all parts of my medical record in order to obtain payment for any service rendered to me.

5. I understand that in order to facilitate the best care and treatment, my doctor may need to access information about me from my other providers and facilities where I have received care and services, such as specialists, diagnostic center, laboratories, and he/she may need to access my prescription history information.

6. I understand and agree that VMG may disclose any or all parts of my medical record to other providers for health care services or goods in order to make arrangements for coordinated health care delivery.

7. I understand and agree that the information, which my doctor may disclose, may include information about and/or reference HIV/AIDS related diagnoses/conditions, drug or alcohol use or abuse, pain management and psychiatric or psychological information, reports, evaluations and diagnoses, as well as history and physical examinations results, consultations and treatment recommendations.

8. I understand and agree that other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the surgery.

9. After treatment is received, I will follow the medical advice and instructions given and I will continue treatment and follow-up care with the physician/provider to whom I am referred as indicated on this record.

10. I, the undersigned agree, whether the patient or an authorized agent of the patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the practice in accordance with the regular rates and terms of VMG.

    I certify that I have read and understand this consent form, and that I have been given the opportunity to have any questions related to this treatment which have been answered by the clinical staff of this facility.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Name of Person Signing Relationship to Patient

_____ _____

Witness Date

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# PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Valley Medical Group patient.

## Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen a Valley Medical Group physician as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Valley Medical Group permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and the Valley Medical Group physician is not your PCP, you may be responsible for deductibles, co-insurance, and other non-covered services.
- If your plan requires referrals from your Valley Medical Group PCP to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

## Financial Obligations

1. Co-payments are due at the time of service.
2. Valley Medical Group will bill participating insurance companies after verifying coverage. If claims are not paid, Valley Medical Group will bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Valley Medical Group, the payment must be forwarded to us. You may issue a personal check to Valley Medical Group. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance that Valley Medical Group participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Valley Medical Group bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

**I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:**

Patient/Guardian:_____ Date: _____

Witness:_____ Date: _____

A copy of this form is available upon request.

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, and Valley Physician Services, NY

Valley Medical Group
Valley Health System

# AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH OTHERS AND/OR LEAVE TELEPHONE MESSAGES

The purpose of this document is to inform us if we have your permission to:

- Relay information to other people regarding your care and treatment.
- Leave information about your care and treatment on your telephone answering machine.
- Call you at work, and/or on your cell phone or other telephone number.

**Patient Name**:_____ **Date of Birth**:_____

**E-mail Address**: _____

When our physicians or office staff need to speak with you about your healthcare, we generally place a telephone call and ask to speak with you, our patient, first. Some examples of when we may need to call you are: to see how you are feeling after a visit to us; with follow-up instructions after a visit; and/or with laboratory, radiology, or other diagnostic test results, etc.

*If you are unavailable when we telephone you*,

- May we leave such information on your answering machine? ☐ No ☐ Yes
  Comment: _____
- May we leave such information with other people in your household? ☐ No ☐ Yes
  Comment:_____

  If "Yes", please note specifically who: _____

  _____
- May we contact you at work? ☐ No ☐ Yes Telephone: _____
- May we contact you via cell phone? ☐ No ☐ Yes Cell phone: _____
- Is there any other telephone number you would like us to call to reach you or another person you would like us to contact to discuss your health care? _____
- PLEASE INDICATE YOUR PREFERRED METHOD FOR OUR FOLLOW-UP COMMUNICATIONS WITH YOU:
  ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other: _____
  *(E-mail can only be used to contact you when all other means fail.)*
- Is there someone you have given the authority to schedule, confirm, or cancel appointments for you? ☐ No ☐ Yes If "Yes", please specify: _____

Patient Signature: _____ Date: _____

Valley Medical Group will abide by the guidelines given in this document unless you instruct us differently.
*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, and Valley Physician Services, NY

**NOTICE OF PRIVACY PRACTICES**

*Effective as of: September 13, 2013*
*Revised: November 27, 2013*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this Notice, please contact the Executive Director, Valley Medical Group by calling 201-291-6456.

WHO WILL FOLLOW THIS NOTICE

This Notice describes Valley Medical Group's practices and that of:

- Any healthcare professional authorized to enter information into your patient chart.
- All departments and units of Valley Health System (System), including The Valley Hospital; Valley Home Care, Valley Health Medical Group; and The Valley Hospital Foundation.
- Any member of a volunteer group we allow to help you while you are at a Valley Medical Group facility.
- All employees, staff, and other Valley Health System personnel.
- The Valley Hospital; Valley Home Care; Valley Medical Services t/a Valley Medical Group; Valley Physician Services t/a Valley Medical Group; Valley Physician Services NY, PC t/a Valley Medical Group; Valley Health Medical Group; and The Valley Hospital Foundation follow the terms of this Notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or operations purposes described in this Notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by any Valley Medical Group facility.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices concerning medical information about you; and
- follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

We use and disclose medical information in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, nursing and medical students, or other personnel who are involved in taking care of you and who may call to see how you are doing. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments within the System also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and X-rays. We also may disclose medical information about you to people outside Valley Medical Group who may be involved in your medical care, such as family members, clergy, rehabilitation centers or others we use to provide services that are part of your care.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about the care you received so your health plan will pay us or reimburse you for services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations**. We may use and disclose medical information about you for the facility's operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services should be offered, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other System personnel for review and learning purposes. We may also combine the medical information we have with medical information from other medical groups to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Health Information Exchange**. Consistent with federal regulation, we have partnered with Jersey Health Connect, which is a Health Information Exchange (HIE). An HIE is governed by a strict set of rules designed to protect patient confidentiality, privacy and security. The purpose of an HIE is to allow physicians and healthcare facilities to share your clinical information electronically. The goals of this exchange are to reduce medical errors, eliminate redundant care and reduce unnecessary costs. Ultimately the HIE will also allow you to access your information stored in the HIE and become a more active, informed participant in your overall care. You are entitled to opt-out of this HIE by contacting Jersey Health Connect at 855-624-6542 or via the internet at http://www.jerseyhealthconnect.org/.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at a Valley Medical Group facility.

- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities**. We may use demographic information about you, such as name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of services, department of services, treating physician or information regarding outcome, to contact you in an effort to raise money for the hospital, home care or hospice. We may disclose medical information to The Valley Hospital Foundation so that the Foundation may contact you in raising money for the hospital, home care or hospice. You are free to opt-out of fundraising solicitation and your decision will have no impact on your treatment or payment for services. If you do not want the hospital to contact you for fundraising efforts, you must notify us. If you do not want the Foundation to contact you for fundraising and you wish to opt-out of these contacts, you may call the Foundation at 201- 291-6300. You may also opt-out of these contacts by contacting the Foundation in writing at The Valley Hospital Foundation, 223 North Van Dien Avenue, Ridgewood, New Jersey 07450-2736.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition.. In addition, we may disclose medical information about you to an entity helping in a disaster relief effort so that your family can be notified about your condition, status, and location.

- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility.

- **As Required By Law**. We will use and disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Business Associates**. We may disclose medical information about you to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract or as permitted by federal, state or local law.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

➢ **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

➢ **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

in response to a court order, subpoena, warrant, summons or similar process;

to identify or locate a suspect, fugitive, material witness, or missing person;

about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

about a death we believe may be the result of criminal conduct;

about criminal conduct at hospital medical group facility; and

in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **Coroners, Medical Examiners, and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

➢ **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

➢ **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

➢ **Correctional Institutions**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

➢ **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by the medical group will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

➢ **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all the information, both old and new, is kept by or for the medical group.

To request an amendment, your request must be made in writing and submitted to the. Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652 In addition, you must provide a reason that supports your request.

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:

was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

is not part of the medical information kept by or for the medical group;

is not part of the information which you would be permitted to inspect and copy; or

is accurate and complete.

➢ **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment, and healthcare operations.
To request this list or accounting of disclosures, you must submit your request in writing to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➢ **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had.

***We are not required to agree to your request in most cases.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or as required by law. We are required by law and will agree to restrict disclosure of your medical information if your request pertains solely to a disclosure to a health plan when you have paid for services out-of-pocket and in full. For example, if you pay for a service completely out of pocket and ask us not to tell your insurance company about it, we will abide by this request.

To request restrictions, you must make your request in writing to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➢ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to follow your request.

➢ **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our web site, www.ValleyHealth.com.

To obtain a paper copy of this Notice, please write to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652.

➢ **Right to be Notified of a Breach.** You have the right and we will notify you of any breach of your unsecured protected health information.

CHANGES TO THIS NOTICE.
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current Notice in effect.

COMPLAINTS.
If you believe your privacy rights have been violated, you may file a complaint with the medical group or with the Secretary of the Department of Health and Human Services at the Office of Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278. To file a complaint with the medical group, please write to the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. Such information includes most (i) uses and disclosures of psychotherapy notes (if recorded by us); (ii) uses and disclosures of your protected health information for marketing purposes; (iii) disclosures that constitute a sale of your protected health information; and (iv)other uses and disclosures that may not be described in this Notice.

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

For further information, please contact the Executive Director, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652, 201-291-6456.

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, Inc. and Valley Physician Services, NY, PC

Valley Medical Group
Valley Health System

# ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge by signing below that I have received or have been given the opportunity to receive a copy of Valley Medical Group Notice of Privacy Practices.

# HIPAA

_____ _____

Patient Name (please print clearly) Date

_____

Patient/Guardian Signature

_____ _____

Person Signing on behalf of the patient Relationship to Patient

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**THE VALLEY HOSPITAL**
**Ridgewood, New Jersey**

**AUTHORIZATION FOR THE VALLEY HOSPITAL CENTER FOR CHILD DEVELOPMENT TO RELEASE PATIENT MEDICAL RECORDS**

I, _____, born on _____ do hereby consent and authorize
**(Name of Patient)** **(Date of Birth)**

The Valley Hospital Center For Child Development to disclose _____ information
**(e.g., identify, diagnosis, prognosis and treatment)**

from my medical records and provide it to:

| **PARENT NAME AND ADDRESS:** | **PEDIATRICIAN NAME AND ADDRESS:** |
|---|---|
| | |
| | |
| | |
| ATTENTION: | ATTENTION: |

The purpose or need for this disclosure is _____

_____

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization , I must do so in writing and present my written revocation to the Privacy Officer at The Valley Hospital, 223 North Van Dien Avenue, Ridgewood, N.J. 07450. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Unless otherwise revoked, this Authorization will expire on the following date, event, or condition:** _____

_____

(If you fail to specify an expiration date, event or condition, this authorization will expire in 1 year.)

**Please indicate type of record(s) requested and approximate date(s) of service**

**Inpatient** ( ) _____ _____
**Date(s)** **Date**

**Outpatient** ( ) _____
**Date(s)**

**Emergency Room** ( ) _____ _____
**Date(s)** **Patient's Signature**

**Clinic** ( ) _____ _____
**Date(s)** **Parent/Legal Guardian or Authorized Representative**

**Type of Outpatient Test:**

_____ _____
**Witness to Signature(s)**

If it is determined by the hospital that your records are protected by Federal or State law and regulations concerning confidentiality of alcohol and drug abuse patient records, the diagnosis and treatment of AIDS, HIV infection or HIV related illness; the following note will be attached to the information sent to the recipient.

**NOTE to Recipient of Information:** This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR ' 2.1 et seq; N.J.S.A. 26:5c-1 et. Seq.) Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR ' 2.1 et seq. or N.J.S.A. 25:5c-1, et seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# New Patient Intake Form for Pediatric Endocrinology

**Name:_____** **DOB_____**

| | Yes | No |
|---|---|---|
| Has your child ever been hospitalized overnight? (If yes, list dates and reason below) | □ | □ |
| Has your child ever had surgery (If yes, list dates and reason below) | □ | □ |
| Does your child have any chronic medical problems? (if yes, list below) | □ | □ |
| What was our child's weight at birth:_____ | | |
| Was the pregnancy full term (at least 37 weeks) | □ | □ |
| If no, how many weeks were you at delivery?_____ | | |
| Were there any complications with your child at the time of delivery? | □ | □ |
| Was your child in the NICU after being born? | □ | □ |
| Was the mother diabetic during the pregnancy? | □ | □ |
| Was the delivery a vaginal or C-Section? | □ | □ |
| Did your child go thru their developmental milestones on time? | □ | □ |
| What grade is your child in? _____ | | |
| Who does your child live at home with? _____ | | |
| If your child has siblings, are they healthy? (If not, please list healthy issues below) | □ | □ |

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| | | |
|---|---|---|
| Is your child allergic to anything? (if yes, please list below) | □ | □ |
| Are your child's vaccines up to date? | □ | □ |
| Is your child taking any medications/vitamins/supplements? (If yes, list below) | □ | □ |

_____

Family History (if your child is adopted and you do not have the biological parents information, disregard the following questions)

Mother: What is your ethnicity? _____
How tall are you?_____
How old were you with your first period? _____
Do you have any medical issues? (if yes, please list) _____

Father: What is your ethnicity? _____
How tall are you?_____
Did you go thru puberty at an average age or do you feel you were an early or late bloomer?
_____
Do you have any medical issues? (if yes, please list) _____

Is there any diabetes or thyroid disease in the family? If yes, please list below which relative and there medical condition._____
_____

| **Female Patients:** | **Yes** | **No** |
|---|---|---|
| Has your child had their period ever? | □ | □ |
| If yes, when was their last date of the period? | | |

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**All Patients:**

| | | |
|---|---|---|
| Does your child suffer from frequent fevers? | □ | □ |
| Does your child suffer from frequent fatigue? | □ | □ |
| Is your child drinking more than normal lately? | □ | □ |
| Is your child bothered by the hot weather more than other people? | □ | □ |
| Is your child bothered by the cold weather more than other people? | □ | □ |
| Has your child ever suffered a seizure? | □ | □ |
| Does your child suffer from frequent headaches? | □ | □ |
| Does your child have any visual problems? | □ | □ |
| Does your child were corrective lenses? | □ | □ |
| Does your child snore? | □ | □ |
| Does your child have episodes where he or she stops breathing at night or gasps for air? | □ | □ |
| Does your child suffer from Asthma? | □ | □ |
| Does your child have frequent or current cough? | □ | □ |
| Does your child have chest pain? | □ | □ |
| Does your child have heart palpitations? | □ | □ |
| Does your child suffer from frequent constipation? | □ | □ |
| Does your child suffer from frequent diarrhea? | □ | □ |
| Does your child suffer from frequent nausea? | □ | □ |
| Does your child suffer from frequent vomiting? | □ | □ |
| Does your child have any difficulty or pain urinating? | □ | □ |
| Does your child have any blood in their urine? | □ | □ |
| Does your child have any broken bones? | □ | □ |
| Does your child suffer from acne, dry skin, or other rashes? | □ | □ |
| Does your child have any depression, mood, or behavior problems? | □ | □ |