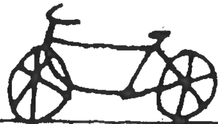


West 11th Street Pediatric Associates, LLP

Genevieve Ferrer, M.D., F.A.A.P.
Lori Rosello, M.D, F.A.A.P
Alessandra Zullo, M.D. F.A.A.P.
Pamella Brownstein, M.D., F.A.A.P.

Today's Date________________________

NEW PATIENT INFORMATION

1. Patient's Name____
   First Last

Date of Birth____________________Sex_______________SS#___________________________

2. Patient's Name____
   First Last

Date of Birth____________________Sex_______________SS#___________________________

3. Patient's Name____
   First Last

Date of Birth____________________Sex_______________SS#___________________________

➢ Address____________________________Apt#__________City____________________

State__________________Zip Code____________Home Phone#_________________________

❖ Father's/Partner's Name____

Occupation_____________________________Work Phone#____________________________

Cell Phone_____________________________E-mail_________________________________

Address If Different from Patient's Address_______________________________________

❖ Mother's/Partner's Name____

Occupation_____________________________Work Phone#____________________________

Cell Phone_____________________________E-mail_________________________________

Address If Different from Patient's Address_______________________________________

Pharmacy Name___________________________Phone#_______________________________

Pharmacy Address (including zip code)____

Emergency Contact (not parent)_________________________________relation__________

Cell Phone_____________________________home phone___________________________

Insurance Plan____Co-pay amount $___________

Policy ID/Member/Subscriber#________________________________Group#_______________

Primary Insureds's Name____

Primary Insured's DOB___________________________Insured's SSN___________________

Secondary insurance Name and policy #____

I,____(parent or guardian), have received a copy of West 11th Street Pediatric Associates, LLP's Notice of Privacy Practice.

Financial Policy

Payment for service is required at the time of your child's visit. Payment includes copays and deductibles, balances from prior visits, medical form fees, or payment in full if we do not accept your insurance. (You will be given a receipt to submit to your insurance company if you have out of network coverage).
Initial ____________

If you have HMO insurance, it is your responsibility to notify your insurance plan that you have chosen a doctor in our practice to be your child's Primary Care Provider.
Initial____________

It is your responsibility to notify our office of any change in your insurance coverage or contact information. If you fail to do this, all medical service fees will be your responsibility.
Initial_____________

I understand that West 11th Street Pediatric Associates, LLP will charge me $25 for any missed appointment that is not cancelled at least 24 hours in advance.
Initial____________

Payment agreement

I/We, the undersigned, do hereby expressly guarantee payment in full and within 30 days of any and all

charges for medical services to____ (child's name)

West 11th Street Pediatric Associates, LLP commencing ________________ 20_______.

____ ________________________________
(parent signature) (printed name)

Credit Card Payment Authorization

We request that your credit card information be kept on file with us. We will mail you a receipt.

_____I authorize automatic use of my card for all outstanding balances, including copays, form fees and deductibles.

_____I authorize automatic use of my card for all outstanding copays and form fees. Please notify me first of any larger charges, such as deductibles.

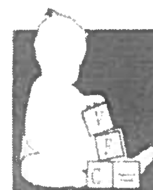
Name on card: ____

Card name: ____

Card number: ____ Expiration date: ___________

Signature: ____

NYC Department of Health and Mental Hygiene
Immunization Program
Vaccines For Children Program



ELIGIBILITY SCREENING FORM

Provider Name: ______________________ **Date of Screening:** _____/_____/_______
MM DD YYYY

HEALTH CARE PROVIDER: A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the **parent, guardian, individual of record, or healthcare provider.** The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PATIENT INFORMATION:

Child/Patient Date of Birth: ____/____/________
MM DD YYYY

______________________ ______________________ ______
Child/Patient Last Name First Name M.I

______________________ ______________________ ______
Parent/Guardian's Last Name First Name M.I

Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.

1. Medicaid/Medicaid managed care enrolled ____________ Date
2. Uninsured (no insurance) ____________ Date
3. Underinsured (insurance does not cover vaccines) ____________ Date
4. Native American/Alaskan Native ____________ Date
5. Not Eligible (insurance covers immunization) ____________ Date
6. Child Health Plus B (CHPlus B) ____________ Date

EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK

DOH 3835P (Revised 12/2008)

West 11th Street Pediatric Associates, LLP

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Patient MRN/Patient ID:

Please Fax signed consents to: **917-829-2096**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please ☑ Check

☐ 1. **I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ 2. **I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

____
PRINT Name of Patient

____
Patient Date of Birth

____
Signature of Patient or Patient's Legal Representative

____
Date

____
Print Name of Legal Representative (if applicable)

____
Relationship of Legal Representative to Patient (if applicable)