Instruction for New Patients:

1 Fill out new patient and medical release forms - (listed under Policies & Procedures link on our website) Breakdown of forms are: **Patient Registration**
Assignment of Insurance Benefits
Patient Questionnaire
HIPPA Forms
Medical Records Release
Copy of Insurance card (Front & Back)

2 If your Insurance requires you to choose a PCP, please call your insurance company to have that changed. Insurance companies that require PCP- Fidelis, MVP, Emblem Health HIP)

3 We will need your child's previous doctor records, including most recent physical and vaccine records before we can schedule appointments.

4 Once forms are completed please email or fax them back to the office so we can register your child into your system.

Email- info@gergelypediatrics.com
Fax (845) 424-4664

* **Email is not** for prescription requests, appointment requests/cancellations.*
(Please call the office during business hours for these requests)
* Our Answering service is available after hours for any emergency requests 7 days a week. **(845) 838-6502**

5 Newborn Patients:

- Notify Insurance companies once your baby is born
- You will be required to submit your babies birth certificate and social security card to your insurance company. It can take up to 2 months for insurance to become active for your newborn. In the meantime, you may receive bills from our office. This is more of a notice to follow up with your insurance company. Once your newborn becomes active under the insurance policy, we will resubmit claims to your insurance company.

Gergely Pediatrics 34 Route 403 Garrison, NY 10524 845-424-4444 fax 845-424-4664

PATIENT REGISTRATION: **TODAY'S DATE:**__________

PATIENT INFORMATION: (Please use full legal name, not nicknames please)

LAST NAME____________________ **FIRST NAME:**____________________

DATE OF BIRTH ____/____/____ **Sex: Female (___) Male (___)**

Street Address:____

City:____________________ **State:**__________ **Zip:**__________

Home Phone#: (______)______________ **Cell Phone # (______)**______________

Emergency Contact Name:____________________ **Emerg Phone #:**

____

PARENT FIRST & LAST NAME:____________________ **DOB:**__________

EMAIL: ____________________ **SS#**__________

MAIDEN NAME: ____________________ **CELL #**__________

OCCUPATION/EMPLOYER: ____________________ **WORK#**__________

PARENT FIRST & LAST NAME: ____________________ **DOB:**__________

EMAIL:____________________ **SS#**__________

MAIDEN NAME: ____________________ **CELL #**__________

OCCUPATION/EMPLOYER: ____________________ **WORK#**__________

PARENTS: MARRIED________ **DIVORCED:**________ **SINGLE:**________

ADDRESS (If different from above) ______________________________

____

****

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

****POLICY HOLDER'S NAME:** ________________ **INSURANCE NAME:** ________________

****POLICY HOLDER'S SS#:** ________________ ****POLCY HOLDER'S DOB:** ________________

****POLICY /ID#:** ________________ **GROUP #:** ____________ **EFF DATE:** ________

Insurance Claims Address & Phone: ______________________________

____

SECONDARY INSURANCE:

****POLICY HOLDER'S NAME:** ________________ **INSURANCE NAME:** ________________

****POLICY HOLDER'S SS#:** ________________ ****POLCY HOLDER'S DOB:** ________________

****POLICY /ID#:** ________________ **GROUP #:** ____________ **EFF DATE:** ________

Insurance Claims Address & Phone: ______________________________

____

PLEASE READ AND SIGN BACK OF FORM. -> -> -> -> ->

Gergely Pediatrics 34 Route 403 Garrison, NY 10524 845-424-4444 fax 845-424-4664

ASSIGNMENT OF INSURANCE BENEFITS

***I nearby authorize direct payment of medical benefits to Dr Gergely for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.**

AUTHORIZATION TO RELEASE INFORMATION

***I nearby authorize Dr. Gergely to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.**

MEDICAID

***I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.**
A photocopy of these assignments shall be valid as the original.

PATIENT(please print) ____**DATE**__________________

____ ____

PARENT/GUARDIAN (please print)
Signature

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F
Previous Physician		Request for Records Transfer Complete Y N	Date of Last Well Child Exam	
Mother's Full Name		Father's Full Name		
Step-Mother's Full Name (If Applicable)		Step-Father's Full Name (If Applicable)		
Custodial Provider's Full Name (If different from above)		Relationship to Patient		

Birth History

Birth Weight________ Preg#______ Mom's age______ Was the birth ◻ Vaginal ? ◻ Cesarean? ◻ Early? ◻ Late?

If birth was early, how many weeks early? ____________ If Cesarean, why? ____________________________

Did mother have any illnesses/problems with her pregnancy? ◻ Yes ◻ No Explain ____________________________

Did baby have any problems right after birth? ◻ Yes ◻ No Explain____________________________________

Before mother knew she was pregnant or at any time during her pregnancy did she:

◻ Smoke Cigarettes (amount)____________________ ◻ Drink Alcohol (amount) ________________

◻ Use "street" drugs (type)____________________ ◻ Use Prescription Drugs (type)________________

Was initial feeding ◻ Breast Milk? ◻ Formula?

Current and Past History

Is your child currently on any medication?	◻ Y	◻ N	Explain________________
Does your child have any serious or chronic illnesses?	◻ Y	◻ N	Explain________________
Has your child had serious injuries or accidents?	◻ Y	◻ N	Explain________________
Has your child had any surgeries?	◻ Y	◻ N	Explain________________
Has your child ever been hospitalized?	◻ Y	◻ N	Explain________________
Is your child allergic to any medications?	◻ Y	◻ N	Explain________________
Has your child ever reacted to immunizations?	◻ Y	◻ N	Explain________________

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	◻ Y	◻ N	Explain________________
Nasal allergies or eczema	◻ Y	◻ N	Explain________________
Frequent ear infections or sore throat	◻ Y	◻ N	Explain________________
Problems with ears or hearing	◻ Y	◻ N	Explain________________
Problems with eyes, vision or teeth	◻ Y	◻ N	Explain________________
Frequent headaches or other neurologic problems	◻ Y	◻ N	Explain________________
Frequent abdominal pain	◻ Y	◻ N	Explain________________
Constipation requiring doctor visits	◻ Y	◻ N	Explain________________
Bladder/kidney problems or bedwetting	◻ Y	◻ N	Explain________________
Any heart problems/murmur	◻ Y	◻ N	Explain________________
Anemia or bleeding problem	◻ Y	◻ N	Explain________________
Thyroid or other gland problem	◻ Y	◻ N	Explain________________
Diabetes	◻ Y	◻ N	Explain________________
ADD/ADHD	◻ Y	◻ N	Explain________________
Mental Health Issues	◻ Y	◻ N	Explain________________
Use of drugs or alcohol	◻ Y	◻ N	Explain________________

Household Information

Please List All Those Living in the Child's Home		
Name	Relationship to Child	DOB

Are there siblings not listed above? If so, please list their full names and ages and where they live. ____________________

____

____

Child Care: ____

Smokers in household? ☐ Y ☐ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	☐ Y	☐ N	Who________	Comments________
Allergies	☐ Y	☐ N	Who________	Comments________
Asthma	☐ Y	☐ N	Who________	Comments________
Birth Defects	☐ Y	☐ N	Who________	Comments________
Blood Disorders	☐ Y	☐ N	Who________	Comments________
Bone Disorders	☐ Y	☐ N	Who________	Comments________
Cancer	☐ Y	☐ N	Who________	Comments________
Diabetes	☐ Y	☐ N	Who________	Comments________
Endocrine Disease	☐ Y	☐ N	Who________	Comments________
Ear/Nose/Throat Disorders	☐ Y	☐ N	Who________	Comments________
Eye Disorders	☐ Y	☐ N	Who________	Comments________
Gastrointestinal Disorders	☐ Y	☐ N	Who________	Comments________
Heart Disease	☐ Y	☐ N	Who________	Comments________
High Blood Pressure	☐ Y	☐ N	Who________	Comments________
High Cholesterol	☐ Y	☐ N	Who________	Comments________
Immune Disorders	☐ Y	☐ N	Who________	Comments________
Joint Problems	☐ Y	☐ N	Who________	Comments________
Kidney Disease	☐ Y	☐ N	Who________	Comments________
Liver Disease	☐ Y	☐ N	Who________	Comments________
Lung Disease	☐ Y	☐ N	Who________	Comments________
Migraine Headaches	☐ Y	☐ N	Who________	Comments________
Metabolic Disorders	☐ Y	☐ N	Who________	Comments________
Obesity	☐ Y	☐ N	Who________	Comments________
Seizure Disorders	☐ Y	☐ N	Who________	Comments________
Skin Disorders	☐ Y	☐ N	Who________	Comments________
Stroke History	☐ Y	☐ N	Who________	Comments________
Thyroid Disorders	☐ Y	☐ N	Who________	Comments________
Mental Health History	☐ Y	☐ N	Who________	Comments________
Other Medical History	☐ Y	☐ N	Who________	Comments________
Other Medical History	☐ Y	☐ N	Who________	Comments________

Gergely Pediatrics, PC
34 Route 403
Garrison, NY 10524
845-424-4444

PATIENT AUTHORIZATION FORM

Patient

Name______________________________ DOB___________

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.c

Description of the specific information to be used or disclosed:
- *Diagnosis and Treatment
- *Doctor and Nurse Practitioner Notes
- *Growth Chart
- *Immunization Records
- *Medical Sheets
- *Lab Records

Person or entity requesting the information and authorized to make the requested use or disclosure:
- *Parents or Legal Guardians

Recipient of the information:
- *Schools, Daycare Centers, Hospitals and Pharmacies

This information is being requested for the following purpose(s):
- *To demonstrate compliance with state law.
- *To clear patients pre-operatively.
- *To share medical data with consenting specialists.
- *To alert other providers of patient's known allergies or special health conditions.

The authorization shall remain in effect from the date signed below until I revoke authorization.

I understand that:
- *I may inspect or copy the protected health information to be used or disclosed.
- *I may revoke this authorization in writing by contacting your office at the address above.
- *Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPPA.
- *I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)
- *Medical messages can be left at my home, on my cell phone, or at work.

Patient Name:______________________Signature:____________________

Guardian____________________________Signature____________________
Relationship to Patient:_____________________
(If signed by personal representative of Patient)

Gergely Pediatrics
34 Route 403
Garrison, NY 10524

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physican certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________

Signature: ________________________________

Date: ____________________________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Gergely Pediatrics 34 Route 403 Garrison, NY 10524

9(a). Specific information to be released:

- ☐ Medical Record form (insert date) ________________ to (insert date) ________________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ______________________________

Include: (*Indicate by Initialing*)

_______ **Alcohol/Drug Treatment**
_______ **Mental Health Information**
_______ **HIV-Related Information**
_______ **Genetic Testing**

Authorization to Discuss Health Information

(b). ☐ By initialing here _____ I authorize ______________________________
Initials — Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: ______________________
Signature of Patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.