General Pediatrics
Boston Children's Health Physicians
Until every child is well™

PATIENT NAME: _____ **DATE:** _____

PATIENT ADDRESS: _____

_____

DATE OF BIRTH: _____ **GENDER:** _____ **PREFERRED LANGUAGE:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

E-MAIL: _____ **PRIMARY PHYSICIAN:** _____

We are committed to providing culturally-sensitive, whole person medical care. Collecting information on race, ethnicity and language gives us information that can help us serve your family better. This information helps us to determine if you have a higher risk of certain diseases and illness and can help us to understand your cultural background and beliefs. With all of this in mind, we ask that you complete the following.

PATIENT RACE: WHITE BLACK/AFRICAN AMERICAN NATIVE AMERICAN INDIAN ASIAN/PACIFIC ISLANDER OTHER

PATIENT ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO IF HISPANIC: MEXICAN PUERTO RICAN CUBAN OTHER

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

PHONE NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ **EFFECTIVE DATE:** _____

INSURANCE ADDRESS: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

CARDHOLDER NAME: _____ **CARDHOLDER DOB:** _____ **SEX:** _____

SECONDARY INSURANCE NAME: _____ **EFFECTIVE DATE:** _____

INSURANCE ADDRESS: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

CARDHOLDER NAME: _____ **CARDHOLDER DOB:** _____ **SEX:** _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare and other insurance carries responsible for my or my dependent's care. I request payment of authorized Medicare and other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

Signature of Patient/Guardian: _____ **Date:** _____

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New Patient Questionnaire

Name _____
DOB _____
Doctor _____

Reason for Visit

What is the reason for today's visit? _____
Who was your child's previous doctor(s)? _____ ☐N/A

Birth History

Was your child adopted? ☐No ☐Yes: Country: _____ At what Age? _____

Pregnancy: Age of mother at delivery: _____ Illnesses in mother: _____
Medications taken during pregnancy: _____
Were any abnormalities noted on screening tests (ultrasound, amniocentesis, or blood tests)? ☐No ☐Yes:
_____

Delivery: ☐Vaginal ☐C-section; reason for c-section: _____
Hospital: _____ ☐Full term ☐Pre-term (# of weeks _____)
Birth weight: _____
Complications: _____
Did your child require NICU care? ☐No ☐Yes: How long? _____

Development

Has your child ever been referred to Early Intervention? ☐Yes ☐No
Has your child been diagnosed with a disability? ☐No ☐Yes: _____
Do you believe your child has a developmental disability? ☐No ☐Yes: _____
Does your child receive (please circle): PT OT Speech
Is your child receiving special education services? ☐No ☐Yes: weakness: _____
Has your child ever had to repeat a grade? ☐No ☐Yes: (grade): _____
Has your child ever skipped a grade? ☐No ☐Yes: (grade): _____

Medical History

Does your child have any chronic or recurrent medical problems? ☐No ☐Yes
If yes, please list: 1. _____
2. _____
3. _____
4. _____

Does your child take medication on a regular basis for a chronic problem?
☐No ☐Yes: _____
Is your child allergic to any drugs or medications? (if yes, list drug and the reaction)
☐No ☐Yes: _____

Has your child ever been hospitalized? ☐No ☐Yes (list and detail below)

	Age	Hospital	Problem(s)
1.			
2.			
3.			
4.			
5.			

Diet

Does your child have any food allergies or sensitivities? ☐No ☐Yes: _____
Does your child have any dietary restrictions? ☐No ☐Yes: _____
Is your child's diet well balanced? ☐Yes ☐No: _____
Does your child drink fluoridated water? ☐Yes ☐No ☐I don't know
Who is your child's dentist? _____
Does your child take any nutritional supplements? ☐No ☐Yes: _____

Social situation

Who lives in the home with your child? _____

Mother's occupation: _____ Father's occupation: _____
Marital status of parents: ☐Married ☐Unmarried, living together ☐One parent deceased ☐Separated
☐Divorced: What is the custody arrangement? _____
Does the child have a ☐Stepmother ☐Stepfather?
Does anyone in the home smoke? ☐No ☐Yes: _____
Are there any pets in the home? ☐No ☐Yes: _____

Age 0 – 5: Who cares for your child during the day? ☐Mother/father, ☐Relative, ☐Nanny/Au Pair, ☐Child goes to Babysitter's home, ☐Home-based group childcare, ☐Center-based group childcare
Age 5 – 18: What school does your child attend? _____
Does your child attend an after-school program? ☐No ☐Yes: _____
What activities does your child participate in? _____

Family History

Has anyone in your child's family been diagnosed with (check appropriate relationship to child):

	Mom	Dad	Sibling	Other
Allergies				
Anemia				
ADHD				
Birth defects				
Bleeding disorder				
Cancer				
Cystic Fibrosis				
Diabetes				
Eczema				
Genetic abnormality				
Hearing loss				
Heart attack before age 50				
Heart defect from birth				
High Blood Pressure				
High Cholesterol				

	Mom	Dad	Sibling	Other
Lead poisoning				
Learning disability				
Mental Retardation				
Metabolic disease				
Migraine Headaches				
Obesity/ Overweight				
Sickle cell disease				
Spina Bifida				
Sudden infant death syndrome				
Thyroid disease				
Tuberculosis				
Asthma				
Autism				
OTHER				
OTHER				

If you have ANY questions about any of the above items, please discuss it with your nurse or doctor. Thank you.

Parent's Signature _____ Physician's Signature _____ Date _____

healthlinkny
Your link to Statewide Health Information

HealthlinkNY Health Information Exchange

LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: **Boston Children's Health Physicians, LLP**

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I receive health care. HealthlinkNY is a not-for-profit organization that electronically shares information about people's health and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to receive medical care or obtain health insurance coverage. Your choice to give or deny consent may not be used as the basis for denial of health services. The choice you make on this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

Before making your decision, please carefully read the Consent Form Information Sheet about how your information is used.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. This form must be filled out completely to be valid.

Please choose only one of the following two options:

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

Printed First Name of Patient | Printed Last Name of Patient | Patient Date of Birth (MM / DD / YYYY)

Signature of Patient | Date of Signature (MM / DD / YYYY)

---------- *This section below is to be completed by the Patient's Legal Representative (if applicable)* ----------

rinted First Name of Legal Representative | Printed Last Name of Legal Representative | Relationship of Legal Representative

egal Representative Signature | Date of Legal Representative Signature (MM / DD / YYYY)

Boston Children's Health Physicians
formerly CWPW
Until every child is well™

I hereby acknowledge that a copy of ***Boston Children's Health Physicians, LLP's*** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *BCHP's* privacy practices or my rights with regard to my personal health information, I may contact *BCHP's* Privacy Officer for further information as set forth in the Notice.

Patient Name:

Guarantor's Name:

Patient Signature:

Guarantor's Signature:

Date:

Relationship to Patient:

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Identification #: _____

I hereby certify that on ___/___/___ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of BCHP's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name) _____

Signature of Staff Person

Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

Boston Children's Health Physicians

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PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your and your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments/Coinsurance/Deductibles
Your specific insurance plan determines the amounts you may be required to pay. Our contract with your plan and applicable laws prohibit us from discounting or waiving copayments, deductibles, or coinsurance for visits and procedures. Copays are required at the time of every visit and BCHP accepts cash, check or credit card as payment.
Some insurance plans may require an additional copay for additional services done at your appointment. If this is required by your insurance, we will require the additional copayment at the time of service. If you have any questions regarding the additional copay requirement, we suggest you contact your insurance carrier to review your plan details.

For your convenience, BCHP utilizes a credit card processing system which allows us to keep your credit card on file securely. Please note that no staff members at BCHP have access to your credit card number at any time. We will charge your card for amounts due, as indicated by your insurance carrier, unless you advise us otherwise.

No Show/Late Cancel Policy
A $40 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to 24 hours before the scheduled visit.

Insurance
We will require a copy of your (or your dependent's) insurance card for our files. It is your responsibility to inform us of any change in your insurance coverage.

Participating Plans
BCHP participates in most insurance plans. In order to properly bill your insurance company, we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits and you are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans
If we are out of network for your insurance and your insurance will be paying you directly, we expect payment at the time of service unless other arrangements have been made prior to the visit.

Referrals
If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral, you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

Annual Visits
Before making annual physical appointments, it is your responsibility to check with your insurance company regarding whether the visit will be covered as a well visit. Not all plans cover annual physicals.

Non-Covered Services
We pride ourselves on providing exceptional, state-of-the-art medical care, and extended services for our patients. We offer many health screenings that are recommended by the American Academy of Pediatrics and our providers. Some insurance companies choose not to pay for recognized service codes and apply these services to a patient's deductible.

Any non-covered service is your responsibility. This can include but is not limited to hearing screens, vision screens, lab work, and developmental screening; even when they occur at a well visit. If not covered, you will be responsible for those charges according to your benefits plan. Plans differ within each insurance company, so it is impossible for us to know what routine health screenings your plan will or will not cover.

Boston Children's Health Physicians

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Financial Hardship

We realize some families from time to time experience financial difficulties and we want to always be here to care for your children. Please contact our office manager to discuss payment options.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in. Adolescents who come alone should be prepared to settle their visits at the time of service

BCHP is not a party in divorce or separation decrees, or in child support arrangements. We bill one guarantor at one address. We do not handle billing or insurance coverage disputes between parents. In situations of divorce or separation of parents or guardians, the individual bringing in the child for services will be held financially responsible for any unpaid charges on the account.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

I give consent to BCHP, its staff, physicians, and other practitioners to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by BCHP for my (child's) health and well-being

There will be an additional charge submitted to your insurance company for patients seen on Saturdays, Sundays, federal holidays, and after normal business hours on weekdays. We are required by law to report all the charges for services provided. Some insurance companies cover the charge in full, and others assign all or part to patient responsibility. If you have any questions about your specific coverage, please ask your insurance company. As plans within the same company differ, it is impossible for us to know in advance if there will be any patient responsibility.

For high insurance deductible plans we may require a deposit towards your policy deductible requirements. You will receive a statement for any outstanding balances owed for services provided.

Name of Patient	Date of Birth
Name of Patient	
Name of Patient	
Signature of Parent or Authorized Person	Print name of Parent or Authorized Person
Date	

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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Adopted Under
Health Insurance Portability and Accountability Act ("HIPAA") of 1996

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW THEY CAN GET ACCESS TO THEIR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO PRIVACY

Boston Children's Health Physicians, LLP (hereinafter, "BCHP") is a multispecialty medical practice. We are dedicated to maintaining the privacy of our patients' individually identifiable health information or protected health information ("PHI"). We are required by law to maintain the confidentiality of health information that identifies our patients and to provide them with this notice of our legal duties and our privacy practices concerning their PHI. This notice applies to the PHI of our adult and pediatric patients. Accordingly, use of the terms "you" and "your" in this notice applies to our patients and their PHI and to the personal representatives of our patients, e.g., the parent or guardian of a minor, the guardian of an adult who lacks legal capacity or a person authorized on behalf of a deceased patient.

We are required to furnish our patients with the important information discussed below regarding how we may use and disclose their PHI, our obligations concerning such use and disclosure, and their privacy rights concerning such information. The following briefly summarizes some important rights of patients with respect to their PHI:

- right to receive a copy of this Privacy Notice;
- right to inspect and copy certain health information;
- right to receive an accounting of certain disclosures that we make of their PHI;
- right to request restrictions on how we use and disclose PHI;
- right to be notified after a breach of any of your unsecured PHI has occurred;
- right to request amendments to the PHI;
- right to revoke an authorization that we obtained to disclose the PHI; and
- right to complain about suspected violations of their privacy rights.

The terms of this notice apply to all records containing PHI of our patients created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of the records that our practice has created or maintained in the past and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR SECURITY OFFICER:

Security Officer
Boston Children's Health Physicians, LLP
40 Sunshine Cottage Road
Skyline Drive
Valhalla, NY 10595

Telephone # 914-922-2271

C. TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

1. Treatment. Our practice may use the PHI of our patients to treat them. For example, we may disclose your PHI (or your child's PHI) as follows:

- To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.
- To write a prescription, or we might disclose your PHI to a pharmacy when we order a prescription for you.
- To treat or to assist others in the treatment of our patients.
- To inform you of potential treatment options or alternatives or programs.
- To others who you have given authorization to bring your child to the office and/or to consent to their treatment. For example, if you ask a relative or babysitter to bring your child to our office for treatment of a cold, the relative or babysitter may have access to the child's medical information.
- To other health care providers for purposes related to their treatment of our patients.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items that we provide to our patients. For example, we may disclose your PHI as follows:

- To contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if the insurer will cover or pay for the treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose our patients' PHI to operate our business. As examples, include, but are not limited to, the following:

- To evaluate the quality of and to improve our care or to conduct cost-management and business planning activities for our practice.
- To a social worker as a part of case management.
- To contact you and remind you of appointments.
- To inform you of health-related benefits or services that may be of interest to you.
- To engage in teaching and learning activities with medical and other health profession students and trainees (e.g., for medical students, residents, nurses, technicians and others).

D. USE AND DISCLOSURE OF PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose individually identifiable health information:

1. Public Health Risks. Our practice may disclose PHI to public health authorities or others that are authorized by law to collect information for the following purposes:

- To maintain vital records, such as births and deaths.
- reporting child abuse or neglect.
- To prevent or control disease, injury or disability.
- To report potential exposure to a communicable disease.
- To report a potential risk for spreading or contracting a disease or condition.
- To report reactions to drugs or problems with products or devices.
- To report to your employer for certain work-related illness or injuries.

2. Health Oversight Activities. Our practice may disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute where we receive satisfactory assurance that you have been notified of the request and have been given time to object and other appropriate precautions have been taken.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations even if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.

5. Victims of Abuse, Neglect or Domestic Violence. We may disclose personal health information about a child whom we reasonably believe to be a victim of abuse, neglect, exploitation or domestic violence to a government authority, including a social service or protective service agency authorized by law to receive reports of child abuse, neglect, exploitation or domestic violence. Any such disclosures will be made in accordance with applicable law.

6. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

7. Research. Our practice may use and disclose PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not

practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Fundraising Activities. We may provide basic contact information and the dates that you received treatment to the Children's Health and Research Foundation, Inc. ("http://www.chrfoundation.net/"), a public charity whose mission is to support and promote the health of poor children and families in New York's Hudson Valley and surrounding regions. You may be contacted to make a donation to this charity. You may opt out from receiving any fundraising communications by sending a written request to the Privacy Officer.

9. Serious Threats to Health or Safety. Our practice may use and disclose PHI when necessary to reduce or prevent a serious threat to a patient's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

10. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

11. Organ Donation. As allowed by law, we may disclose PHI to organ procurement organizations for organ, eye or tissue donation purposes.

12. Business Associates. There are some services that we provide through contracts with our business associates who work on our behalf. In such situations, we may disclose PHI to our business associates so that they can perform the jobs we asked them to do. We require all business associates to execute an agreement that requires them to comply with the HIPAA privacy requirements to safeguard your PHI.

13. Compliance. We are required to disclose PHI to the Secretary of the Department of Health and Human Services or his/her designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to Section E.3 below.

14. Appointment Reminders. We may use or disclose your PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that we believe may be of interest to you. We may remind you of appointments by mailing a postcard to you at the address provided by you or by telephoning your home and leaving a message on your answering machine or with the individual answering the phone. These appointment reminders will disclose the patient's name, address and the time, date and location of the appointment.

15. Required by Law. In addition to those uses and disclosures listed above, we may use and disclose PHI if and to the extent we are otherwise required by law.

E. RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location using alternative mailing addresses or telephone numbers. For instance, you may ask us not to contact you at work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for care, such as family members and friends. **Generally, we are not required to agree to your request, but, if we do agree, we are bound by our agreement, except when otherwise required by law, in**

emergencies, or when the information is necessary for treatment. We must honor your request to restrict disclosure to a health plan if you pay your bill without use of insurance. If your bill is paid in full directly by you or another on your behalf on an "out-of-pocket" basis without submission of a claim to an insurer, you may request that BCHP restrict the disclosure of your PHI to your health plan and BCHP will honor your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- the information that you wish to be restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Upon request, we will provide access to your records that are maintained in electronic form if they are readily available in that format. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. In that case, another health care provider chosen by us who was not involved in denying your original request will review your request and the denial.

4. Amendment. You may ask us to amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the supporting reasons in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of our patients' PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Examples include the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. We also will not provide an accounting of disclosures made to you, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request in writing before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Breach Notification. You have the right to be notified after a breach of your unsecured PHI has occurred.

9. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Without limiting the foregoing, BCHP will not use or disclose your PHI without your written authorization for marketing or to sell your PHI. Our practice also will not use or disclose psychotherapy notes other than as explained in section F.2. below. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing but will not apply to uses or disclosures made prior to our receipt of such revocation. The revocation is not effective with respect to actions we took in reliance on your authorization, or where the authorization was obtained as a condition of obtaining insurance coverage for your care. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

F. SPECIAL CIRCUMSTANCES

1. Minors. Under New York State law, minors (under the age of 18) have the right to request and receive medical care without parental consent when medical care is provided under the following circumstances:

- A minor of either sex who has a child can consent to his or her own medical care.
- A minor who is requesting specific medical services for pregnancy can consent to her own medical care.
- A minor who is requesting contraceptive services can consent to her own medical care.
- A minor of either sex who is seeking treatment for sexually transmitted disease can consent to his or her own medical care.

Medical information obtained under any of the above circumstances is confidential and cannot be disclosed to anyone, including a parent or guardian, without the minor's consent.

2. Psychological Treatment.

Psychotherapy notes are defined as any notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record. We will not use or disclose your psychotherapy notes without your written authorization except in limited exceptions such as for use by the therapist in the course of your treatment, disclosures to students who are learning under supervision to improve their skills in counseling and to prevent a serious and imminent threat to your health or safety or the health and safety of others.

Medication prescription and monitoring, counseling session start times, modality and frequency of treatment, results of clinical tests and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date are all excluded from the definition of psychotherapy notes.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

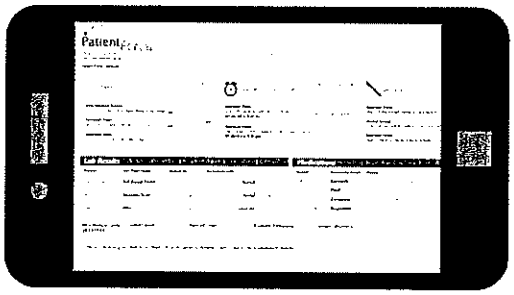
Effective Date. This Notice is effective as of December 2, 2013.

Ask us how to register today!

Fast, reliable communication

Patient Portal

Accessible 24/7 and only a click away



BCHP is proud to offer you access to our Patient Portal, a secure and easy-to-use, Internet-based portal which simplifies communication with your physician

You can utilize the portal 24/7 to:

- ✓ View a chart summary including lab results
- ✓ View documents such as school forms and immunizations
- ✓ View a summary of my most recent visit
- ✓ View educational materials
- ✓ Request medication refills
- ✓ Send non-urgent communications

You can access the Patient Portal from any browser or the NextGen Patient Portal app.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199