Post Road Pediatrics
Boston Children's
Primary Care Alliance

Post Road Pediatrics, LLP

Dear New Patient,

We would like to welcome you to your new medical home. Please find information below regarding our practice and services available to you. We ask that you provide your child's complete medical record including immunizations, growth charts, office notes from all previous primary care physicians, and all specialist reports. Certain insurances require that you update your PCP prior to your first visit so please call and inform them of the change ahead of time. Please also remember to bring your insurance card and co-pay to each visit!

Our office hours are Monday through Friday 8:30am – 5:00pm.
We are also open Saturday mornings starting at 9am (for urgent care by appointment only)
A physician is on call anytime the office is closed
Phone: 978-443-6005
Fax: 978-443-8429

MyChart

Post Road Pediatrics uses **MyChart,** a web-portal that allows patients to access portions of their medical records, send and receive non-urgent messages to/from staff and physicians, schedule certain types of appointments, and more. You can sign up for **MyChart** by calling the office or we can activate your account during your next office visit.

Well Child Care and Vaccine Policy

Post Road Pediatrics follows the American Academy of Pediatrics (AAP) schedule for well child visits and vaccines, and provides evidence-based care per AAP recommendations**. We expect our patients to make and attend routine well child visits and adhere to our vaccine policy.** The physicians at Post Road Pediatrics believe that fully vaccinating your child is one of the most important things we can do to protect your child's health. We understand that the decision to vaccinate may be a difficult one for some parents. If you have concerns, please discuss them with one of the physicians prior to your child's visit. We will do everything we can to reassure you that vaccinating your child according to the recommended schedule is the best way to protect your child. To best protect all of the families we care for, we may ask you to find another provider if you refuse to vaccinate your child despite our recommendations. Failure to attend routine well child visits may also result in discharge from our practice.

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Urgent Care

We want to help you avoid unnecessary ER visits! If your child is sick, please call us and speak to our triage nurse for advice or a same-day urgent care visit.

Other services/supports

- We have an Integrated Behavioral Health Clinician and Registered Dietitian in our office, available by appointment.
- We have a care coordinator to assist our families and patients with complex medical, developmental, behavioral, and social needs.
- ImPACT ® testing is available by appointment (recommended for ALL children 12 years and older who participate in contact sports)
- Telehealth – We also offer telehealth appointments for certain conditions.

We send a quarterly newsletter and other important updates by email. Please provide us with your email address so we can add you to our list.

To join our Facebook group or to view other updates and information about our practice, please visit our website https://www.childrenshospital.org/alliance/practices/post-road-pediatrics, where we also have provided many resources to help you manage the health and well-being of your family.

We look forward to providing your medical care!

The Post Road Pediatrics Team

Sana Assaf, MD
John Reap, MD
Brian DiGiovanni, MD
Katherine Medford, MD

616 Boston Post Road
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978-443-6005 / fax: 978-443-8429
www.postroadpediatrics.com

Patient Registration Form

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978-443-6005 | *fax* 978-443-8429

Patient last name:_____

First name: _____ MI: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing address: (if different from street address)

Address: _____

City: _____ State: _____ Zip: _____

Home phone:_____

Patient's cell (If over 14):_____

Patient email (if over 13): _____

Race (select one):

❍ Asian ❍ Black/African American
❍ Caucasian ❍ Hispanic
❍ Latino ❍ American Indian or Alaska Native
❍ Pacific Islander ❍ Multiracial ❍ Other

Ethnicity (select one): ❍ Hispanic ❍ Non-Hispanic ❍ Other

Language (select one):

❍ English ❍ Arabic ❍ French
❍ German ❍ Hindi ❍ Mandarin
❍ Spanish ❍ Vietnamese ❍ Other

Gender ❍ Male ❍ Female

Guardian 1 name: _____

Relationship to child: _____ Date of birth: _____

Cell phone: _____

Email:_____

Social Security #: _____

Guardian 2 name: _____

Relationship to child: _____ Date of birth: _____

Cell phone: _____

Email:_____

Social Security #: _____

Siblings

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Emergency contact: _____

Relationship: _____ Phone:_____

Patient's primary care doctor (as listed with insurance company):

_____

Preferred pharmacy: _____

Address: _____

City: _____ State: _____ Zip: _____

Person responsible for bill: (must be parent/guardian; If 18 or older, or mature/emancipated minor, must be self)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insurance information:

(Patients will be required to show insurance card at all visits)

Primary insurance company: _____

ID#: _____ Group #: _____

Secondary insurance company: _____

ID#: _____ Group #: _____

Subscriber's name: _____

Date of birth: _____

Address (If different from above):

_____

City: _____ State: _____ Zip: _____

Signature: _____

Parent/Guardian name (print): _____

Date: _____

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Financial Policy

It is important to us that our relationships with patients and families are not clouded by unclear expectations. For that reason, we want you to completely understand our office financial policy. Please read it carefully before signing.

Prior to your first visit, please verify your child's insurance coverage. If the insurance requires you to choose a Primary Care Physician (PCP), be sure the correct one is listed for your child. If a PCP is required but not listed, the insurance company may deny your claim leaving you responsible for payment. If our doctors do not participate in your plan, you will be responsible for the bill. You should also review your insurance policy for information about referrals, authorizations, procedures and well visit coverage.

Changes, co-pays and outstanding charges

Please check in at the Front Desk at every visit with your most recent insurance card. Please inform us of any changes to your insurance policy or demographic information. Copays are due and expected at the time services are rendered. We will also ask for payment of any outstanding balance. If you are not covered by insurance, payment is due at the time of service.

Deductibles, co-insurance and unpaid claims

Post Road Pediatrics will bill participating insurances on your behalf. If we have not rece ved payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. We are obligate by our insu ance contracts to bill you for deductibles, co-insurance and non-covered balances as dictated by your insurance company. We ask that you help us keep our costs down by making prompt payment.

For your convenience, payments may be made by phone, mail or online via MyChart. We accept most major credit cards, in-state checks, and cash. There is a $25.00 service charge for returned checks.

Well visits with extra services

If, during a well visit, you receive treatment for a medical condition outside the scope of routine preventative care, or a pre-existing problem is addressed in the process of performing your regular well visi , your insurance company may advise us that a copayment is required. If this happens, you may be billed for that copayment.

Referrals and managed care

If you are enrolled in a managed care plan (HMO) you must receive a referral from our office before you see a specialist. Referrals should be requested a minimum of 3–5 days prior to your visit so that your PCP has time to review and authorize each visit. Backdated referrals are not guaranteed. Failure to follow this process may leave you responsible for payment of the charges incurred at the specialist visit.

Missed appointments

We ask that you, whenever possible, notify our office within 24 hours if you are unable to come to a scheduled appointment. Missed appointments represent a cost to our office and may prevent other patients from being seen at that time. For this reason, we reserve the right to charge a fee of $50.00 for a missed or late-cancelled appointment. Excessive abuse of scheduled appointments may result in discharge from our practice.

Please contact our billing office (ext. 119) or the office manager (ext. 116) if you have any questions.

Agreement

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand and agree that I am responsible for full payment of any non-covered services, medical records fees, returned checks, and missed appointments. I will notify Post Road Pediatrics of any changes to my insurance coverage and contact information.

Responsible party: _____

Relationship to patient: _____

Signature: _____

Date: _____

Policy updated 02/01/2018

Notice of Privacy Practices

As required by HIPAA: The Health Insurance Portability and Accountability Act of 1996

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This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and disclosure of protected information

- Federal law provides that we may use your PHI for your treatment, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to a specialist.
- Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered.
- Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:
  1. required for public health purposes
  2. required by law to report child abuse
  3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
  4. required by law in judicial or administrative proceedings
  5. required for law enforcement purposes by a law enforcement official
  6. required by a coroner or medical examiner
  7. permitted by law to a funeral director
  8. permitted by law for organ donation purposes
  9. permitted by law to avert a serious threat to health or safety
  10. permitted by law and required by military authorities if you are a member of the armed forced of the U.S.
  11. required for national security, as authorized by law
  12. required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
  13. otherwise required or permitted by law.
  14. Certain types of uses and disclosures of protected health information require authorization, these include:
      - uses and disclosures of psychotherapy notes
      - uses and disclosures of PHI for marketing purposes; and
      - disclosures that constitute the sale of PHI.
  15. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

Minors

- For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or guardian to take their child to the pediatrician's office may have access to this child's medical information. We prefer to have written authorization from the parent or guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.
- You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.
- Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

- You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
- You have the right to request 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 e.g. at home and not at work. Such requests must be made in writing to your physician. Our practice will accommodate reasonable requests.
- You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosures we make of your medical information. This is a list of certain non-routine disclosures our practice has made of your health information for non-treatment, payment or health care operations purposes. An accounting does not have to be made for disclosures we make to you,

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or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.

- You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item or service
  - You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction
  - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time period, which may not be longer than six (6) years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have a right to receive electronic copies of health information.

Obligations that we have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization contact information

If you have questions about this notice please contact our office manager at 978-443-6005.

Your acknowledgement

The purpose of this notice is to inform you, the patient, of how your PHI is used and/or disclosed by this provider or organization. We want you to be fully aware of how we use your PHI so that you can provide us with your Acknowledgement in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other activities necessary to operate the practice and carry out our mission.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis/es and other health information to my bill(s)
- A means by which my health plan or health insurance company can verify that services billed were actually provided
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.
- An important part of studies that may be conducted to further research efforts and the development of new knowledge

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Post Road Pediatrics
- I have the right to review the Notice of Information Practices prior to signing this Acknowledgement
- Post Road Pediatrics will promptly revise and distribute its Notice of Information Practices whenever changes are made to any of its privacy practices
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that Post Road Pediatrics is not required to agree to those restrictions
- I may revoke this Acknowledgement in writing at any time. Further, I am aware that Post Road Pediatrics can proceed with uses and disclosures that pertain to treatment, payment or healthcare issues that took place before the Acknowledgement was revoked.

Restrictions on the use and disclosure of your PHI

To request a restriction on the use and disclosure of your personal health information related to your treatment, payment for service, or for the health care operations of Post Road Pediatrics, please do so after reading the Notice of Information Practices.

I request the following restrictions to the use or disclosure of my personal health information:

_____

_____

Please provide your signature below to indicate that you have read the above Acknowledgement and have reviewed the Notice of Information Practices.

Patient name: _____

Parent/Guardian signature (or patient if 18 or over):

_____

Date: _____

Revised 9/17/21