FOOTPRINTS
PEDIATRIC MEDICINE, P.C.

**1023 Forest Hill Rd**
**Staten Island, NY, 10314**
**Phone: 718-534-0505 / Fax: 718-228-4087**
**Email: Info@footprintspediatrics.com**

# Pediatric Intake Form

| | |
|---|---|
| Intake Date: | Preferred Language: |
| Person Completing Form: | Relationship to Patient: |

| **Patient Information** | | | |
|---|---|---|---|
| Patient Name: | | Age: | DOB: |
| Ethnicity: | Gender: | SS#: | |
| Address: | | | |
| Phone: | Email: | | |

| **Parent(s) Information** | |
|---|---|
| **Mother's Name:** | Mothers DOB: |
| Address: | Mothers SS#: |
| Email: | Cellphone#:<br>Home# |
| Employers' name: | Occupation: |
| **Father's Name:** | Father's DOB: |
| Address: | Father's SS#: |
| Email: | Cellphone#: |
| Employers' name: | Occupation: |

| Guardian's Name: | | | |
|---|---|---|---|
| Address: | | | |
| Email: | Cellphone#: | | |
| Employers' name: | Occupation: | | |
| Who is the Patient's Primary Caretaker? | ☐ Mother | ☐ Father | ☐ Other: |

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone. **I authorize the staff of Footprints Pediatric Medicine, P.C. to leave medical information pertaining to the patients care by following methos and will assume responsibility to notify them whenever this information changes:**

- Home telephone/ Answering machine
- Work telephone/ Answering machine
- Cellphone/ Voice mail/ Text

**Please list names of authorized people we may leave a message with (i.e., spouse, boyfriend, girlfriend, parent, grandparents ext.)**

_____

**Names and Relationships**

**Please list names of authorized people we may discuss your financial situation with**

_____

**Names and Relationships**

**Signature (Parent/Guardian)** _____ **Date**_____

| Insurance Information | |
|---|---|
| Insurance Name: | |
| Member ID: | Group Number: |
| Insurance Phone#: | Insurance Address: |
| Policy Holder's Name: | Phone#: |
| Relationship to Insured: | |
| Person Responsible for Account: | |

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## Insurance Coverage Waivers

| Name of insurance: | Insurance Address: | Insurance Phone#: |
|---|---|---|
| Member I.D#: | Group I.D#: | PCP if required: |

I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to Footprints Pediatric Medicine, P.C all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by my insurance. I will be responsible for collection agency fees of 25% of the balance added to the amount owed if in the event my account is forwarded to our collection agency. I hereby authorize Footprints Pediatric Medicine, P.C to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature/Relationship _____Date:_____

## Insurance Coverage Waiver

I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. I wish to receive services from Footprints Pediatric Medicine, P.C if it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature Parent/Legal Guardian: _____Date: _____

## Medicaid Coverage Waiver

I understand that your office does not take straight Medicaid. I wish to receive medical services from Footprints Pediatric Medicine, P.C If it is determined that my Medicaid funded plan is not in effect at the time of service, then I am willing to take financial responsibility for the services rendered. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature Parent/Legal Guardian: _____Date: _____

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# FINANCIAL POLICY

## IT IS IMPORTANT THAT YOU TAKE THE TIME TO REVIEW THIS POLICY.

1. All new patients must complete our patient forms prior to being seen. Established patients must provide the office with any insurance changes prior to being seen.

2. Please be aware of your insurance benefits. Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to be aware of your insurance company's provisions for payment of office visits, well-child visits, immunizations, co-payments, deductibles, and co-insurance.

3. If your insurance company requires you to choose a PCP, it is your responsibility to call and change the Primary care physician.

4. Unless a financial agreement has been made, self-pay payments are due at the time of service.

5. For the convenience of our patients, we accept cash, checks, money orders, Visa, Mastercard, Discover, and American Express. Payments may also be made by credit card via the telephone.

6. All returned checks will be charged a $25 returned check fee. After two returned checks, We will no longer except personal checks on your account.

7. All forms are $20 per child per year.

The office is available during office hours to discuss charges, insurance questions, the status of your account, and to help you with any questions.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO THE TERMS LISTED ABOVE.

_____ _____

Parent/ Legal Guardian signature Relationship Date

_____

Patient Name Date of Birth

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PEDIATRIC MEDICINE, P.C.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge the Footprints Pediatric Medicine, P.C has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have any questions or complaints I may contact:

Privacy Contact
ELIZABETH DARCY, MD, OR ELIZABETH MIRAGLIA
**718-534-0505**

I also understand that I am entitled to receive updates upon request if **Footprints Pediatric Medicine, P.C** amends or changes it's Notice of Privacy Practices in a material way.

Patients Name_____

Parent/ Guardian
Signature_____

Relationship to Patient_____ Date_____

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## THIS SECTION IS TO BE COMPLETED BY FOOTPRINTS PEDIATRIC MEDICAL, P.C IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above- named patient, but was unable to because:

- Notice of Privacy Practices Given- Patient Declined to Sign
- Other (Specify)_____

| Medications | | | |
|---|---|---|---|
| **Medication** | **Reason for Taking** | **Prescribed By** | **Currently Taking?** |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

| Surgeries/Hospitalizations | | |
|---|---|---|
| **Reason/Surgery** | **Hospital/Doctor** | **Date** |
| | | |
| | | |

| Allergies |
|---|
| 1. |
| 2. |
| 3. |

| Specialist visits | Reason |
|---|---|
| 1. | |
| 2. | |
| 3. | |

| Pregnancy History | | | |
|---|---|---|---|
| Place of Birth: | ☐ Hospital _____ | ☐ Home | ☐ Other: |
| Maternal Blood Type: | | | |
| Problems in pregnancy: Check all that apply. | | | |
| ☐ Bleeding<br>☐ Diabetes<br>☐ High Blood Pressure | | ☐ GBS status (if known)<br>☐ Other: | |
| Were any medications or drugs used in pregnancy? | ☐ Yes | ☐ No | ☐ Unknown |
| ☐ Prenatal Vitamins<br>☐ Folic Acid<br>☐ Prescription | ☐ Supplements<br>☐ Alcohol<br>☐ Smoking | ☐ Other Drugs<br>☐ Other: | |

| **Delivery** | | | | |
|---|---|---|---|---|
| Term: | ☐ Full | ☐ Premature | ☐ Late | ☐ Birth Weight |
| Labor: | ☐ Induced | ☐ Spontaneous | Delivery: ☐ Vaginal | ☐ C-section |
| Were there any problems during delivery? | | | ☐ Yes ☐ No | ☐ Unknown |
| Please describe: | | | | |

| **Birth History** | | |
|---|---|---|
| Weight: | Length: | Days Spent in Hospital: |
| Did your child spend time in the NICU? | | ☐ Yes ☐ No |
| If yes, please explain: | | |
| Were there any medical concerns when the child was born? | | ☐ Yes ☐ No |
| ☐ Breathing Problems<br>☐ Birth Defect<br>☐ Feeding Problem | ☐ Jaundice<br>☐ Other: | |

| **Biological Mother** | **Biological Father** |
|---|---|
| Allergies: | Allergies: |
| Medications: | Medications: |
| Health Concerns: | Health Concerns: |
| Drug/Alcohol use: | Drug/Alcohol use: |
| Smoker: Y/N | Smoker: Y/N |

| **Sibling** | **Sibling** |
|---|---|
| Allergies: | Allergies: |
| Asthma: Y/N | Asthma: Y/N |
| Anemia: Y/N | Anemia: Y/N |
| Developmental Delays: | Developmental Delays: |

## Social History

1. Who lives in home:_____
2. Pets in home:_____
3. Smokers in home: Y/N
4. Guns in home Y/N

| **Developmental History** | | | | |
|---|---|---|---|---|
| Were you ever concerned about your child's development? | | | | ☐ Yes ☐ No |
| How was (in months) was your child when he/she began to: | | | | |
| Smile: | Roll over: | Sit: | Crawl: | Pull to Stand: |
| Walk: | Use single words: | | Make sentences: | |
| Is your child's speech delayed now? | | | | ☐ Yes ☐ No |
| Is your child in a special education program right now? | | | | ☐ Yes ☐ No |
| If so, which one? | | | | |
| Does your child currently receive any special therapy? | | | | ☐ Yes ☐ No |
| ☐ Speech (times per week):<br>☐ Physical Therapy (times per week): | | | ☐ Occupational Therapy (times per week):<br>☐ ABA Therapy<br>☐ Other _____ | |
| Do you have any concerns about your child's behavior? | | | | ☐ Yes ☐ No |
| ☐ ADHD<br>☐ ADD<br>☐ Anxiety<br>☐ Aggressive<br>☐ Autism Spectrum Disorder | | ☐ Self Injury<br>☐ Bipolar Disorder<br>☐ Depression<br>☐ Frequent Tantrums | | ☐ Hyperactive<br>☐ OCD<br>☐ PTSD<br>☐ Self-Stimulation |
| Other: | | | | |

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature _____ Printed Name _____ Date _____

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# Medical Records Release Form

| **Patient Information** | | | |
|---|---|---|---|
| Name (First, Middle, Last): | | | DOB: |
| Address: | City: | State: | Zip: |
| Phone #: | Email: | | |

## Records Request Details

| **Entity Releasing Records (Previous Pediatrician)** | | | |
|---|---|---|---|
| Entity Name: | | Contact Name: | |
| Address: | City: | State: | Zip: |
| Phone #: | Fax #: | Email: | |
| **Entity Receiving Records** | | | |
| Entity Name: **Footprints Pediatric Medicine, P.C** | | Contact Name: **Elizabeth** | |
| Address: **1023 Forest Hill Rd** | City: **Staten Island** | State: **NY** | Zip: **10314** |
| Phone #: **718-534-0505** | Fax #: 718-228-4087 | Email: **Info@Footprintspediatrics.com** | |
| **Information Release Details** | | | |
| Reason for Disclosure: | | | |
| Information to be Disclosed: Entire Medical Records | | | |

## Authorization

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial).

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____.

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named **Footprints Pediatric Medicine, P.C**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name Representative's Relationship to Patient

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# Authorization for Credit Card Use

I, **(Card Holder Name):**_____authorize **Footprints Pediatric Medicine, P.C** to charge my credit/debit card for the following:

- ☐ Copay
- ☐ School Form Fee (Once yearly -$20 per child)
- ☐ Coinsurance/ Deductible
- ☐ Any portion of billable services not covered by the client's insurance policy.
- ☐ Other

| **Credit Card Information** | | |
|---|---|---|
| Card Type: ☐ Master Card ☐ Visa ☐ Amex ☐ Discover ☐ Other | | |
| Cardholder Name (as shown on card): | | |
| Card Number: | | Security Code: |
| Expiration Date: | Zip Code: | Email: |

I,(Name)_____understand that payment is due at the time of service, including treatment expenses not covered by insurance, copayments, and school form fee. I will have the option of paying with check, cash or credit card at the time of service. If I have an outstanding balance or missed appointment, I (Name)_____authorize **Footprints Pediatric Medicine, P.C** to use this credit/debit card information as payment for services.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Patient Signature | Date | Print Name |
| _____ | _____ | _____ |
| Parent/Guardian Signature (if client is a minor) | Date | Print Name |

# NYU LANGONE HEALTH
## HEALTH INFORMATION EXCHANGE CONSENT FORM

In this Consent Form, you can choose whether to allow NYU Langone Health to obtain access to your medical records through a health information exchange ("HIE") called Healthix. Healthix is a not-for-profit organization certified and regulated by the State of New York that collects and aggregates information about the medical services you receive from different providers and makes it available electronically to the providers treating you. If you consent to share your information through Healthix on this form, you are giving your permission for employees, agents, and members of the medical staff of NYU Langone Health and affiliated entities to see and obtain access to your electronic health records from your other health care providers that are authorized to disclose information through Healthix for the purposes described in the attached fact sheet. A complete list of current authorized Healthix providers who submit clinical data to Healthix is posted on the Healthix website at http://www.healthix.org or may be obtained by calling Healthix at 877-695-4749. If you want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access your electronic health information through Healthix, you may do so by contacting Healthix at compliance@healthix.org or calling Healthix at 877-695-4749 Ext 2.

You may also use this Consent Form to decide whether or not to allow NYU Langone Health to share your medical records with your non-NYU Langone Health providers and whether to allow NYU Langone Health to access information about care provided to your by other non-NYU Langone Health providers through the following HIEs for the purposes described in the attached fact sheet: (1) Epic Care Everywhere, which is an electronic health record sharing program through Epic (the company that provides NYU Langone Health's electronic health record system), which would enable healthcare providers at other organizations that use Epic to access information in your NYU Langone Health electronic health record, (2) Carequality (carequlity.org) and (3) eHealth Exchange (ehealthexchange.org).

**THE CHOICES YOU MAKE ON THIS FORM 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.PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.**

**Your Consent Choices.** You can fill out this form now or in the future. You can change your decision in the future by contacting your NYU Langone Health provider and completing a new form. You have the following choices:

Please check one box ☑ below:

☐ 1. **I GIVE CONSENT** to ALL of the organizations, providers, and programs explained in this Consent Form to access ALL of my NYU Langone Health electronic health information **I GIVE CONSENT** to ALL employees, agents and members of the medical staffs of NYU Langone Health and affiliated entities to access ALL of my electronic health information through all of the organizations, providers, and programs explained in this Consent Form, including Healthix, Care Everywhere, eHealth Exchange and Carequality, in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services.

☐ **2. I DENY CONSENT** to the organizations, providers, and programs explained in this Consent Form, that would otherwise require my consent, to access my electronic health information in my NYU Langone Health medical record and **I DENY CONSENT** to employees, agents and members of the medical staffs of NYU Langone Health and affiliated entities to access my electronic health information through Healthix contributed by a non-NYU Langone participant 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 Healthix and the other HIEs described herein. IF YOU DON'T MAKE A CHOICE, the records will not be shared and/or accessed except in an emergency as allowed by New York State Law.

| | | |
|---|---|---|
| Print Name of Patient | Patient's Date of Birth | Date |
| Signature of Patient or Patient's Legal Representative | Print Name of Legal Representative and Type of Authority to Sign (if applicable) | |

Revised 7/2024