PEDIATRIC HEALTHCARE ASSOCIATES
615 6TH AVENUE
ALTOONA, PA 16602
Phone 814-944-7383 fax 814-944-7608
ALTOONAPEDIATRICS.COM

Office Hours
Mon, Tues, Weds, Friday 8am to 5:00pm
Thurs 8am to 6:00pm

Walk-in visits
Monday – Friday 8am to 9am

Saturday sick calls only 9:00am to 12:00pm

Our Providers

Mohamad Moussa, M.D.	Nader Younes, M.D.
Sathya Aswathappa, M.D.	Adnan Youssef, M.D.
Cara Bennett, PA-C	Natalie Aikens, PA-C

We are a group practice.
Patients will be seen in rotation by all the physicians/physician assistants.

All patients should bring the following to their appointments:
- Insurance card
- Current immunization record
- List of any and all medications

EMERGENCIES
If an emergency should arise, please call 911 or go to the nearest emergency room. Emergencies are considered to be those conditions that are life-threatening: loss of consciousness, severe bleeding, seizures, etc.

NON EMERGENCIES
In case of minor emergencies: sprains, ear pain, low grade fevers, etc. Please call the office and we will work you into the schedule as expeditiously as possible to help you avoid an ER visit.

Please join our patient portal and discover all the features offered

https://health.eclinicalworks.com/pedi

Please provide the following information:

Patient name_____DOB:_____

Parent/legal guardian email _____

PATIENT INORMATION **Today's Date:_____**

Last name _____ First name _____Initial_____

Date of Birth _____Social Security Number _____ Male/Female

Address _____

City _____State _____Zip _____

Home phone _____Cell _____

Race: □Asian □ Native American □White □Black □ Hispanic □Unknown
Previous patient of Pediatric Healthcare Associates: □Yes □No
Email address _____

INSURANCE

Primary insurance _____ Effective date_____
Subscriber (Id) number _____Group number _____
Policy Holder name _____Date of birth _____
Employer_____ Relationship to patient _____

Secondary insurance _____Effective date_____
Subscriber (Id) number _____ Group number _____
Policy Holder name _____ Date of birth _____
Employer_____ Relationship to patient _____

RESPONSIBLE PARTY

1st Parent
Last name _____ First name _____Initial___ Male/Female

Date of Birth _____Social Security Number _____Marital Status _____

Address _____

City _____State _____Zip _____

Home phone _____Cell phone _____

Employer _____Employer address _____
Employer phone number _____

RESPONSIBLE PARTY CONTINUED

2nd Parent
Last name _____First name _____Initial____ Male/Female

Date of Birth _____Social Security Number _____ Marital Status _____

Address _____City _____State_____Zip _____
Home phone _____Cell phone _____

Employer _____Employer address_____
Employer phone number _____

Emergency contact:_____**phone**_____
Address _____Relationship to patient_____

OFFICE/FINANCIAL POLICIES

IT IS IMPORTANT THAT YOU TAKE TIME TO REVIEW OUR POLICIES.

1. All new patients must complete our patient information forms prior to being seen. Established patients must update their information on a yearly basis or as information changes.

2. Please notify the office 24 hours in advance if you are unable to keep your appointment.

3. If your child has school, camp, or physical form to be completed, please allow 3 to 5 days for completion.

4. Before making an annual physical appointment, check with your insurance company. Not all plans cover annual healthy physicals, hearing and vision screenings, or immunizations. It is **YOUR** responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for any balance not covered.

5. Our office participates with many managed care insurance companies. Should your insurance coverage be with one of these companies, we will bill your insurance company along the guidelines of our contract. Co-payments, co-insurances, deductibles and non-covered services that have not been satisfied, are the responsibility of the patient.

6. To ensure accuracy when billing your insurance company, we must have a current copy of your insurance card on file. If we are unable to verify your insurance benefits you will be required to pay at the time of service. Your insurance is billed as a courtesy only and all charges including non covered services, deductibles, and co- pays are your responsibility.

7. All insurance co-pays and percentages are due on the day of the visit, if not paid on day of visit a $5.00 late fee will be added. You will be required to pay for office visits in full until your yearly deductible is met.

8. We must be notified of any changes in your insurance coverage and have the insurance verified prior to seeing the doctor. If you do change insurance carriers, please call the office prior to coming in for your appointment. This way we can have your insurance verified prior to your appointment.

9. New babies must be added to your insurance policy before any claims will be paid. Most insurance companies require that you do this within thirty days after the baby is born. Please verify this with your insurance.

10. Patient's balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of your bill. If your insurance company has not responded within ninety days from the date the claim was filed, you will be responsible for payment of the bill. In the event the insurance company pays after you have paid, you may request a refund. Any balance over 120 days will be forwarded to our collection agency.

11. You are required to notify us at the time of service if this is a visit due to a **motor vehicle accident-MVA** must be filed with your automobile insurance company. Please have your automobile insurance card available with the claim # from your insurance agent.

12. There are times when making a payment can be a financial hardship. Please advise our staff prior to your visit if you are in need of a special payment arrangement. All returned checks will be assessed a $30.00 return check fee. After two returned checks, we will no longer accept personal checks on your account.

_____ _____ _____

Parent/Legal Guardian/signature Parent/Legal Guardian printed name Date

Patient Name _____

IMMUNIZATION INFORMATION Patient name _____DOB_____

A copy of the Centers for Disease Control and Prevention Vaccine Information Statements will be provided upon request. I/We have read, or have had explained, the information about the diseases and the vaccines listed below. There is an opportunity to ask questions and have them answered satisfactorily. I/We believe that I/We understand the benefits and risks of the vaccine cited, and ask that the vaccine(s) listed on the immunization record to be given to me/us or the person named above (for whom I/We are authorized to make this request).

ABBREVIATIONS:

PENTACEL	**=**	**DTaP, Ipv, Hib (Combination Vaccine)**
KINRIX	**=**	**DTaP, Ipv**
DTaP	**=**	**Diptheria, Tetanus, and Acellular Pertussis**
IPV	**=**	**Injectable Polio**
HEP B	**=**	**Hepatitis B**
HIB	**=**	**Haemophilus Influenza**
MMR	**=**	**Measles, Mumps, and Rubella**
MMRV	**=**	**Measles, Mumps, Rubella, Varicella (combination)**
VARIVAX	**=**	**Varicella, Chickenpox**
PCV	**=**	**Pneumococcal conjugate (Prevnar 13)**
HEP A	**=**	**Hepatitis A**
MENACTRA	**=**	**Meningococcal**
MENINGOCOCCAL B	**=**	**Meningococcal B**
Tdap	**=**	**Tetanus, Diptheria, and Acellular Pertussis**
Td	**=**	**Tetanus and Diptheria**
HPV	**=**	**Human Papillomavirus**
FLU	**=**	**Influenza**

RECOMMENDED SCHEDULE FOR IMMUNIZATIONS

Birth	**Hepatitis B #1**
2 months	**Pentacel #1, Hep B #2, Prevnar 13 #1, Rotavirus #1**
	(if combination vaccine not given, Dtap #1, Ipv, #1 Hib #1)
4 months	**Pentacel #2, Prevnar 13 #2, Rotavirus #2**
	(if combination vaccine not given, Dtap #2, Ipv, #2 Hib #2)
6 months	**Pentacel #3, HepB #3, Prevnar 13 #3, Rotavirus #3**
	(if combination vaccine not given, Dtap #3, Ipv, #3 Hib #3)
Seasonal flu	**recommended age 6 months and up**
12 months	**Varicella #1, HepA #1, Prevnar 13 #4**
15 months	**Pentacel #4 MMR #1**
	(if combination vaccine not given, Dtap #4, Hib #4)
18 months	**HepA#2**
4-6 years	**Kinrix, MMR#2,Varicella #2**
11-21 years	**Tdap, Menactra, Meningococcal B, Hpv**

_____ _____

Parent/Legal Guardian signature Date

_____ _____

Print Parent/Legal Guardian name Relationship to patient

Pediatric Healthcare Associates

Notice of Privacy Practice

Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy office at the address or phone number at the bottom of this notice. This notice of Privacy describes how may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI (protected health information is about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Who will follow this notice?

Pediatric Healthcare Associates provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by any health care professional who treats you at any location, all employed associates, staff, or volunteers of our organization, and any business associate or affiliated entity with whom we share health information.

Our pledge to you

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. We are required by law to: Keep medical information about you private, give you this notice of our legal duties and privacy practices with respect to medical information about you, and follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you

We may use and disclose medical information about you for treatment. Such as: discussing or sending medical information about you with other physicians or staff, to obtain payment for treatment, sending billing information to your insurance company, comparing patient data to improve treatment methods, and analyzing data and information to determine new updated services to provide to you the patient, to contact you regarding an appointment reminder, to mail you a letter telling you of normal laboratory results.

We may use or disclose medical information about you without your prior authorization for several other reasons, including, public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies funeral arrangements, workers' compensation purposes, required by military command authorities and emergencies, response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders, to a caregiver or family member who is involved in your medical care, and disaster relief authorities so that your family can be notified of your location and condition.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

In most cases you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If your request is denied you may submit a written request for review of that decision. If you believe that information in your record is incorrect or if important information is missing you have the right to request that we correct the records by submitting a written request that provided your reason for requesting the amendment. We could deny your request to amend if the information was not created by us or if it is not part of the medical information maintained by us, or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6 year period of staring after April 14, 2003. You will receive the list on paper. The first disclosure list requested in a 12 month period is free. Other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

You have the right to request a paper copy of this notice at any time.

You may request in writing, that we not use or disclose medical information about you for treatment, payment, or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We ill consider your request but we are not legally required to accept it. We will inform you of our decision. All written requests or appeals should be submitted to our Privacy Office listed at the bottom of this notice.

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer.

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.

Under no circumstances will you be penalized or retaliated against for filing a complaint.

Acknowledgment of Receipt of Notice of Privacy Practices
Version effective April 14, 2003

_____ _____

Signature Date

_____

Printed name

Right to make complaints

Please submit your complaint or question in writing to :
Privacy Officer
615 6th Avenue
Altoona, PA 16602

PEDIATRIC HEALTHCARE ASSOCIATES

Consent to obtain external prescription history

I, _____, whose signature appears below, authorize Pediatric Healthcare Associates to view my (my child's) external prescription history via our electronic health record system, eClinical Works.

I understand that prescription history form multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions back in time several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

PLEASE LIST ALL CHILDREN

PATIENT NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PARENT/LEGAL GUARDIAN_____

IF OVER 18 _____

□ I **DO NOT** consent to my provider accessing any of my (my child's) medication history

FAMILY HISTORY

PATIENT NAME_____ Date of Birth _____

	ALIVE	DECEASED	UNKNOWN
FATHER	☐	☐	☐
MOTHER	☐	☐	☐
SIBLINGS	☐	☐	☐

Immediate family history ONLY

	FATHER	MOTHER	SIBLINGS
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Hypertension	☐	☐	☐
Heart disease	☐	☐	☐
Stroke	☐	☐	☐
Mental Illness	☐	☐	☐
Cancer	☐	☐	☐
Unknown	☐	☐	☐

PLEASE PROVIDE THE NAMES OF SIBLING WITH ANY OF THE ABOVE HISTORY

- _____DOB:_____
- _____DOB:_____
- _____DOB:_____
- _____DOB:_____
- _____DOB:_____
- _____DOB:_____