CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES

179 ROSELAND AVENUE
WATERBURY, CONNECTICUT 06710
Phone (203) 574-4747
Fax (203) 755-3109

Permission Form

DATE: ____

PATIENT: ____

I, __________________________________ give my permission for the following people to authorize immunizations and medical treatment for my child in my absence.

1. _______________________________ RELATIONSHIP _______________________________

2. _______________________________ RELATIONSHIP _______________________________

3. _______________________________ RELATIONSHIP _______________________________

PRINTED NAME: ____

SIGNATURE: ____ DATE: ________________________

CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES (CAHCA)

PATIENT / PARENT CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I, ___________________________________, understand that as part of my child's health care, CAHCA originates and maintains paper and / or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as: *A basis for planning my child's care and treatment. *A means of communication among the many health professionals who contribute to my child's care. *A source of information for applying my child's diagnosis and surgical information to my bill. *A means by which a third party payer can verify that services billed were actually provided. *A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: *The right to review the notice prior to signing this consent. *The right to object to the use of my child's health information for directory purposes. *And the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that CAHCA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CAHCA reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CAHCA change their notice, they will send a copy of any revised notice to the address I have provided (whether by US Mail or, if I agree, by E-Mail).

I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my child's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

PARENTS' SIGNATURES: ____

DATE: _______________________________________

CHILD'S NAME: ____

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DATE: ____

DEAR PATIENTS:

WE ALL DEPEND UPON INSURANCE TO COVER OUR MEDICAL EXPENSES.

Recently, we have had problems being paid by insurance companies, because patient families have not provided information about additional insurance coverage. Insurance companies and the State Insurance Commission have very strict rules about how health insurance may be used.

For instance, if a person is covered by more than one insurance, both insurances must be considered. Neither you nor we can pick and choose which one to use. You must provide us with all insurance information, so that the correct insurance company handles the reimbursement. Not revealing a second insurance is dishonest and could lead to penalties, such as loss of coverage or dismissal from the practice.

A non-custodial parent often has insurance that covers that person's children, and must be included. Divorce does not change insurance coverage rules.

Please review the information you have provided and be sure that it is complete. Then, please sign the following:

I, _____________________________, have provided complete insurance information to CAHCA, and I understand that I may be responsible for payment of medical bills, if I have failed to provide complete information about all insurances covering my children.

CHILD'S NAME: ____

PARENT / GUARDIAN SIGNATURE: ____

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Child and Adolescent Health Care Office Policy

Due to rising costs, we will no longer be able to extend credit. This policy will take effect immediately. The method of payment will be cash, check, or credit card.

IF YOU DO NOT HAVE INSURANCE

We have three methods of payment – CASH, CHECK or CREDIT CARD. The bill is to be paid on the day the services are rendered. We will no longer be able to bill you.

PRIVATE INSURANCE

Visits and co-pays are to be paid on the day services are rendered by cash, check, or credit card. You are responsible to inform us of ALL the insurance information, including insurance cards and primary carrier. We will submit to your insurance company.

CO-PAYS

Co-payments are to be paid at the time of service by CASH, CHECK, or CREDIT CARD. Failure to pay your co-pay may result in a letter to your insurance company. Co-payments are YOUR responsibility. When your Maximum or your contract limit has been met, all future visits are to be paid at the time of service.

If there are any extenuating circumstances or a financial hardship, you are to contact this office immediately prior to your visit to work out a financial arrangement that is agreeable to both parties.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the physicians to provide from their record any information including substance abuse or other confidential information requested by my insurance company, or other third party payers, in connection with payment for incurred charges. I also authorize the physicians to provide information from my medical records to any utilization and/or quality review organization affiliated with my insurer for use in utilization management.

I agree to pay all charges incurred by me. I assign any insurance benefits to which I may be entitled to the physicians providing the services. I understand that I am responsible for any charges not covered by this assignment.

PARENT'S SIGNATURE: ____ **DATE:** _______________

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Dear Patient / Parent(s),

We are glad that you have chosen us to provide your medical care, but if you MISS YOUR APPOINTMENTS, that care is compromised as is our ability to provide quality care to others.

A doctor / patient relationship is built on mutual trust and respect. As such, we stive to provide quality care during your scheduled appointments and we ask that you give us the courtesy of a call when you are unable to keep your appointments.

A missed appointment is when you fail to show up for an appointment without a phone call or cancel within 24 hours' notice.

By scheduling an appointment with our office, you agree to the terms our

MISSED APPOINTMENT* POLICY

1. FIRST MISSED APPOINTMENT: We will reschedule this appointment. You may be charged a missed appointment fee of $50.00. You will receive a written notice of your missed appointment.
2. SECOND MISSED APPOINTMENT: May result in a $50.00 fee. You will receive a written notice of your missed appointment and no well visits will be scheduled until the matter is resolved. It is YOUR responsibility to call our office to discuss and resolve the matter.
3. THIRD MISSED APPOINTMENT: May result in a $50.00 fee and we may immediately terminate our relationship as your child's / children's physician and your child / family will no longer be a patient of our practice.

* ANY SCHEDULED APPOINTMENT FOR YOUR CHILD / CHILDREN: SUCH AS A WELL VISIT, BEHAVIORAL, SCHOOL PHYSICAL / MEDICATION FOLLOW UP AND/OR SICK VISIT.

I, THE RESPONSIBLE PARTY BELOW, ACKNOWLEDGE AND UNDERSTAND THE TERMS ABOVE AND THAT ANY MISSED APPOINTMENT FEES ARE NOT COVERED BY MY PRIVATE / HUSKY INSURANCE AND WILL BE MY RESPONSIBILITY TO PAY.

PATIENT'S / PATIENTS' NAME(S): ____

PARENT'S NAME: ____

SIGNATURE: ____ DATE: ____________________

NO PATIENT WILL BE DENIED URGENT CARE WHILE A PATIENT OF THIS PRACTICE OF THE SAME IS NECESSARY IN THE MEDICAL DETERMINATION OF THE PRACTICE.

CONNECTICUT VACCINE PROGRAM (CVP)

Patient Eligibility Screening Record

Child's Name:____

Date of Birth:____

Parent/Guardian:______________________________________

Provider:____

This child qualifies for immunization through the Connecticut Vaccine Program since he/she is under 19 years of age and (check only one box):

VFC eligible:

(A) Is enrolled in Medicaid (HUSKY A) ☐

(B) Has no health insurance/self-pay ☐

(C) Is American Indian or Alaskan Native ☐

(D) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a Federally Qualified Health Center (FQHC). These patients can receive all vaccines at their FQHC. ☐

State eligible:

(E) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a private health care provider. These patients can receive all vaccines at their private health care provider's office. ☐

(F) Is enrolled in S-CHIP (HUSKY B) ☐

(G) *Is Privately Insured ☐

*Note private insurance patients can receive all vaccines from the CVP except for Human Papillomavirus Vaccine (HPV) for 9-10 & 13 through 18 year olds. These vaccines are only available for patients in categories A, B, C, D, E & F.

A record must be kept in the healthcare provider's office (paper copy or in an EHR/EMR) that reflects the status of all children 18 years of age and younger who receive vaccine from the CVP.

Patient Eligibility must be verified and documented for **every immunization visit**. Please document that eligibility screening was verified with the initials of the person who performed the screening. If the screening result above (A-G) changed, please complete a new patient eligibility screening record.

Date of screening (mo/day/year)	Initials

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