

# CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES

Today's Date \_\_\_\_\_ Patient over 18 - Cell phone # \_\_\_\_\_

Child's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Child's D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_

Child's Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Child Lives With: \_\_\_\_\_ Patient  
Email \_\_\_\_\_

Child's Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Ins. Subscriber \_\_\_\_\_

Child's Race: American Indian/Alaskan Asian Black White Hispanic Native Hawaiian/Other

---

Mother's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Parent/Guardian  
Email \_\_\_\_\_

Father's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Parent/Guardian  
Email \_\_\_\_\_

Other Adult in the Home \_\_\_\_\_

---

Emergency contact

Other than parent \_\_\_\_\_

Phone: \_\_\_\_\_ relationship \_\_\_\_\_

Child's siblings \_\_\_\_\_

---

\* **FAMILY HISTORY** - Please indicate the affected persons' relation to the patient such as:

Child's Mother = M    Child's Father = F    Sister = S    Brother = B

Mother's Mother = MGM    Father's Mother = PGM    Mother's Father = MGF    Father's Father = PGF

Please give any helpful details, such as name of particular condition, severity, age of onset, etc.

Birth/Genetic defects \_\_\_\_\_

Mental Retardation \_\_\_\_\_

Convulsions/Epilepsy \_\_\_\_\_

Asthma \_\_\_\_\_

Allergies \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_

Heart problems \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Kidney problems \_\_\_\_\_

Digestive problems (ulcer, colitis) \_\_\_\_\_

Other \_\_\_\_\_

\* **FAMILY HABITS** - Mom, Dad, other household member(s)

Smoking \_\_\_\_\_

Alcohol \_\_\_\_\_

Drug Abuse \_\_\_\_\_

\* **PARENTS' HEALTH**

Mother's Age \_\_\_\_\_, health status

Father's Age \_\_\_\_\_, health status

\* **MOTHER'S PREGNANCY HISTORY**

Pregnancy number this child \_\_\_\_\_ Obstetrician's Name \_\_\_\_\_

Number of children now \_\_\_\_\_

Problems or illnesses during this pregnancy \_\_\_\_\_

Medications during this pregnancy \_\_\_\_\_

Delivery Type \_\_\_\_\_

Labor or delivery problems \_\_\_\_\_

**Parent Signature** \_\_\_\_\_

# 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: \_\_\_\_\_

# CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES

179 ROSELAND AVENUE  
WATERBURY, CONNECTICUT 06710

Phone (203) 574-4747

Fax (203) 755-3109

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: \_\_\_\_\_

# CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES

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

## 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: \_\_\_\_\_

# CHILD AND ADOLESCENT HEALTH CARE ASSOCIATES

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

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 strive 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 with 24 hours' notice.

By scheduling an appointment with our office, you agree to the terms of 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 IF THE SAME IS NECESSARY IN THE MEDICAL DETERMINATION OF THE PRACTICE.**

**CHILD AND ADOLESCENT  
HEALTH CARE ASSOCIATES, P.C.**

179 Roseland Avenue • Waterbury, Connecticut 06710  
Phone (203) 574-4747 • Fax (203) 755-3109

**VACCINE POLICY**

Vaccines are essential to keep our patients and community safe. We believe it is important to vaccinate against preventable diseases according to the well-studied CDC schedule of immunizations. We firmly believe that all recommended vaccines are safe and effective.

We are excited that you would like to join our practice, and we require that you vaccinate your child according to the CDC schedule with all required vaccines for CT Public Schools (see attached). We do not make exceptions for personal, religious, or philosophical objections for required vaccines.

Additionally, highly recommended vaccines include Flu, HPV, Rotavirus, Meningitis B.

By signing below, you understand and agree to our policy.

Patient \_\_\_\_\_

Name of Parent / Guardian \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

By signing below, you understand and agree to our policy.

Patient \_\_\_\_\_

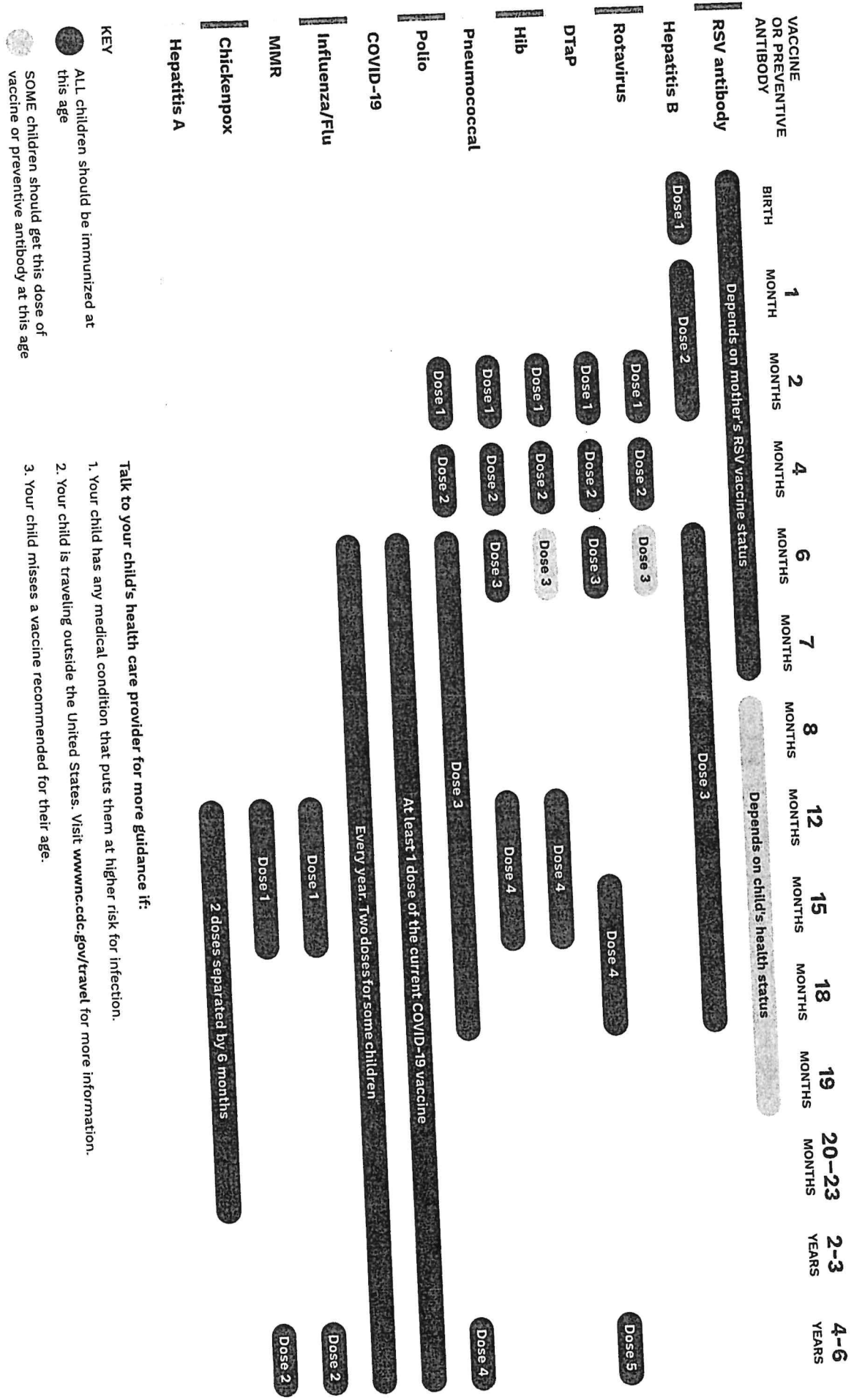
Name of parent /guardian \_\_\_\_\_

Signature of  
parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Your child needs vaccines as they grow!

## 2025 Recommended Immunizations for Birth Through 6 Years Old

Want to learn more?  
Scan this QR code to find out which vaccines your child might need. Or visit [www2.cdc.gov/vaccines/childdquiz/](http://www2.cdc.gov/vaccines/childdquiz/)

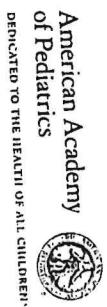


**KEY**  
 ALL children should be immunized at this age  
 SOME children should get this dose of vaccine or preventive antibody at this age

- Talk to your child's health care provider for more guidance if:**
1. Your child has any medical condition that puts them at higher risk for infection.
  2. Your child is traveling outside the United States. Visit [www.nccdc.gov/travel](http://www.nccdc.gov/travel) for more information.
  3. Your child misses a vaccine recommended for their age.



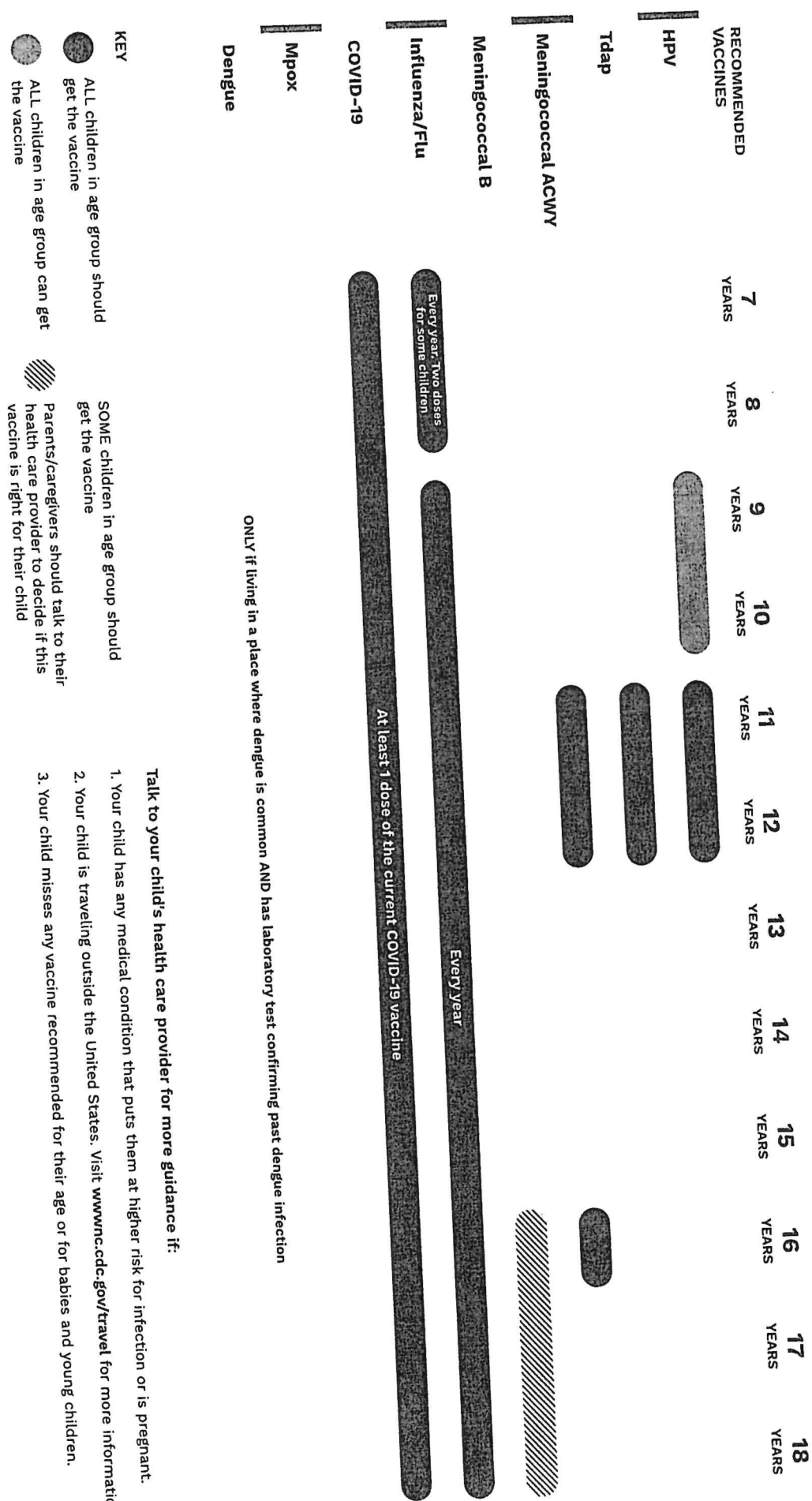
**FOR MORE INFORMATION**  
 Call toll-free: 1-800-CDC-INFO (1-800-232-4636)  
 Or visit: [www2.cdc.gov/vaccines/childdquiz/](http://www2.cdc.gov/vaccines/childdquiz/)



# Older children and teens need vaccines too!

## 2025 Recommended Immunizations for Children 7-18 Years Old

Want to learn more?  
Scan this QR code to find out which  
vaccines your child might need. Or visit  
[www2.cdc.gov/vaccines/childquiz/](http://www2.cdc.gov/vaccines/childquiz/)



**FOR MORE INFORMATION**  
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)  
Or visit: [www2.cdc.gov/vaccines/childquiz/](http://www2.cdc.gov/vaccines/childquiz/)

