UB|MD PEDIATRICS

THE PHYSICIANS AT
Oishei Children's Hospital

DIVISION OF ENDOCRINOLOGY/DIABETES

Welcome to the Division of Endocrinology/Diabetes. Our goal is to deliver the best care to children with diabetes and endocrine disorders in Western New York and beyond, while bringing to them the latest in research development.

We Treat:

- Short stature & growth disorders
- Thyroid & adrenal conditions
- Disorders of pubertal development & sexual differentiation
- Bone health & disorders of calcium metabolism
- Overweight & obesity
- Type 1 & type 2 diabetes

Attending Endocrinologists & Advanced Practice Provider

Attendings are members of the faculty at the University at Buffalo and are board certified in both Pediatrics and Pediatric Endocrinology. They are responsible for your child's care.

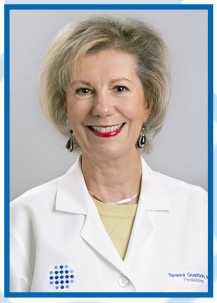
Lucy Mastrandrea, MD, PhD
Division Chief

Kathleen Bethin, MD, PhD

Robert Borowski, DO

John Buchlis, MD

Indrajit Majumdar, MBBS



Teresa Quattrin, MD

Casey Wild, RN, CPNP

In order to continue being the best health care provider in the community, we would appreciate you taking a few minutes to complete our confidential patient satisfaction survey you will receive when you check in. Please drop off the completed survey in the locked box located in the waiting room before you leave. We take your opinion very seriously and strive for continuous improvement and excellence; so if you cannot give us the highest rating, please tell us now and tell us why. That way we can make changes right away to fit you and/or your child's special needs.

Outpatient Centers	Contact Information	About Us
Conventus 1001 Main Street, 4th Floor Buffalo, NY 14203 **University Commons** 1404 Sweet Home Road, Suite 5 Amherst, NY 14228 **Southwestern Office Park** 4535 Southwestern Blvd., Suite 712 Hamburg, NY 14075	**Endocrinology:** **716.323.0170** **Diabetes:** **716.323.0160** **716.323.0297** **UBMDPediatrics.com**	UBMD Pediatrics is one of 18 practice plans within UBMD Physicians' Group. We provide premier health care to infants, children, adolescents, and young adults throughout Western New York and beyond. Our doctors make up the academic teaching faculty within the Department of Pediatrics at the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo and are also the physicians at Oishei Children's Hospital.

UB|MD PEDIATRICS

DIVISION OF ENDOCRINOLOGY/DIABETES
1001 MAIN STREET, 4TH FLOOR
BUFFALO, NY 14203
ENDOCRINOLOGY: 716.323.0170 | DIABETES: 716.323.0160 | F: 716.323.0297

Patient Name: _____ Date of Birth: _____

Dear Parent/Guardian,

Please answer the following questions, which are an important part of your child's evaluation. Please bring this form with you to your child's visit. We appreciate your assistance.

Patient's Mother's History

How many pregnancies have you had? _____ How many living children? _____

Any childhood deaths in the family? ☐ No ☐ Yes (Cause of death: _____)

Length of pregnancy with this child: ☐ Full-term ☐ Premature (_____ weeks) ☐ Post-term

While pregnant, did you use:

Medication (hormones, antibiotics, etc.): _____

Alcohol: ☐ No ☐ Yes Cigarettes: ☐ No ☐ Yes Other Drugs: ☐ No ☐ Yes

Did you require fertility treatment to become pregnant? ☐ No ☐ Yes

Complications during pregnancy:

Infections: ☐ No ☐ Yes High blood pressure: ☐ No ☐ Yes

Diabetes: ☐ No ☐ Yes Other complications: ☐ No ☐ Yes, explain: _____

Weight gain: _____ Length of labor: _____

Type of delivery: ☐ Vaginal ☐ C-Section Hospital your child was born: _____

Birth History

Birth weight: _____ Birth length: _____

Breathing problems: ☐ No ☐ Yes Jaundice: ☐ No ☐ Yes Abnormal blood work: ☐ No ☐ Yes

Regular nursery or intensive care unit? _____

Other problems? _____

Growth and Development

Any problems during the first month of life? ☐ No ☐ Yes, explain: _____

How old was your child when he/she:

Walked:	Toilet Trained:
Talked:	School Grade:
1st Tooth:	

Illnesses

Please list your child's serious illnesses and the date they occurred (include any medications):

_____

_____

_____

Was your child ever hospitalized? ☐ No ☐ Yes, list why, when and where:

_____

_____

_____

Family History

Family Member	Age	Height	Weight	Onset of Puberty (male: age began shaving; females: age of menses)	Health Problems
Father					
Mother					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Paternal Grandmother					
Paternal Grandfather					
Maternal Grandmother					
Maternal Grandfather					

If your child is evaluated for short or tall stature, please list the height and weight of:

Family Member	Height	Weight
Paternal Aunt/Uncle		
Paternal Aunt/Uncle		
Paternal Aunt/Uncle		
Maternal Aunt/Uncle		
Maternal Aunt/Uncle		
Maternal Aunt/Uncle		

Family History (continued)

Do you have any family members with:

Diabetes ☐ No ☐ Yes (insulin, pills & who: _____)

Heart attack ☐ No ☐ Yes (deceased & who: _____)

High blood pressure ☐ No ☐ Yes (who: _____)

High cholesterol ☐ No ☐ Yes (who: _____)

Thyroid problems ☐ No ☐ Yes (who: _____)

Other ☐ No ☐ Yes (what & who: _____)

Tell Us About Your Child

Who does your child live with? _____

What activities does your child participate in? _____

_____

_____

Are there any stressors at home or school that we should know about? _____

_____

_____

Please list the patient's Primary Physician/Pediatrician and any other specialist(s) seen:

Thank you for taking the time to fill out this form. The information is very important in determining a diagnosis and treatment plan for you or your child.

This form was completed by (your name): _____

Your relationship to patient: _____

For Office Use Only:

I have reviewed the information above.

Provider signature: _____ Date: _____

UB|MD PEDIATRICS

SERVICES FORM

PATIENT NAME: _____

PHONE #: _____

SECONDARY PHONE #: _____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION (i.e. SPOUSE, GRANDPARENT, FRIEND)

EMERGENCY CONTACT NAME: _____

PHONE #: _____

RELATIONSHIP TO CHILD: _____

RACE (PLEASE CHECK)

_____ BLACK AFRICAN AMERICAN

_____ ASIAN AMERICAN

_____ AMERICAN INDIAN, ALASKA NATIVE

_____ CAUCASIAN

_____ NATIVE HAWAIIAN, OTHER PACIFIC ISLANDER

_____ UNKNOWN

_____ OTHER (PLEASE SPECIFY): _____

ETHNICITY (PLEASE CHECK ONE)

_____ HISPANIC OR LATINO

_____ NOT HISPANIC OR LATINO

_____ UNKNOWN

PRIMARY LANGUAGE (PLEASE CHECK ONE)

_____ ENGLISH

_____ BURMESE

_____ SPANISH

_____ RUSSIAN

_____ OTHER (PLEASE SPECIFY): _____

UB|MD PEDIATRICS

Date: _____

CONSENT FOR TREATMENT

Patient Name: _____

Parent or Guardian (if patient is under 18): _____

I hereby voluntarily consent to and/or authorize the performance of medical examinations, treatments, diagnostic procedures, blood tests, and/or laboratory procedures, which the doctor(s) in attendance at the UBMD PEDIATRICS OUTPATIENT CENTER considers medically necessary and/or appropriate.

I acknowledge that no guarantees have been made as to the effect of such examinations or treatments on my or my child's condition.

This consent will remain in effect for as long as the patient remains a client of the UBMD Pediatrics Outpatient Center.

_____ _____

Patient or Parent/Guardian Signature | Parent/Guardian Relationship to Patient

_____ _____

Witness | Date

UB|MD PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of UBMD Pediatrics' Notice of Privacy Practices.

_____

Signature

_____

Name or Personal Representative

_____

Date

_____

Relationship to Patient

**********FOR OFFICE USE ONLY**********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify: _____)

UB|MD PEDIATRICS

HIPAA

(Health Insurance Portability and Accountability Act)

AUTHORIZATION TO SHARE PHI

Disclosure of Protected Health Information

You have a right to request that we share certain information about your health care with family members or friends that may be involved in your care. You may also request limitations on how we disclose information about you to family or friends involved in your care. We will not share information such as test results, prescription refills, or appointments with anyone unless you authorize us to do so. Please indicate below with whom we may share certain health information. You also have the right to revoke this authorization, in writing, at any time.

PATIENT INFORMATION

Patient Name: _____ DOB _____/_____/_____

Telephone (daytime): _____ (evening): _____

AUTHORIZATION REQUESTED (With whom can we share health information?)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

WHAT KIND OF HEALTH INFORMATION ARE YOU AUTHORIZING US TO SHARE?

Please place an X next to the information that can be shared:

_____ Make appointments for me
_____ Test results can be shared
_____ Call for prescription refills
_____ My overall health status

Other (Please specify: _____)

NOTIFICATIONS

With my consent, UBMD Pediatrics may call my home or other designated location, including those listed on my demographic page, and leave a message on voicemail, answering machine or in person in reference to items, such as appointment reminders, insurance information. Any restrictions are listed below:

_____

PATIENT UNDERSTANDING AND SIGNATURE

By signing below I am authorizing UBMD Pediatrics to share the indicated health information with those listed above.

_____ _____
Signature Patient Name or Personal Representative

_____ _____
Description of Personal Representative's Authority Date

UB|MD
PHYSICIANS' GROUP

MyUBMD
Pediatric Proxy Access Request

Please read this form carefully before signing. This authorization will permit your healthcare provider to release portions of your electronic medical record information to you, as a parent or legal guardian. The use of MyUBMD Patient Portal powered by FollowMyHealth is voluntary.

As a proxy for your child (ages 0-12 years), you will have access to his/her medical record and the ability to send messages to providers, refill prescriptions and request appointments.

As a proxy for your child (ages 13-17 years), you will only have the ability to send messages to providers, refill prescriptions and request appointments. New York State law requires that your child's healthcare providers keep information about certain protected health conditions confidential even from you. As part of our compliance with this law, we refrain from passing medical record updates from your child's record after he/she reaches the age of 13.

On your child's 18th birthday, he/she will be able to create his/her own account to have access to his/her own medical record. On your child's 18th birthday, the parent or legal guardian will only be able to access historical data and can no longer message providers.

Both parents/legal guardians are allowed to have access to the FollowMyHealth patient portal. Please note that the patient's information will be accessed through your MyUBMD account.

Return completed forms to the healthcare provider from whom this form was obtained.

Child's Information (All sections required—Please print clearly.)

Patient's Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Your (Proxy) Information (All sections required—Please print clearly.)

Your Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Relationship to Patient (Circle one): Parent Guardian

FollowMyHealth Terms and Conditions: I certify that I am the birth/adoptive parent or legal guardian of the individual listed above and that all information I have provided is correct.

_____/_____/_____

Your (Proxy) Signature | Relationship to Patient | Date

The use of MyUBMD is governed by the FollowMyHealth Proxy Terms and Conditions of Use, a copy of which may be accessed when you sign in to your FollowMyHealth account and whose terms are incorporated herein. By signing above, you agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use. If, for any reason, you do not agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use, FollowMyHealth proxy access will immediately be terminated. Following termination, you have the right to request in writing health information which you are legally entitled to access in accordance with New York law. If, at any time after proxy access is granted, your relationship to the patient changes such that you no longer have the legal right to access his/her health information, you will immediately cease accessing any information regarding the patient in FollowMyHealth chart and notify your healthcare provider's office of the change of circumstances.

SECURITY CODE/PASSWORD IS PATIENT'S BIRTH YEAR: _____

UB|MD
PHYSICIANS' GROUP

MyUBMD
Adult Proxy Access Request

Please read this form carefully before signing. This authorization will permit your healthcare provider to release portions of your electronic medical record information to the person listed on page 1 of this form. I understand that the use of MyUBMD Patient Portal powered by FollowMyHealth is voluntary. I am not required to use MyUBMD or authorize a proxy.

This form is an authorization that will permit your healthcare provider to release your (patient) electronic medical record information to the adult you have designated and authorized to access your MyUBMD FollowMyHealth account. You have the opportunity to opt out of or revoke the access at any time.

To request access to the record of an adult through MyUBMD, please complete this form. The patient whose information you are requesting to access must sign this form. Please note that the patient's chart will be accessed through your MyUBMD account.

Return completed forms to the healthcare provider from whom this form was obtained.

Patient's Information (All sections required—Please print clearly.)

Patient's Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Your (Proxy) Information (All sections required—Please print clearly.)

Your Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Access Level (Circle one): Full Access Read Only

FollowMyHealth Terms and Conditions: I hereby designate the person named above as my FollowMyHealth proxy, thereby allowing him/her access to my FollowMyHealth medical record.

_____/_____/_____
Signature of Patient or Authorized Person | Relationship to Patient | Date

_____/_____/_____
Your (Proxy) Signature | Relationship to Patient | Date

The use of MyUBMD is governed by the FollowMyHealth Proxy Terms and Conditions of Use, a copy of which may be accessed when you sign in to your FollowMyHealth account and whose terms are incorporated herein. By signing above, you agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use. If, for any reason, you do not agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use, FollowMyHealth proxy access will immediately be terminated. Following termination, you have the right to request in writing health information which you are legally entitled to access in accordance with New York law. If, at any time after proxy access is granted, your relationship to the patient changes such that you no longer have the legal right to access his/her health information, you will immediately cease accessing any information regarding the patient in FollowMyHealth chart and notify your healthcare provider's office of the change of circumstances.

SECURITY CODE/PASSWORD IS PATIENT'S BIRTH YEAR: _____

UB|MD PEDIATRICS

FINANCIAL POLICY

We are committed to providing you with the best care, and we are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

At the time of service, **ALL PATIENTS** must present the following documentation:

1. PATIENT'S current insurance card

2. In accordance with HIPAA regulations, we maintain the right to request social security numbers; however, you have the right to decline to give the information.

Our receptionists will ask you to verify information at each visit. You will also be asked to confirm current address and phone number. We accept **CASH, PERSONAL CHECKS, MONEY ORDERS, VISA, & MASTERCARD** for all out-of-pocket expenses which include copayments, deductibles, and balances due. These expenses cannot legally be waived by our practice, as it is part of the contract between you and your carrier.

1. **INSURANCE PROGRAMS THAT CONTRACT DIRECTLY WITH US:** Blue Cross/Blue Shield, Independent Health, Univera, United HealthCare, Medicare, Medicaid, Community Care, Medisource, Your Care, and Fidelis.

   - You are responsible for understanding the policy you have chosen and for providing our office with all necessary billing information.

   - COPAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT. If you do not have your copayment at the time of your visit, you may be asked to reschedule your appointment.

2. **IF YOU DO NOT HAVE INSURANCE OR BELONG TO AN INSURANCE PROGRAM THAT DOES NOT CONTRACT DIRECTLY WITH US, YOU WILL BE EXPECTED TO PAY THE FOLLOWING FEES AT THE TIME OF SERVICE:**

   - $256 as a down payment for a visit as a NEW patient. Depending on the level of services you received, you may owe more or less than this amount. If you do not have this payment at the time of service, you may be asked to reschedule your appointment. At the time of service, our financial policy and the amount due should be explained to you and noted on your registration.

     PLEASE NOTE: The first time consulting with a sub-specialist is considered a new visit, even if your child may have received a consultation from another UBMD Pediatrics sub-specialty in the past.

   - $78 for a visit as an ESTABLISHED patient. Depending on the level of services performed, you may owe more or less than this amount. If you do not have this payment at the time of service, you may be asked to reschedule your appointment. Our financial policy and the

amount due at the time of service should be explained to you and noted on your registration.

If the total charges for the date of service are more than what you paid at the time of service you will be responsible for the difference.

If the total charges are less than what you paid at the time of service you will be refunded the difference within 30 days.

If UBMD Pediatrics does not contract directly with your insurance company, the Billing Department will submit a courtesy claim to your insurance company. You will need to contact your insurance company to ensure prompt payment. The balance will remain your obligation.

PLEASE NOTE: A $30 fee will be applied for ALL RETURNED CHECKS.

3. MEDICAID MANAGED CARE AND MEDICAID PROGRAMS

- Every Managed Care/Medicaid patient must show a current Medicaid card at the time of service.

- If your insurance plan requires a current referral, you are required to provide our office with a current referral PRIOR to your appointment date. IF YOU DO NOT PROVIDE US WITH THIS INFORMATION, YOUR APPOINTMENT MAY BE RESCHEDULED.

4. APPOINTMENT CANCELLATION POLICY

We require a 48-hour notice of cancellation for all scheduled appointments. If you fail to notify this office, you may be charged $35.

You will receive a billing statement for balances that are not paid. Payment is expected upon receipt of statement. Accounts with outstanding balances will be forwarded to our collection agency as necessary.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our business office by calling 716.932.6060 ext. 102. This will avoid misunderstandings and enable you to keep your account in good standing.

We are not party to any legal agreement between divorced or separated parents. Any financial arrangements between divorced or separated parents must be worked out between those parties.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES, AND I AGREE TO ACCEPT RESPONSIBILITY FOR ANY FINANCIAL OBLIGATIONS INCURRED.

_____ _____

Signature Date