PEDIATRIC ASSOCIATES OF WESTMORELAND

Patients Name: _____

Patients Date of Birth: _____

Patients Gender: MALE OR FEMALE

Patients Address: _____

_____

Patients Home Phone: _____

Patients Cell Phone: _____

Okay to text message to confirm? YES OR NO

Patients Email: _____

Patients Pharmacy (City, Location, and Phone Number):

_____

Patients Ethnicity: HISPANIC or NON – HISPANIC

Patients Language: ENGLISH, FRENCH, GERMAN, VIETNAMESE, ITALIAN,

MANDARIN, SPANISH, ARABIC

Patients Race: ASIAN, BLACK OR AFRICAN AMERICAN, AMERICAN INDIAN OR ALASKA NATIVE,

CAUCASIAN, HISPANIC, NATIVE AMERICAN, OTHER_____

Pediatric Associates of Westmoreland
Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

I, _____, the parent/legal guardian of the below named child

Name of Child:_____ Date of Birth:_____ Sex:_____

Patient Address:_____ City:_____ Zip code:_____

hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Associates of Westmoreland. I acknowledge that I have received the Notice of Privacy Practices for Pediatric Associates of Westmoreland. In addition, I give permission for the following person(s) to bring my child to PAW in my absence and to act in my behalf in authorizing medical care and treatment that may be involved in the healthcare of the patient. In the event of emergency or other illness, I understand that the physicians and staff of PAW will deliver any medical care deemed necessary regardless of the accompanying adult. For patients who reside with only one parent or guardian/foster care/non-biological caregivers, a current custody agreement must always be on file to ensure proper contacts.

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #: _____

Our offices use our Electronic Medical Records (EMR) system to notify patients of upcoming appointments, and remind you of routine well visits, etc. Please tell us how you want to be notified, either by phone and/or email. The EMR system will attempt to reach contact number 1 first and then attempt contact number 2 if contact number 1 cannot be reached.

Contact number 1:

Name:_____ Your preference: text or email (circle)

Phone number:_____ and/or email:_____

Contact number 2:

Name:_____ Your preference: text or email (circle)

Phone number:_____ and/or email:_____

Authorization to Bill Insurance

Insurance Name: _____

Policy Holder Name: _____

Insurance ID: _____

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Pediatric Associates of Westmoreland to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I further understand that excessively overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that this authorization shall remain valid for (1) year of date signed.

Patient/Parent/Guardian Signature: _____Date: _____

*******BELOW IS FOR PEDIATRIC ASSOCIATES USE ONLY*******

I have offered the above named patient/representative with the Pediatric Associates of Westmoreland Notice of Privacy Practices and they have accepted_____ or refused_____ delivery (and/or patient/representative was asked to sign form and refused_____).

Signature of Pediatric Associates Representative:_____ Today's Date:_____

Revised 12/22/2021

AUTHORIZATION FOR VACCINES

Childs Name: _____ DOB: _____

I _____ give permission for the following named person(s) to consent to vaccines or sign a refusal to vaccinate form on my behalf if I am not present for the appointment. **If parents/ legal guardians are the only one that is capable of making these decisions please indicate below by marking "none" on the first line.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Parent/ Guardian Signature Date

_____ _____

Witness

PEDIATRIC ASSOCIATES OF WESTMORELAND

Patient's Name: _____ Sex:_____

Date of Birth: _____ Social Security #: _____

Phone #: _____ Email Address: _____

Home Address: _____ City: _____

State: _____ Zip: _____

Father's Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Father's Address: _____ City: _____

State: _____ Zip: _____

Father's Employer: _____ Phone #: _____

Employer's Address: _____

Mother's Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Mother's Address: _____ City: _____

State: _____ Zip: _____

Mother's Employer: _____ Phone #: _____

Employer's Address: _____

Please List all siblings and their date of births: _____

_____

Pediatric Associates of Westmoreland

Initial Assessment

Patients Name: _____ Date of Birth: _____ □ Male □ Female

History to be completed by caretaker. Please print & sign caretakers name:

_____

Please fill out as much as applicable for the patient and patient's family. Thank You.

THIS SECTION SHOULD ONLY BE COMPLETED AT THE VERY FIRST VISIT ONLY!

Pregnancy History

1. Mother's age at child's birth? _____
2. Prenatal care began at _____ Months
3. Did mother have any medical problems during this pregnancy? □ Yes □ No
4. Were any medication/drugs used during this pregnancy? □ Yes □ No
5. Did mother smoke or drink during this pregnancy? □ Yes □ No

Birth History

1. Was baby a vaginal delivery or a c-section?
2. Birth weight _____ Length _____
3. Did baby breathe right away? □ Yes □ No
4. Did baby have trouble in hospital? □ Yes □ No
5. Was baby born: □ on time □ early □ late
6. Where was baby born? _____
7. Did baby get Hepatitis B vaccine in the hospital? □ Yes □ No
   If yes, please list date: _____
8. Does baby need a repeat PKU Test?
   □ Yes □ No

Family Medical History (Please check if child's parents, grandparents, aunts, uncles, brothers, or sisters have)

□ Cancer □ Obesity □ High Blood Pressure
□ Anemia □ SIDS □ Mental Retardation □ Asthma
□ Seizures □ Sickle Cell Trait □ Mental Illness
□ Sickle Cell Disease □ Inherited Disease
□ Allergies □ Diabetes □ Heart Disease

□ Other

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Allergies:

1. Is your child allergic to any medications?
   □ Yes □ No
   If yes, please list: _____
   _____
2. Does your child have any other allergies?
   □ Yes □ No
   If yes, please list: _____
   _____

Medications:

1. Does your child take any medications?
   □ Yes □ No
   If yes, please list: _____
   _____
2. Do you understand how to give these medications to your child? □ Yes □ No

Significant Health Problems/ Hospitalizations:

1. Has your child ever been in the hospital overnight or had surgery and gone home the same day? □ Yes □ No

Date	Where	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Significant Health Problems/Hospitalization Cont.

2. Does your child have any other major health problems? □ Yes □ No
3. Has anyone in your family had a very bad cough for a long time? □ Yes □ No

Infections, Illnesses, Miscellaneous Problems

1. Has your child had any of the following?
   □ Chickenpox □ Frequent ear infections
   □ Frequent sore throats □ Chest Pain
   □More than 8 colds/yr □Frequent headaches
   □ Frequent stomach aches
   □ Frequent fevers □ Problems with teeth
   □ Convulsions (seizures)

Environmental History

1. Parental exposures:
   A. Father's occupation _____
   B. Mother's occupation _____
   C. Have the mother or father had any chemical or unusual exposures before the birth of this child? □ Yes □ No
2. Exposures of child:
   A. Has the child had any chemical or unusual exposures? (including insecticides)
      □ Yes □ No
   B. Are there any sick animals in the home?
      □ Yes □No
   C. Has the child been around any birds or birdhouses? □ Yes □No
   D. Does anyone smoke around the child?
      □ Yes □ No

Nutrition/ Metabolic Pattern

1. Does your child have colic or any unusual feeding problems in the first 3 months?
   □ Yes □ No
2. Is your child's appetite usually good?
   □ Yes □ No
3. Is your child on a special diet? □ Yes □No
4. Do you think your child is:
   □ too thin □ too fat □ just right

Elimination Pattern

1. Does your child have problems with:
   □ diarrhea □ constipation □ soiling in pants
2. Does he/she have any problems with bedwetting? □ Yes □No
3. Is your child potty trained? □ Yes □ No
4. Do you ever have to use a laxative or suppository for your child? □ Yes □ No

Activity/ Exercise Pattern

1. Is your child able to entertain self?
   □ Yes □ No
2. How active is your child?
   □ normal for age
   □ more active (than other children their age)
   □ less active (than other children their age)
3. Does your child seem tired a lot? □ Yes □ No
4. Does your child have any special problems that limit his/her activity? □ Yes □ No
5. How often does your child take a bath or shower? _____

Cognitive/ Perceptual Pattern

1. Does your child have any hearing problems that you know of? □ Yes □ No
2. Does your child talk as much as other children his/ her age? □ Yes □ No
3. Does your child have any eye problems that you know about? □ Yes □ No
4. Has your child ever had his/her eyes checked? □ Yes □ No
5. Does your child have trouble in school?
   □ Yes □ No
6. Is your child in the grade he/she is supposed to be in? □ Yes □ No

Role/ Relationship Pattern

1. Does your child live with you? □ Yes □ No
   If not, who does your child live with?
   _____

Role/ Relationship Pattern Cont.

2. Family members who live with the child:
   □mother □father □stepmother □stepfather
   □brother(s); How many _____ Age _____
   □sister(s); How many _____ Age _____
   □ grandparents □other _____
3. Does your child play with other children?
   □ Yes □ No
4. Is your child easy to manage? □ Yes □ No
5. Child/ Children are disciplined by?
   □ taking away privileges
   □ isolation/ timeout
   □ swatting/ paddling
   □ yelling □ spanking

Self-Perception/ Conceptual Pattern

1. Which of the following words would you use to describe your child's personality?
   □ Happy □ Cooperative □ Obedient
   □ Fearful □ Outgoing
   □ Other _____

Sexual/ Reproductive Pattern

1. Do you think your child's development pattern is normal for his/her age?
   □ Yes □ No
2. Does your child have playmates of both sexes? □ Yes □ No
3. Does your child have a male adult role model? □ Yes □ No
4. Does your child have a female adult role model? □ Yes □ No

Coping Stress Comfort Pattern

1. Do you or your child have any major problems or stresses in your life now?
   □ Yes □ No
2. Have you or your child had any recent losses in your lives? (people, pets, jobs, move)
   □ Yes □ No
3. Do you have a support person to help you if you have problems or stresses in your lives?
   □ Yes □ No

Sleep/ Rest Pattern

1. Does your child have trouble with:
   A. Falling asleep at night? □ Yes □ No
   B. Nightmares? □ Yes □ No
   C. Waking up at night? □ Yes □ No
2. Does your child sleep in their own bed?
   □ Yes □ No
3. How many hours does your child sleep at night? _____

POLICIES

SCHEDULING

•We have 5 M.D.'s and 11 physician extenders. We like to keep our patients with one individual provider during preventive visits to establish a great provider/patient relationship.
•On same day sick visits, our office staff makes every effort to schedule you with the provider that you normally see.
•At any time a parent can request to have a note put in your child's chart to only see or not see any specific provider.

NO SHOWS

•We value the time set aside to see and treat your child(ren). We understand that things happen, however, if you can't make it, we ask that you please call 724-832-7045 to cancel or reschedule your appointment at least 24 hours before you are scheduled to come in. Our ability to provide quality healthcare comes very challenging when patients are late for appointments or do not show.
•For families who have scheduled appointments for 2 or more children at the same time that do not show nor call to cancel or reschedule, you will be charged a $50 no-show fee.

COPAYS AND INSURANCE CARDS

•Copays are due at the time of service and will be collected at the front window prior to your appointment. Insurance cards will also be requested and copied at every visit. Please make sure to bring your copay and insurance card with you. We accept cash, check, visa, mastercard, discover and american express.

AFTERHOURS ON CALL

•Pediatric Associates of Westmoreland has a trained professional on call after hours to assist you on an emergency basis. Please call the main phone number to the clinic (724) 832-7045 and the recording will give you the phone number for the answering service which will get you in touch with the on call provider.
•No prescriptions will be called in after hours.
•For any non-emergency questions please wait to call back during normal business hours 8:30-7 Monday through Friday and 8:30-5 on the weekends.

IMMUNIZATIONS

•Parents are given the choice to immunize. We recommend vaccinating your child according to the American Academy of Pediatrics and will offer vaccinations at all appropriate ages. A parent has the choice to decline these vaccinations however a refusal to vaccinate form must be signed by the parents stating that we have offered the vaccines to you and you would like to defer or decline as this time.

MEDICATION/FORMS

•When requesting medication refills or to have a form filled out please give the office staff at minimum of 48 hours to fulfill your request.

INSURANCE PLANS

•All insurance plans are accepted. If your child is not insured we would be happy to provide care at a discounted self pay rate. Pennsylvania is a cover all kids state.

EXTENDED OFFICE HOURS

•Private insurance holders may encounter a minimal additional charge for extended office hour appointments averaging $20.

Revised 12/22/2021

PEDIATRIC ASSOCIATES OF WESTMORELAND

HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information 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. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 10, 2008, and will remain in effect until we replace it. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or health care provider providing treatment to you, We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the Federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Joint Operations: We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangements.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosers permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

Personal Representation: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Health Related Services: We may use your PHI to contact you with information about health related benefits and services or about treatment alternatives that may be of interest to you.

Public Benefits: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;

- For public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To avert a serious threat to health or safety;
- To military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization; and
- In connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information. For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

HIV Test Information: We may not disclose the result of any HIV test or that you have been the subject of an HIV test unless required by law or the disclosure is to you or other persons under limited circumstances or you have given us written permission to disclose.

Genetic Information: We may not use or disclose your genetic information unless the use or provide us with written permission to disclose such information.

Mental Health Information Records: We may not disclose your mental health information records except to you and anyone else authorized by law to inspect and copy your mental health information records or you provide us with written permission to disclose.

Alcoholism or Drug Abuse Information: We may not disclose any alcoholism or drug abuse information related to your treatment in an alcohol or drug abuse program unless the disclosure is allowed or required by law or you provide us with written permission to disclose.

Individual Rights

You may request that we provide copies in a format of photocopies. You must make a request in writing to obtain access to your PHI and may obtain a request from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on your behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting us or by using our website, www.pawkidz.com. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Pediatric Associates of Westmoreland

Hours of Operation

Due to rising deductibles and copayments when using emergency rooms and urgent cares, we provide extended hours to accommodate the healthcare needs of busy families.

Greensburg Location
555 West Newton St
Greensburg, PA 15601
724-832-7045

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:30-5	8:30-7	8:30-7	8:30-7	8:30-7	8:30-7	8:30-5

Irwin Location
27 North Thompson Lane Suite A
Irwin, PA 15642
724-864-1830

Monday	Tuesday	Wednesday	Thursday	Friday
8:30-7	8:30-5	8:30-7	8:30-5	8:30-5

Mount Pleasant Location
508 South Church St
Mt. Pleasant, PA 15666
724-547-4547

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:30-5	8:30-5	8:30-5	8:30-5	8:30-5	8:30-5	8:30-5

Connellsville Location
205 N. Carnegie Ave
Suite A
Connellsville, PA 15425
724-603-2757

Monday	Tuesday	Wednesday	Thursday	Friday
8:30-5	8:30-5	8:30-5	8:30-5	8:30-5

Hours are subject to change

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