NEW PATIENT INTAKE PACKET

☐ **Greensburg**	☐ **North Huntingdon**	☐ **Mount Pleasant**	☐ **Connellsville**
(724) 832-7045	(724) 864-1830	(724) 547-4547	(724) 603-2757

PATIENT CONTACT INFORMATION AND DEMOGRAPHICS

Patient Name: ________________________ DOB: ____________ Gender: ☐ Male ☐ Female

Address: ____

City, State, Zip: ____

Home Phone: ______________________ Cell Phone: ____________________ Text Msg to Confirm? ☐ Y ☐ N

Email Address: ________________________________ Pharmacy: _________________________

Patient Language:	☐ English ☐ Spanish ☐ Other: ______________________________
Patient Ethnicity:	☐ Hispanic ☐ Non-Hispanic
Patient Race:	☐ Caucasian ☐ Asian ☐ African American ☐ Native American ☐ Native Alaskan ☐ Hispanic or Latino ☐ Pacific Islander

Mother's Name: ________________________ DOB: ____________ SSN: _________________

Address: ☐ *Same as Patient* or ____

City, State, Zip: ____

Best Phone Number: ___________________________ Alt Phone (*if applicable*): ___________________________

Employer Name: ____

Father's Name: ________________________ DOB: ____________ SSN: _________________

Address: ☐ *Same as Patient* or ____

City, State, Zip: ____

Best Phone Number: ___________________________ Alt Phone (*if applicable*): ___________________________

Employer Name: ____

Please list all siblings and their birthdates: ____

____

____

____

PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURG · NORTH HUNTINGDON · MOUNT PLEASANT · CONNELLSVILLE

ACKNOWLEDGEMENT OF RECEIPT: PRIVACY PRACTICES/CONSENT TO TREAT

I, ____, the parent/legal guardian of the below named child:

Name of Child: ____ DOB: _____________ Sex: __________

Patient Address: _______________________________________ City, State, Zip: ___________________________

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 Pediatric Associates of Westmoreland in my absence and to act in my behalf and authorize 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.**

1. Name: _____________________________________ Relationship: _____________ Phone: ________________

2. Name: _____________________________________ Relationship: _____________ Phone: ________________

3. Name: _____________________________________ Relationship: _____________ Phone: ________________

4. Name: _____________________________________ Relationship: _____________ Phone: ________________

AUTHORIZATION FOR VACCINES

I, ____, give permission for the following named person(s) to consent to vaccines, or sign a vaccine refusal form, on my behalf, if I am not present for the appointment.

*** If parents/legal guardians are the only ones that are capable of making these decisions, please indicate below by marking '**none**' on the first line. ***

1. Name: ____ Relationship: ____________________

2. Name: ____ Relationship: ____________________

3. Name: ____ Relationship: ____________________

4. Name: ____ Relationship: ____________________

Parent/Guardian Signature: ____ Date: _________________

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

I have offered the above-named patient/representative with the Pediatric Associates of Westmoreland Notice of Privacy Practices and they have: ☐ accepted ☐ refused delivery ☐ patient/representative was asked to sign form and refused.

PAW Representative Signature: ______________________________________ Date: __________________________

PEDIATRIC ASSOCIATES OF WESTMORELAND

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AUTHORIZATION TO BILL INSURANCE

Patient Name: ____ DOB: ___________________

#1 Primary Insurance Name: _________________________________ ID #: ___________________

Policy Holder Name: _____________________________________ DOB: ___________________

#2 Secondary Insurance Name: _______________________________ ID #: ___________________

Policy Holder Name: _____________________________________ DOB: ___________________

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 or Parent/Guardian Signature: _______________________________ Date: ___________________

PATIENT COMMUNICATION PREFERENCES

Our offices use our Electronic Medical Records (EMR) system to notify patients of their upcoming appointments and remind them of routine well visits, etc. Please tell us if you prefer to be notified by *phone call* or by *text*. Our EMR system will attempt to reach Contact #1 first, and then attempt Contact #2 if Contact #1 cannot be reached.

Contact #1 Name: ___________________________ Phone #: ____________________ ☐ Call ☐ Text

Contact #2 Name: ___________________________ Phone #: ____________________ ☐ Call ☐ Text

PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURG · NORTH HUNTINGDON · MOUNT PLEASANT · CONNELLSVILLE

PATIENT MEDICAL HISTORY

Patient Name: ____ DOB: ______________________

Completed By: ____ Date: ______________________

	Please answer the following to the best of your ability.	NO	YES	IF YES, EXPLAIN
1.	Serious injuries or accidents?	☐	☐	
2.	Surgeries?	☐	☐	
3.	Hospitalizations?	☐	☐	
4.	Chickenpox?	☐	☐	
5.	Frequent ear or sinus infections?	☐	☐	
6.	Pharyngitis / Tonsillitis?	☐	☐	
7.	Other infections illnesses?	☐	☐	
8.	Allergic rhinitis or other allergies?	☐	☐	
	a. Animals?	☐	☐	
	b. Outdoor allergens?	☐	☐	
	c. Indoor allergens?	☐	☐	
9.	Asthma, bronchitis, bronchiolitis, pneumonia, or croup?	☐	☐	
10.	Heart problems or heart murmur?	☐	☐	
11.	Abdominal pain / GERD?	☐	☐	
12.	Constipation requiring doctor visits?	☐	☐	
13.	Bladder or kidney infection or other urological problem?	☐	☐	
14.	Bedwetting after 5 years of age?	☐	☐	
15.	Eye conditions or corrective lenses?	☐	☐	
16.	Problems with ears or hearing?	☐	☐	
17.	Chronic or recurrent skin problems (acne, eczema, etc.)?	☐	☐	
18.	Anemia or bleeding problems?	☐	☐	
19.	Blood transfusions?	☐	☐	
20.	Frequent headaches?	☐	☐	
21.	Seizures, developmental delays, ADD/ADHD, or other neurologic disorders?	☐	☐	
22.	Mental health concerns?	☐	☐	
23.	Orthopedic problems?	☐	☐	
24.	Diabetes?	☐	☐	
25.	Thyroid or other endocrine problems?	☐	☐	
26.	If female, have menstrual periods started?	☐	☐	
27.	If female, any problem with periods?	☐	☐	
28.	Use of alcohol or drugs?	☐	☐	
29.	Emotional problems?	☐	☐	
30.	Other significant problems?	☐	☐	
31.	Receiving medical care from a specialist?	☐	☐	
32.	Taking any daily medications, vitamins, or herbal supplements?	☐	☐	
33.	Significant family medical problems?	☐	☐	
34.	Significant social history?	☐	☐	

PEDIATRIC ASSOCIATES OF WESTMORELAND

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FAMILY & SOCIAL HISTORY

Patient Name: ____ DOB: ____________________

FAMILY MEDICAL HISTORY

Do any of your child's biological parents, siblings, and grandparents have the following conditions for which they are being seen by a physician or treated with medication? Please complete any that apply. ***If none apply, or biological family history is unknown, check this box:*** ☐

	CONDITION	WHO	DETAILS / COMMENTS
1.	Nasal allergies or other allergies?		
2.	Asthma / lung disease?		
3.	Heart disease or heart condition?		
4.	High blood pressure?		
5.	High cholesterol?		
6.	Diabetes or other endocrine problem?		
7.	Cancer?		
8.	Anemia?		
9.	Bleeding disorder?		
10.	Epilepsy or convulsions?		
11.	Mental retardation or developmental disorders?		
12.	Neurologic disorders including ADHD/ADD?		
13.	Liver disease?		
14.	Bedwetting after 10 years of age?		
15.	Hearing impairment?		
16.	Vision impairment or eye disorder?		
17.	Immune problems, recurrent infections, or HIV/AIDS?		
18.	Alcohol abuse?		
19.	Drug abuse?		
20.	Mental illness?		
21.	Tuberculosis?		
22.	Additional pertinent conditions?		

	SOCIAL HISTORY	NO	YES	IF YES, EXPLAIN
1.	Lives with intact family?	☐	☐	
2.	Non-intact custody status?	☐	☐	
3.	Visitation status of non-custodial parent(s)?	☐	☐	
4.	Siblings? (List names and ages)	☐	☐	
5.	Pets? (List types)	☐	☐	
6.	Smokers in the home?	☐	☐	
7.	Guns in the home?	☐	☐	
8.	Guns locked and kept separate from ammunition?	☐	☐	

Other history you would like your provider to know: ____

____

____

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PAST MEDICAL HISTORY

Patient Name: ______________________________________ DOB: __________________ Gender: ☐ M ☐ F

Completed By: ____ Date: _________________

PREGNANCY HISTORY

Mother's age at time of birth: ___________ First prenatal visit was at: ___________ weeks

Did the mother have any complications during this pregnancy? ☐ No ☐ Yes ______________________________

____

____

List any medications or drugs used during this pregnancy: ____

____

Did the mother smoke during this pregnancy? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes

BIRTH HISTORY

Baby was born by ☐ vaginal delivery ☐ cesarean (c-section), and the birth was ☐ on time ☐ early ☐ late

Birth weight: ________ lb _________ oz Birth length: _________ inches

Did baby breathe right away? ☐ No ☐ Yes Did baby have any trouble in the hospital? ☐ No ☐ Yes

Birth location: ☐ Home ☐ Facility: Facility Name: ____

Did baby receive the Hepatitis B vaccine after birth? ☐ No ☐ Yes, vaccine date: _____________________________

Did baby require a repeat PKU test? ☐ No ☐ Yes

ALLERGIES

Does your child have any known allergies? ☐ Yes ☐ No known allergies

If yes, please specify: ☐ Medication Allergy ☐ Food Allergy ☐ Environmental Allergy ☐ Latex Allergy

Please list all allergies: ____

____

____

____

MEDICATIONS

Does your child take any medications? ☐ No ☐ Yes

If yes, please list all current medications: ____

____

____

____

SURGERIES OR HOSPITALIZATIONS

Has your child ever been admitted to the hospital overnight OR had surgery and went home same day? ☐ N ☐ Y

Admit/Surgery Date	Location	Reason
________________	______________________________	____________________________________
________________	______________________________	____________________________________
________________	______________________________	____________________________________
________________	______________________________	____________________________________
________________	______________________________	____________________________________
________________	______________________________	____________________________________

SIGNIFICANT HEALTH CONDITIONS

Does your child have any major health problems? ☐ No ☐ Yes ______________________________________

Has anyone in your family had a very bad cough for an extended period of time? ☐ No ☐ Yes

Has your child had any of the following?

☐ Chickenpox ☐ Frequent sore throats ☐ Frequent ear infections ☐ Frequent colds (8+ per year)

☐ Frequent headaches ☐ Frequent stomachaches ☐ Frequent fevers ☐ Dental problems ☐ Seizures

ENVIRONMENTAL EXPOSURES

PARENTAL EXPOSURES

Father's Occupation: ______________________________ Mother's Occupation: ______________________

Has the mother or father had any chemical or unusual exposures before patient was born? ☐ No ☐ Yes

CHILD EXPOSURES

Has your child had any chemical or unusual exposures (including insecticides)? ☐ No ☐ Yes

Are there any sick animals in the home? ☐ No ☐ Yes

Has your child been around any birds or birdhouses? ☐ No ☐ Yes

Does anyone smoke around your child? ☐ No ☐ Yes

NUTRITION & METABOLIC PATTERN

Did your child have colic or any unusual feeding problems in the first 3 months? ☐ No ☐ Yes

Is your child's appetite usually good? ☐ No ☐ Yes Is your child on a special diet? ☐ No ☐ Yes

Do you think your child is: ☐ too thin ☐ too fat ☐ just right

ELIMINATION PATTERN

Does your child have problems with: ☐ diarrhea ☐ constipation ☐ soiling in pants

Does your child struggle with bedwetting? ☐ No ☐ Yes Is your child potty trained? ☐ No ☐ Yes

Does your child ever need you to use laxatives or suppositories? ☐ No ☐ Yes

ACTIVITY & EXCERCISE

Is your child able to self-entertain? ☐ No ☐ Yes

How active is your child compared to others of the same age? ☐ Normal ☐ More active ☐ Less active

Does your child often seem tired? ☐ No ☐ Yes

Does your child have any issues that limit his/her activity? ☐ No ☐ Yes

How often does your child bathe? ____

NERVOUS SYSTEM

Does your child have any problems with hearing? ☐ No ☐ Yes

Does your child talk as much as other children of the same age? ☐ No ☐ Yes

Does your child have any problems with vision? ☐ No ☐ Yes

Has your child ever had an eye exam? ☐ No ☐ Yes

Does your child struggle in school? ☐ No ☐ Yes Has your child had to repeat a grade? ☐ No ☐ Yes

HOME & FAMILY

Does your child live with you? ☐ Yes ☐ No, my child lives with ____

My child lives with his/her ☐ mother ☐ father ☐ siblings ☐ step-mother ☐ step-father ☐ step-siblings

Does your child enjoy playing with other children? ☐ No ☐ Yes

Is your child easy to manage? ☐ No ☐ Yes

My child is disciplined by: ☐ taking away privileges ☐ isolation/timeouts ☐ swatting/paddling

☐ spanking ☐ yelling ☐ other ____

SELF-PERCEPTION & CONCEPTUAL PATTERN

Which of the following words would you use to describe your child's personality?

☐ Happy ☐ Cooperative ☐ Obedient ☐ Fearful ☐ Outgoing ☐ Other __________________________________

REST & SLEEP

My child has trouble with ☐ falling asleep at night ☐ nightmares ☐ waking up in the middle of the night

Does your child sleep in his/her own bed? ☐ No ☐ Yes

How many hours does your child typically sleep at night? ________________

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review carefully.

OUR RESPONSIBILITIES

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" or 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 healthcare 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 healthcare 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 healthcare provider providing treatment to you. We may use or disclose your PHI to a healthcare 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 healthcare services provided to you. We may disclose your PHI to another health plan, to a healthcare 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 healthcare operations of such an organized healthcare arrangement.

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 or 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 location 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 you 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 of 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 website or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

PEDIATRIC ASSOCIATES OF WESTMORELAND

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☐ **North Huntingdon** (724) 864-1830
☐ **Mount Pleasant** (724) 547-4547
☐ **Connellsville** (724) 603-2757

POLICIES

SCHEDULING

- We have five physicians and 11 physician extenders. We try 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 his/her child's chart to only see or not see any specific provider.
- In case of an emergency, call 911.

NO SHOWS

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

CO-PAYS AND INSURANCE

- Co-pays are due at the time of service and will be collected at the front window prior to your appointment. We accept cash, check, Visa, MasterCard, Discover and American Express.
- Insurance cards may be requested and copied at every visit, so please have your insurance card with you.
- For all other payments, you may pay in office using a payment method listed above, or use our online bill pay service (InstaMed) linked on our website.
- All insurance plans are accepted. If your child is not insured, we would be happy to provide care at a discounted self-pay rate.

AFTER-HOURS

- We have a trained professional on call after hours to assist you on an emergency basis.
- Please call the after-hours line at (866) 625-5271 and the answering service will connect you with a provider.

- No prescriptions will be called in after hours.
- For all non-emergent questions, please wait to call back during normal business hours which are Monday through Friday 8:30am to 7:00pm.

EXTENDED OFFICE HOURS

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

IMMUNIZATIONS

- Although 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.
- If a parent declines any vaccinations, a Refusal to Vaccinate form must be completed and signed stating that PAW has offered the vaccines but you would like to defer or decline as this time.

MEDICATIONS / FORMS

- Current turnaround time for medication requests or school/sports forms is two business days. Please plan accordingly.

SOCIAL MEDIA POLICY

- We encourage and welcome your posts and comments in the social media channels maintained by PAW.
- Please understand that we cannot respond to every comment.
- We cannot offer medical advice, diagnosis, or treatment through our social media accounts. If you have medical-related questions or concerns, please contact our office at (724) 832-7045. (As always, in the case of an emergency, please call 911.)
- We reserve the right to delete any comments, as well as restrict, block, suspend, or terminate any access to any of our social media channels without notice.
- Please refrain from using foul language or content that is obscene, threatening, embarrassing, defamatory, or hateful when posting or commenting on our social media channels.
- Please do not use our social media channels to promote commercial products or services in any way.
- For your own privacy, consider carefully before posting personal medical information to the internet. Your posts and comments are available to all who follow our social media channels.
- There are times when we will promote posts within our social media channels. These advertised posts will be viewed outside our normal viewership.
- By posting on our social media channels, you agree to not violate any local, state, federal, or international laws and regulations.
- By posting on our social media channels, you grant PAW the irrevocable right to reproduce, distribute, publish, or display such content and give PAW the right to use such content for promotional purposes.

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

MONDAY	8:30AM-7:00PM
TUESDAY	8:30AM-7:00PM
WEDNESDAY	8:30AM-7:00PM
THURSDAY	8:30AM-7:00PM
FRIDAY	8:30AM-7:00PM
SATURDAY	8:30AM-5:00PM
SUNDAY	8:30AM-5:00PM

555 W Newton St
Greensburg, PA 15601
(724) 832-7045

NORTH HUNTINGDON

MONDAY	8:30AM-7:00PM
TUESDAY	8:30AM-5:00PM
WEDNESDAY	8:30AM-7:00PM
THURSDAY	8:30AM-5:00PM
FRIDAY	8:30AM-5:00PM
SATURDAY	8:30AM-5:00PM
SUNDAY	8:30AM-5:00PM

27 N Thompson Ln Suite A
North Huntingdon, PA 15642
(724) 864-1830

MOUNT PLEASANT

MONDAY	8:30AM-5:00PM
TUESDAY	8:30AM-5:00PM
WEDNESDAY	8:30AM-5:00PM
THURSDAY	8:30AM-5:00PM
FRIDAY	8:30AM-5:00PM
SATURDAY	8:30AM-5:00PM
SUNDAY	8:30AM-5:00PM

508 S Church St
Mt. Pleasant, PA 15666
(724) 547-4547

CONNELLSVILLE

MONDAY	8:30AM-5:00PM
TUESDAY	8:30AM-5:00PM
WEDNESDAY	8:30AM-5:00PM
THURSDAY	8:30AM-5:00PM
FRIDAY	8:30AM-5:00PM
SATURDAY	CLOSED
SUNDAY	CLOSED

205 N Carnegie Ave Suite A
Connellsville, PA 15425
(724) 603-2757

Hours are subject to change.