Wayland Pediatrics
Boston Children's
Primary Care Alliance

73 Pelham Island Road, Wayland, MA 01778
508-358-2918 | *fax* 508-358-6054
waylandpediatrics.com

Welcome to Wayland Pediatrics

Dr. Ellen Mahoney, Dr. Maya Dor, Nancy Crowley, cPNP, Katie Warner, LICSW — along with the entire staff at Wayland Pediatrics — would like to welcome you!

This packet of information is to help familiarize you with our office and some of its policies. Hopefully, it will allow your transition to occur as efficiently as possible. As soon as we receive the requested materials, we can enter your family into our database, and prepare for your first visit.

Please visit waylandpediatrics.com for more details, and directions to the office. Below is a list of the items that we will need from you, to start the registration process:

Completed and signed forms from this package

- ☐ Demographic Information
- ☐ HIPPA Authorization
- ☐ Financial Policy
- ☐ Consent to Treatment and Use of Health Information
- ☐ Vaccine Policy
- ☐ Appointment Policy

Additional records and information

- ☐ Copy of immunizations (or reproduction of Mass Blue Book)
- ☐ Record release for previous physician
- ☐ Copy of both sides of medical insurance card

Thank you, and we look forward to caring for your family!

— Christy Macary, Wayland Pediatrics Office Manager

Demographic Information

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Parent/Guardian information

Parent/Guardian #1 name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2 name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Patient information

Patient #1 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #2 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #3 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #4 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Preferred pharmacy:

_____

Address: _____

City: _____ State: _____ Zip: _____

Insurance information

Physician listed on insurance policy (if required):

❍ Dr. Ellen Mahoney ❍ Dr. Maya Dor

Insurance company: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID#: _____

Guarantor's name: _____

Date of birth: _____

Social Security #: _____

Authorization

I hereby authorize payment for medical treatment by Wayland Pediatrics, L.L.C. I also authorize Wayland Pediatrics to release information as required by other physicians and insurance carriers.

Parent/Guardian signature: _____

Date: _____

HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996

HIPPA Authorization

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This notice describes how your medical information, as a patient of this practice, may be used/disclosed, and how you can get access to this information.

The privacy of your medical information is very important to us. You may be aware that the U.S. government regulators established a privacy rule, the Health Insurance Portability and Accountability Act ("HIPPA"), governing protected health information ("PHI"). PHI includes individually identifiable health information, such as demographic information, and relates to your past, present, or future, physical/mental health, or condition(s), as well as related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and disclosure of protected information

Federal law provides that we may use your PHI for your treatment, without further specific notice to you, or written authorization by you. For example, we may provide laboratory/test data, to a specialist.

Federal law provides that we may use your medical information to obtain payment for our services, without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit, and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations, without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care that you have received from us, or, to conduct cost-management, and business planning activities, for our practice.

We may use, or disclose, your medical information, without further notice to you, or specific authorization by you, where:

- Required for public health purposes
- Required by law to report child abuse
- Required by a health oversight agency for oversight actives authorized by law, such as the Department of Health, Office of Professional Discipline, or Office of Professional Medical Conduct
- Required by law in judicial or administrative proceedings
- Required for law enforcement purposes by a law enforcement official
- Required by a coroner or medical examiner
- Permitted by law to a funeral director
- Permitted by law for organ donation purposes
- Permitted by law to avert a serious threat to health of safety
- Permitted by law and required by military authorities if you are a member of the armed forces of the U.S.
- Required for national security, as authorized by law
- Required by correctional institutions or law enforcement officials, if you are an inmate, or under the custody of a law enforcement official
- Otherwise required or permitted by law.

Certain types of uses and disclosures of protected health information require authorization, these include:

- Uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes; and disclosures that constitute the sale of PHI.
- Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

Minors

For divorced, or separated, parents: each parent has equal access to health information about their unemancipated child{ren), unless there is a court order to the contrary, that is known to us, or unless it is a type of treatment/service, where parental rights are restricted.

We can release your medical information to a friend, or family member, that is involved in your medical care. For example, a babysitter, or relative, who is asked by a parent/guardian to take their child to the pediatrician's office, may have access to this child's medical information. We prefer to have written authorization from the parent/guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. A separate form is available for this purpose.

Other uses/disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

You have the right to request restrictions on certain uses/disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner, or at a certain location e.g. at home, and not at work. Such requests must be made in writing to your physician. Our practice will accommodate reasonable requests.

You have the right to inspect, and obtain, copies of your medical information (a reasonable fee may be charged).

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You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures that we make of your medical information. This is a list of certain non-routine disclosures that our practice has made of your health information for non-treatment, payment, or health care operations purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment, or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.

You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item/service (only healthcare providers are required to include such a statement; other covered entities may retain the existing language indicating that a Covered Entity is NOT required to agree to a requested restriction).

You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction.

A family member or other third party may make payment on your behalf and the restriction will still be triggered.

You have the right to, or will receive, notifications of breaches of your unsecured patient health information.

All requests must state a time period, which may not be longer than six (6) years, from the date of disclosure.

You have the right to receive a paper copy of our notice of privacy policies.

You have the right to receive electronic copies of health information.

Obligations that we have

We are required, by law, to maintain the privacy of protected health information, and to provide individuals with notice of our legal duties, and privacy practices. We are required to abide by the terms of this notice, as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information that we maintain. Any revised notices will be posted in our office, and copies will be available there.

We will inform you of our intentions to raise funds, and your right to opt out of receiving such communications.

If you believe that these privacy rights have been violated, you may file a written complaint with our Privacy Officer, or, with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office, upon your request. No relation will occur against you for filing a complaint.

Organization contact information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR OFFICE MANAGER:

Christy Macary
508-358-2918

Authorization

Signature of parent/guardian, or patient if over 18:

_____

Date: _____

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Financial Policy

Our goal is to provide, and maintain, a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication, and enables us to achieve our goal. Please read this carefully, and if you have any questions, please do not hesitate to ask a member of our staff.

- On arrival, please sign in at the front desk, and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your child's behalf.

  IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT YOU WILL BE RESPONSIBLEF OR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
- If we are your primary care physician, make sure that we are listed as such with your insurance company. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for this visit.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
- It is your responsibility to understand your benefit plan. It is YOUR responsibility to know if a written referral, or authorization, is needed to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, previous balances must be paid prior to the visit.
- If you do not have insurance, payment for an office visit is to be paid at the time of the visit.
- Co-payments are due at time of service. A $10 processing fee (or service fee) will be charged in addition to your co-payment, if the co-payment is not paid at time of service.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
- If previous arrangements have not been made with our billing office, any account balance outstanding greater than 60 days will be forwarded to a collection agency.
- We require 24-hour notice for canceling any appointments. Please refer to our Appointment Policy for details.
- A $30 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- There is a $15 administrative fee per chart, for preparing copies of records for transfer/mailing costs.
- Advance notice is needed for all non-emergent referrals typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
- Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual health physicals, or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of service.
- If someone other than a parent brings your child for care, they must provide the above information, and pay the appropriate charges on your behalf.

We recognize that extenuating circumstances may exist, which could warrant special payment consideration.

Please contact A-Stat Medical Billing at: 401-723-5533, with any questions regarding your bill.

Signature

Signature of parent/guardian, or patient if over 18:

_____

Date: _____

Consent to Treatment and Use of Health Information

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Consent for medical treatment

I allow the healthcare providers of Wayland Pediatrics to give the patient named below medical care, including medical examinations, diagnostic testing/procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic/diagnostic procedures, will not be performed, unless I have had the opportunity to discuss such procedures and the risks associated therewith, to my satisfaction, and I have consented to such procedure. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made to me, promising any specific result, or outcome.

Release of information for payment and assignment of benefits

I agree that Wayland Pediatrics can share the patient's health information with the patient's health plan, or other payment source, in order to receive payment for services rendered. I hereby assign to Wayland Pediatrics the right to health insurance benefits, otherwise payable to me or the patient on Account of the care provided, and I authorize such medical insurance benefits to be paid directly to Wayland Pediatrics. I agree to cooperate and provide information, as needed, to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Sharing information electronically:

Wayland Pediatrics may share information electronically with other healthcare providers involved in the patient's care. Information may be shared using platforms such as the Massachusetts Health Information Highway (MassHIway), Massachusetts Immunization Information System (MIIS}, EpicCare Link, Care Everywhere, and others. I agree that Wayland Pediatrics can use these platforms to share the patient's medical information. I have been provided with a copy of the Wayland Pediatrics Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment

This approval will remain in effect until the patient leaves Wayland Pediatrics.

Signature of parent/guardian, or patient if over 18:

_____

Date: _____

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Vaccine Policy

We strongly believe in the safety and effectiveness of vaccines to prevent serious illness and to save lives. All infants, children and young adults should receive the vaccines according to the schedule supported by the Centers for Disease Control and the American Academy of Pediatrics.

Vaccinating children and young adults may be the single most important health-promoting intervention we perform as pediatricians, and that you can perform as parents/caregivers. The vaccine schedule we use is the result of years of scientific study and data gathering on millions of children by our brightest scientists and physicians. It is precisely because vaccines are so effective at preventing illness that there is discussion about whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or known a friend or family member whose child died of one of these diseases. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to allay any concerns you have about vaccinating your child.

Please know that delaying or "spacing out the vaccines" opposes expert recommendations, and places your child, other children and the community in general at risk for significant illness. If your child is not currently up to date on his or her vaccines we will create a written catch-up vaccine schedule with the goal of having your child caught up with all of the recommended vaccines in a period of 6–12 months, depending on the age of your child and how many vaccines are needed. We will ask you to sign this plan and it will become part of your child's medical record.

If you are unwilling or unable to comply with the vaccine schedule, you will be asked to transfer to another practice in order to protect our other patients, especially those with compromised immune systems.

If you refuse to vaccinate your child despite all our efforts, we will ask you to find another physician who shares your views. We do not keep a list of such physicians nor would we recommend any such physician.

As medical professionals, we feel very strongly that vaccinating on schedule is the right thing to do for all children, adolescents, and adults! Please recognize that by not vaccinating, you place your child at unnecessary risk for life-threatening illness and disability, and even death.

Thank you for reading this policy, and the trust you place in us. Please feel free to raise any questions or concerns you may have about this policy with one of us.

— Ellen Mahoney, MD • Maya Dor, DO • Nancy Crowley, cPNP

Signature

Signature of parent/guardian, or patient if over 18:

_____

Date: _____

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Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation/No show policy for doctor appointments

In order to be respectful of the medical needs of other patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If an appointment is not cancelled with proper notice, you may be charged a fee. Your insurance company will not cover this charge. Insurance companies only consider covering costs for services that were actually rendered.

Fee schedule

First missed appointment
No charge. We understand that mistakes happen.

Second missed appointment
$25 fee will be billed to your account.

Third missed appointment
$50 fee will be billed to your account.

Repeated no shows may result in the patient and/or family being discharged from our practice.

- Fees are the discretion of our business manager.
- Fees are incurred for each child scheduled.
  Example: 2 siblings scheduled = 2 fees

Late arrivals

We understand that delays can occasionally happen; however, we must try our best to keep the doctors on schedule. If a patient arrives more than 10 minutes past their scheduled time, we may have to reschedule your appointment.

Account balances

If you are having a difficult time paying a balance, we are here to work with you. Families who have questions about their bill, or would like to discuss a payment plan option, should call our billing department at 401-723-5533.

How do I cancel my appointment?

Our practice firmly believes that a good physician/patient relationship is based upon understanding, and good communication. To cancel appointments, please call 508-358-2918.

If you do not reach one of the secretaries, you may leave a message with our answering service. If you would like to reschedule your appointment, please leave your phone number. We will return your call, and give you the next available appointment time.

What is a "late cancellation"?

We use the term late cancellation when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

What is a "no-show"?

The term "no-show" is for patients who miss an appointment without calling to notify the office in advance. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

Acknowledgment

I understand the above appointment policy. Any cancellations not made with appropriate notice would be charged to me personally, and cannot be submitted to my insurance company.

Signature of parent/guardian, or patient if over 18:

_____

Date: _____