Dear Selects Academy at Bishop Kearney Parents/Guardians:

Panorama Pediatric Group is used by Bishop Kearney as a resource for medical needs. These needs include, but are not limited to:

- Concussion assessment/management
- Illness
- Wellness exams
- Personal medical needs, etc.

Essentially, students that need an appointment, will be scheduled to see a medical professional at Panorama Pediatrics. Cases that need immediate medical attention will be taken to Urgent Care.

Please find all the necessary forms for Panorama Pediatric included in this email. Forms must be printed, filled out, and signed. **These forms need to be hand-delivered to Bishop Kearney at move-in**. Bishop Kearney will not keep these forms on file, but all forms will be delivered to Panorama Pediatric by a Bishop Kearney representative. Please do not send these forms directly to Panorama Pediatric Group.

If you have any questions, please email Keith Miller at kmiller@bkhs.org.

Sincerely,

Keith Miller
Vice Principal
Bishop Kearney High School/A Golisano Education Partner
125 Kings Highway South
Rochester, New York 14617
585.342.4000 ext 226
585.342.4694 fax

Panorama Pediatric Group, RLLP
220 Linden Oaks, Suite 200 Rochester, NY 14625
Phone: (585) 381-4982 Fax: (585) 381-1821

Medical Records Release

____ ______________________

Patient's First Name Patient's Last Name Patient's Date of Birth

______Handy-carry/pick-up records ____Authorization to give/get records with medical office below
______Send records to address below ____Obtain records from address below

Name:________________________________ Phone#____________________________

Address:______________________________Town, State, Zip:______________________

I authorize Panorama Pediatric Group, RLLP to:
______Release immunization records only (No Charge)
______Release info from the most recent physical exam only (No Charge)
______Release records including growth charts, immunizations, allergies, current medication list, labs, x-rays, specialist reports for last 12 months, most recent physical and last 3 office visits. (No Charge)
______Release all records ($0.75/page charge/Maximum of $50)
______Release all records EXCEPT alcohol/drug related information ($0.75/page charge/Maximum $50)
______Release all records EXCEPT mental health related information($0.75/page charge/Maximum $50)

By Law – All HIV/Aids related information requires a separate authorization form.
Records within the chart from other medical providers will not be transferred.

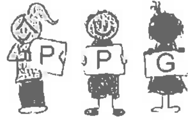
I am releasing these records...
______to send to another medical practice (not transferring out of PPG)
______to transfer to another medical practice/primary care physician
______to a school nurse
______for my own personal records (charge of $0.75/page)
______Other (charge of $0.75/page):____

If transferring out of our office to another doctor, please indicate the reason:
______easier access/closer ______insurance issue ______over age 18
______dissatisfaction ______other
______moving to:
Street Address:_________________________Town, State, Zip:__________________

Note: We will retain your records until age 24 or until it has been 6 years since your last visit. Please allow 7-10 business days to process. If records have been transferred once, there will be a $0.75/page charge (up to $50 maximum per patient) for medical information needed a second time for any reason. This authorization shall remain valid until terminated in writing or upon transferring care from PPG.

____ ______________

Signature of: ___Patient over 16 ___Parent ___Guardian ___Authorized Rep. Date
Printed Name Above________________________________Current Phone#__________________



Panorama Pediatric Group
220 LINDEN OAKS, SUITE 200
ROCHESTER, NY 14625-2839
PHONE (585) 381-4848
FAX (585) 385-7572

Consent Form

Patient's First Name	Patient's Last Name	Patient's Date of Birth
Patient's First Name	Patient's Last Name	Patient's Date of Birth

I, ____, give permission for:
Parent/Guardian or Patient over 13

First Name Last Name	Relation to Patient	Phone #

☐ to have access to medical information regarding the patients listed above.

☐ to pick up prescriptions or forms for the patients listed above.

☐ to make appointments for the patients listed above.

☐ to change or know the address, telephone number, etc of the patients listed above.

☐ to activate the Patient Portal

☐ to access, exchange information, and communicate through the Patient Portal

☐ to pick up and drop off the patients listed above for appointments. (Payments towards the deductible and co-pays are *due at the time of the visit*, no matter who brings the patient in. Deductible payments and co-pays may be paid ahead of time or called in THE DAY OF THE VISIT by calling the Appointment Desk at 381-4848. A $15 service charge will be added if there is no payment made on the day of the appointment.)

☐ Other:____

Printed name of Parent/Guardian or Patient giving authorization	Phone #

Signature of Parent/Guardian or Patient over 13	Date

☐ I am a parent/legal guardian of a patient at Panorama Pediatric Group.

☐ I am a patient at Panorama Pediatric Group 13yrs or older.

Office Use Only: ____________________ Account #

Panorama Pediatric Group
220 Linden Oaks, Suite 200
Rochester, NY 14625
Phone: (585) 381-4848
Fax: (585) 385-7572

AUTHORIZATION FORM FOR PANORAMA PEDIATRIC GROUP TO FAX INFORMATION

Patient Name: ______________________________ Date of Birth: ________________

Patient phone number: ______________________

Please select one of the following for us to send:

☐ Health Appraisal ☐ Daycare ☐ Immunization Record ☐ Gym Excuse

☐ Permission to administer medication - Medication name: ______________________________

☐ Other:____

Attention to (to whom are we sending your information): ____________________________

Fax # (location to which we are sending your information): ___________________________

Date needed by: __________________

Parent/Guardian Name (please print): ____

Signature: ______________________________

Date:________________

Panorama Pediatric Group, RLLP
220 Linden Oaks
Suite 200
Rochester, NY 14625-2839
(585) 381-4982

PRIVACY NOTICE

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

This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control 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 required by law to maintain the privacy of PHI, to provide you with and to abide by the terms of this Privacy Notice and make a good faith effort to obtain an acknowledgment of your receipt of this Notice. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. You may obtain a revised Privacy Notice by visiting our website (www.panoramapeds.com), or you may call the office at the phone number on this Privacy Notice and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment.

Permitted Uses and Disclosures of PHI

Your PHI may be used and disclosed by us for the purpose of providing health care services to you. Your PHI may also be used and disclosed by us to obtain payment of your health care bills and to support the operations of our practice.
Following are examples of the types of uses and disclosures of your PHI that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by us.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at our request, becomes involved in your care by providing assistance to us with your health care diagnosis or treatment.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging other business activities.

For example, we may disclose your PHI to medical school students who see or assist in seeing patients at our office or in the hospital. We may also call you by name in the waiting room when your physician is ready to see you.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

In addition, your name and address may be used to send you a newsletter about our practice and the services we offer.

Uses and Disclosures of PHI Based on Your Written Authorization: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. For example, we may not use or disclosure your PHI for marketing purposes nor may we sell your PHI without your written authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly related to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal

representative or any other person who is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts for the purposes of coordinating uses and disclosures to family or other individuals involved in your health care to notify them of your location, general condition or death.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Research: We may use your de-identified PHI for research purposes. We may not disclose your PHI to researchers without your authorization except when a research project meets specific, detailed criteria established by an institutional review board to ensure that the researchers' protocols will protect the privacy of your PHI.

Coroners, Funeral Directors, and Organ Donation: We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs for your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and we created or received your PHI in the course of providing care to you.

Avert a Threat to Health or Safety: We may disclose your PHI if we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able o prevent or lessen the threat.

Required Uses and Disclosures: Under the law, we must make disclosures to you when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that we use for making treatment decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; or PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, you may have right to appeal our decision to deny you access. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to revoke an authorization. You may revoke any authorization you have given us, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request than any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Except as otherwise provided in this Privacy Notice, we are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we do agree with the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You should request a restriction in writing to the Privacy Officer. However, we must agree to your request to restrict disclosure of your PHI to a health plan if the disclosure is for the purposes of obtaining payment for your health care or other operations of our practice and is not otherwise required by law AND we have been paid in full for the treatment we provided related to the PHI you have asked us not to disclose.

You have the right to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You have the right to have us amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record. Requests for amendment of PHI must be made in writing.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosure for purposes other than treatment, payment and healthcare operations as described in this Privacy Notice. It excludes disclosure we may have made to you, to family members or designated friends involved in your care, for notification purposes, disclosures you have specifically authorized or disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials. You have the right to receive specific information regarding these disclosures that occurred after April, 2007. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us.

Breach Notification

We must notify you if we learn that your PHI may have been subject to unauthorized acquisition, access, use or disclosure.

Complaints

If you believe we have violated your privacy, you may complain to us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer in writing of your complaint. We will not retaliate against you for filing a complaint. If you have any questions about the complaint process or any of the information contained in this Notice, you may contact our Privacy Officer at 585-381- 4982.

Effective Date

This notice is effective as of 23rd September, 2013.

Panorama Pediatric Group Patient Family Medical History

It is important to keep an updated and accurate medical history on our patients. We appreciate you taking the time to fill out the following information.

Patients of PPG:

First Name	Last Name	DOB	Dr at PPG

Family medical history: (please check if appropriate)	Mother	Father	other family member (please specify)
Allergies/seasonal/environmental			
Anxiety/depression			
Cancer *type			
Diabetes/hypoglycemia			
Gastrointestinal issues			
Heart disease			
Hypertension			
Lung disease (asthma etc)			
Medication			
Neurological/stroke/seizure			
Smokers in household			
Weight concerns/management			

Signature: ______________________________ date: ______________

PANORAMA PEDIATRIC GROUP FINANCIAL POLICY

By signing below, I/We understand and agree to:
Provide correct insurance information and will make sure that the correct Primary Care Provider is listed with my insurance company. It is my responsibility to understand my coverage, benefits and limitations set forth by my insurance company. Please bring insurance card to each appointment.

Payment will be collected at the time of the visit for all copays/deductibles/balances due from the parent or guardian who accompanies the child, regardless of any other financial/legal arrangements dictating who will pay. Uninsured patients will be expected to make a payment of $80 at the time of the visit for well and sick visits. Other insurance carriers where allowed costs are not available will be expected to pay $80 towards sick visits.

A $15 service charge will be added to your account if payment is not made at the time of service or within 24 hours. There will be an additional $5.00 billing fee added to my account every 30 days for failure to make payment or payment arrangements with the Business Office. (585-381-4982)

If my child requires lab work that is sent to an outside lab, I understand that I will be billed separately by the lab.

I will be prompt for all appointments. Missed or cancelled appointments with less than 24 hour notice will result in:
1st time you will receive a reminder letter. Second and future missed appointments will incur a $50 charge. In addition, multiple missed appointments may result in discontinuation of care subject to review by your physician.

I understand that in the event a check is returned for insufficient funds, a service charge of $25 will be added to my account.

Financial hardship should never stand in the way of medical care. Since open communication can benefit both parties, any financial hardship should be discussed with the Business Office (585-381-4982) so that payment arrangements can be made as early as possible.

I HAVE READ, UNDERSTAND AND AGREE TO THESE TERMS AND CONDITIONS. I UNDERSTAND THAT FAILURE TO COMPLY WITH THESE TERMS MAY RESULT IN TERMINATION OF CARE FROM PANORAMA PEDIATRIC GROUP.

PATIENT______________________________(Please print)

PATIENT______________________________(Please print)

PATIENT______________________________(Please print)

PATIENT______________________________(Please print)

PATIENT______________________________(Please print)

Parent/ Guardian______________________________Date____________

Account Number ______________________ (Office Use) (Revised 6/16)

Family Data Sheet - Panorama Pediatric Group, RLLP

	(Please complete if applicable)
Parent's Name ________	**Step Parent's Name** ________
Parent's Address ________	**Step Parent's Address** ________
Zip	**Zip**
Phone ________	**Phone** ________
Parent's Employer ________	**Step Parent's Employer** ________
Cell # ________	**Cell #** ________
Work# ________	**Work #** ________
Email ________	**Email** ________
DOB ________	**DOB** ________
Parent's Name ________	**Step Parent's Name** ________
Parent's Address ________	**Step Parent's Address** ________
Zip	**Zip**
Phone ________	**Phone** ________
Parent's Employer ________	**Step Parent's Employer** ________
Cell # ________	**Cell #** ________
Work # ________	**Work #** ________
Email ________	**Email** ________
DOB ________	**DOB** ________

Child Name	**DOB**	Child Cell 13yr & over	Primary Language	Ethnicity*	Race *	**Lives with:** (Circle All That Apply)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)
						Both Parents Mother Father Guardian: (provide legal paperwork)

* Race: White, Black/AM, American Indian, Alaska Native, Asian, Native Hawaiian, or other spec. islander, Other
* Ethnicity: Spanish/Hispanic Y or N

If guardian: Name ________ Relationship ________

Address ________ City/State/Zip ________ Phone ________

If parents are divorced/not married who has legal responsibility for the health insurance coverage for the child(ren)?
(Please provide appropriate legal paperwork)

Name ______________________ Relationship ______________________

Address City/State/Zip Phone

Primary Insurance Information: **Subscriber Name:** ______________________

DOB **Phone:** **Insurance Co:**

List anyone who is authorized (other than parent/guardian) to:

#1. Schedule and attend appointments;
Receive and provide disclosure of medical and financial information;
Make medical decisions
#2. Be used as an emergency cpmtact
#3. All of the above

Please identify which # applies to the individual. (This may include step parents, grandparents, babysitters, etc.)

Name	Relationship	Phone #(s)	#
Name	Relationship	Phone #(s)	#
Name	Relationship	Phone #(s)	#

	Appointment information	Medical information
May we leave message on home phone?	Yes / No	Yes / No
May we leave message on cell phone?	Yes / No	Yes / No
May we send text messages on cell phone?	Yes / No	Yes / No
May we leave messae on office Voice?	Yes / No	Yes / No
May we leave message with another person?	Yes / No	Yes / No
Send information via regular mail?	Yes / No	Yes / No
Send information via e-mail?	Yes / No	Yes / No

Balance due, Panorama Pediatric Group will use any/all phone numbers listed to contact you in regard to account balances, including cell phone numbers.

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medical benefits to above stated physician for services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

(HIPAA Requirement)

By signing below, I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices for Panorama Pediatric Group, RLLP

Parent/Legal Guardian Signature: **Date:**