UB|MD PEDIATRICS

THE PHYSICIANS AT
Oishei Children's Hospital

DIVISION OF GASTROENTEROLOGY & NUTRITION

Welcome to the Division of Gastroenterology & Nutrition. We prevent, diagnose and treat nutritional and gastrointestinal problems in children from birth through young adulthood including:

- Inflammatory bowel disease (Crohn's disease, ulcerative colitis)
- Irritable bowel disease
- Reflux disease
- Chronic diarrhea
- Constipation
- Liver diseases
- Celiac disease
- Eosinophilic esophagitis
- Nutrition
- Obesity
- Failure to thrive
- Abdominal pain
- Pancreatic diseases
- Nausea & vomiting
- Hirschsprung's disease

Attending Gastroenterologists & Advanced Practice Providers

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

Osama Almadhoun, MD
Division Chief

Rachel Borlack, MD

Brian Edelstein, MD

Norine Boyd, CPNP, AE-C, PMHS
Nurse Practitioner

Anita Crawley, RN, CPNP
Nurse Practitioner

Laura White, FNP-BC, MSN, RN
Nurse Practitioner

After your appointment, please visit **UBMDPediatrics.com** to complete our patient satisfaction survey. Your feedback is important to us so that we can provide a consistently positive experience to all of our patients!

Thank you!

Outpatient Centers	Contact Information	About Us
Conventus 1001 Main Street, 4th Floor Buffalo, NY 14203 **University Commons** 1404 Sweet Home Road, Suite 5 Amherst, NY 14228 **Southwestern Office Park** 4535 Southwestern Blvd., Suite 712 Hamburg, NY 14075	**716.323.0080** **716.323.0295** **UBMDPediatrics.com**	UBMD Pediatrics is one of 18 practice plans within UBMD Physicians' Group. We provide premier health care to infants, children, adolescents, and young adults throughout Western New York and beyond. Our doctors make up the academic teaching faculty within the Department of Pediatrics at the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo and are also the physicians at Oishei Children's Hospital.

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Gastroenterology History Form

Patient's Name: _____ Date of birth: _____

Parent/Guardian's Contact Numbers: Home #: _____ Cell #: _____

Patient's Gender: □ Male □ Female
Patient's Ethnicity: □ African American □ Asian/Asian American □ Hispanic/Latino □ White/Caucasian
□ Native American □ Other: _____

Primary Care Physician: _____ Address: _____
Physician's Phone #: _____ Patient's Pharmacy Phone #: _____
Please list any other Doctors your child sees for any medical problems: _____
_____

Allergies: Please specify below
Food: _____
Medication: _____
Environment: _____

Current medications: _____
_____
_____

Reason the patient is being seen by Gastroenterology: _____

A. Abdominal Pain
If your child has abdominal or chest pain, please check one of the responses for each question below. <u>If your child has no abdominal or chest pain, skip this section and go to section B</u>.

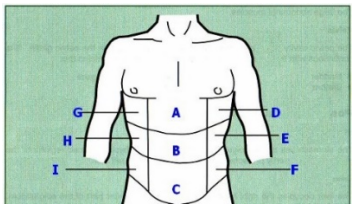
1. How long has your child had the pain?
□ Less than 4 weeks □ 7-12 months
□ 5-7 weeks □ 1-2 years
□ 2-6 months □ More than 3 years

2. In the last *4 weeks*, how often did your child have abdominal pain?
□ 1 time in the last month □ 2-4 times per week in the last month
□ 2-4 times in the last month □ 5-7 times per week in the last month
□ 5-7 times in the last month

3. Since the pain started, has your child been healthy (without abdominal pain) for periods that last *weeks to months*?
□ Yes □ No

4. Was your child sick with a fever, respiratory infection, strep throat, or stomach flu at the time the pain started?
□ Yes □ No
If yes, when? _____ days/weeks/months/years before the pain started

5. In the last *4 weeks*, when your child has had abdominal pain, where does it hurt? (Please mark an **X** on the figure below.)

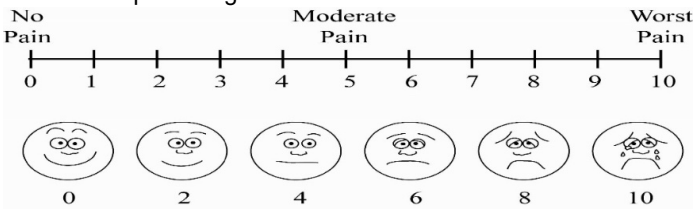


COMPLETE BACK SIDE →

6. During episodes of pain in the last *4 weeks*, how long does the pain usually last?

□ 5 minutes or less
□ 10-30 minutes
□ 30-60 minutes
□ 2-4 hours
□ 5-12 hours
□ 12-24 hours
□ 2-3 days
□ The pain is always there; it never goes away

7. Over the last *2 weeks*, on an average day, what is the typical intensity of your child's pain on a 10-point scale where 0 is no pain and 10 is the worst pain imaginable?



8. Has your child experienced any of the following symptoms in the past *4 weeks*? (Mark all that apply)

□ Fatigue
□ Lightheaded or dizzy
□ Headache
□ Bloating
□ Feeling of fullness
□ Big belly
□ Feeling boated but without a big belly
□ Not being hungry after eating very little
□ Complains of food getting stuck after swallowing
□ Excessive belching
□ Passing excessive gas
□ Big belly worse in the evening
□ Heartburn
□ Chest pain
□ Complain of feeling of throwing up
□ Sour taste in mouth
□ Complains of hurting to swallow food/drink

9. When your child has abdominal pain:

- Is he/she sensitive to light or sound? □ Yes □ No
- Does he/she also have a headache? □ Yes □ No
- Does he/she appear pale? □ Yes □ No

10. *Post-pubertal girls only:*

- In the past *3 months*, did your daughter have belly pain just before/during her menstrual period? □ Yes □ No
- If yes, was the belly pain different from the menstrual pain? □ Yes □ No

B. Bowel Movements

1. How often does your child have a bowel movement?

□ 1-2 times per day
□ 3 or more times per day
□ 3-6 times per week
□ Less than 3 times a week
□ Less than 1 time a week

2. Does your child have the following related to their bowel movements: (Mark all that apply)

□ Bowel movements softer, mushier or watery most of the time
□ Spends a lot of time sitting on the toilet with no results
□ Bowel movements hard or lumpy most of the time
□ Straining with bowel movements
□ Immediate need to have a bowel movement that interrupts activities
□ Pain during a bowel movement
□ Pain improved after bowel movement
□ Passage of mucous with bowel movement
□ Leaks stool in underwear
□ Large stool that clogs the toilet at times

C. Nausea and Vomiting

1. Does your child complain of nausea? □ Yes □ No *If yes*, how often? _____
2. Does your child vomit frequently? □ Yes □ No *If yes*, how often? _____

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3. Does your child have "attacks" of intense nausea and vomiting where they vomit several times an hour? □ Yes □No
If yes, how many of these attacks have they had in the last *3 months*? □ 1-2 □ 3-5 □ 6-8 □ 9 or more
If yes, are the symptoms of the vomiting attack similar each time? (i.e. length of vomiting attack) □ Yes □ No

D. Review of Symptoms

Has the patient had any of the following?

Recurrent fever	**□ Yes □ No**	**Blood in stool**	**□ Yes □ No**	**Joint pain/swelling**	**□ Yes □ No**
Weight loss	**□ Yes □ No**	**Mouth sores**	**□ Yes □ No**	**Painful/itchy Rash**	**□ Yes □ No**
Poor weight gain	**□ Yes □ No**	**Vomiting**	**□ Yes □ No**	**Pain waking them up**	**□ Yes □ No**
Eye problems	□ Yes □ No	Heart problems	□ Yes □ No	Urination problems	□ Yes □ No
Ear problems	□ Yes □ No	Anemia	□ Yes □ No	High blood pressure	□ Yes □ No
Nose problems	□ Yes □ No	Allergies	□ Yes □ No	Seizures or convulsions	□ Yes □ No
Throat problems	□ Yes □ No	Hyperactivity	□ Yes □ No	Endocrine problems	□ Yes □ No
Breathing problems	□ Yes □ No	Nausea	□ Yes □ No	Emotional problems	□ Yes □ No
Dizziness	□ Yes □ No	Constipation	□ Yes □ No	Psychiatric problems	□ Yes □ No
Weakness	□ Yes □ No	Diarrhea	□ Yes □ No	Sexual/physical abuse	□ Yes □ No

E. Impact of Child's Symptoms

If your child is 5 years or older, please answer the following questions:

The following questions assess how much your child's symptoms (belly pain, constipation, diarrhea, etc.) affect his/her day-to-day activities. Your answer should be based on the last *2 months*. There are no "right" or "wrong" answers so please answer with your best guess.

- How many full days of school were missed due to your child's symptoms? _____
- How many partial days of school were missed due to your child's symptoms? _____
- How many days did your child function at less than half of his/her ability in school because of their GI symptoms? (Do not include days counted in the first 2 questions.) _____
- How many days was your child not able to do things at home (chores, homework, etc.) due to his/her symptoms? _____
- How many days did he/she not participate in other activities due to his/her symptoms? (play, go out, sports, etc.) _____
- How many days did he/she participate in these activities, but functioned at less than half of his/her ability? (Do not include days counted in the 5th question.) _____

F. Past Medical History (Mark all that apply)

□ Prematurity (born before 36 weeks gestation)
□ Previous surgeries in the abdomen
□ Required neonatal intensive care
□ Suffered a significant injury to arms or legs
□ A urinary tract infection during infancy treated with antibiotics
□ Gastrointestinal infections (for example, diarrhea or vomiting for more than 3 days)
□ Other illnesses, surgeries, or hospitalizations: _____
_____

G. Family History

Does anyone in your family have any of the following medical conditions? (Mark all that apply)

Irritable Bowel Syndrome	□ Yes □ No	Who? _____
Migraine Headaches	□ Yes □ No	Who? _____
Inflammatory Bowel Disease	□ Yes □ No	Who? _____
Celiac Disease	□ Yes □ No	Who? _____
Depression	□ Yes □ No	Who? _____
Anxiety Disorders	□ Yes □ No	Who? _____
Upper abdominal pain/dyspepsia	□ Yes □ No	Who? _____
ADHD	□ Yes □ No	Who? _____

COMPLETE BACK SIDE →

Heartburn	□ Yes □ No	Who? _____
Chronic Fatigue	□ Yes □ No	Who? _____
Cyclic vomiting syndrome	□ Yes □ No	Who? _____

Other Family Medical History: _____
_____

H. Social History

Parents are: □ Married □ Separated □ Divorced □ Never married

Mother's highest education completed: _____ Mother's job: _____

Father's highest education completed: _____ Father's job: _____

Has your family moved households in the last 12 months?	□ Yes	□ No
Has your child changed schools in the last 12 months?	□ Yes	□ No
Has a family member become seriously ill or died in the last 12 months?	□ Yes	□ No
Has a family member been away from home for long periods of time?	□ Yes	□ No
Has the number of people living in the household increased?	□ Yes	□ No
Does either parent work more than 60 hours per week?	□ Yes	□ No
Has your child experienced bullying at school?	□ Yes	□ No
Does your child worry about grades or school work?	□ Yes	□ No
Does your child have special learning needs?	□ Yes	□ No
Does your child have trouble falling or staying asleep at night?	□ Yes	□ No
Are you concerned that your child might be depressed?	□ Yes	□ No
Are you concerned that your child is very nervous or anxious?	□ Yes	□ No
Has your child witnessed a traumatic event?	□ Yes	□ No

Thank you for taking the time to fill out this form. The information you have provided is very important to your care team.

This form was completed by (your name): _____

Relationship to patient: _____

For Office Use Only:

I have reviewed the information above.

Provider signature: _____ Date: _____

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SERVICES FORM

PATIENT NAME: _____

PHONE #: _____

SECONDARY PHONE #: _____

E-MAIL ADDRESS: _____

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

EMERGENCY CONTACT NAME: _____

PHONE #: _____

RELATIONSHIP TO CHILD: _____

RACE (PLEASE CHECK)

_____ BLACK AFRICAN AMERICAN

_____ ASIAN AMERICAN

_____ AMERICAN INDIAN, ALASKA NATIVE

_____ CAUCASIAN

_____ NATIVE HAWAIIAN, OTHER PACIFIC ISLANDER

_____ UNKNOWN

_____ OTHER (PLEASE SPECIFY): _____

ETHNICITY (PLEASE CHECK ONE)

_____ HISPANIC OR LATINO

_____ NOT HISPANIC OR LATINO

_____ UNKNOWN

PRIMARY LANGUAGE (PLEASE CHECK ONE)

_____ ENGLISH

_____ BURMESE

_____ SPANISH

_____ RUSSIAN

_____ OTHER (PLEASE SPECIFY): _____

UB|MD PEDIATRICS

Date: _____

CONSENT FOR TREATMENT

Patient Name: _____

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

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

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

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

_____ _____

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

_____ _____

Witness | Date

UB|MD PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

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

_____

Signature

_____

Name or Personal Representative

_____

Date

_____

Relationship to Patient

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

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify: _____)

UB|MD PEDIATRICS

HIPAA

(Health Insurance Portability and Accountability Act)

AUTHORIZATION TO SHARE PHI

Disclosure of Protected Health Information

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

PATIENT INFORMATION

Patient Name: _____ DOB _____/_____/_____

Telephone (daytime): _____ (evening): _____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

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

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

Other (Please specify: _____)

NOTIFICATIONS

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

_____

PATIENT UNDERSTANDING AND SIGNATURE

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

_____ _____
Signature Patient Name or Personal Representative

_____ _____
Description of Personal Representative's Authority Date

UB|MD
PHYSICIANS' GROUP

MyUBMD
Pediatric Proxy Access Request

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

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

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

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

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

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

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

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

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

Phone Number: (_____)_____ Email: _____

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

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

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

Phone Number: (_____)_____ Email: _____

Relationship to Patient (Circle one): Parent Guardian

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

_____/_____/_____

Your (Proxy) Signature | Relationship to Patient | Date

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

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

UB|MD
PHYSICIANS' GROUP

MyUBMD
Adult Proxy Access Request

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

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

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

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

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

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

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

Phone Number: (_____)_____ Email: _____

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

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

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

Phone Number: (_____)_____ Email: _____

Access Level (Circle one): Full Access Read Only

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

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

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

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

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

UB|MD PEDIATRICS

FINANCIAL POLICY

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

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

1. PATIENT'S current insurance card

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. MEDICAID MANAGED CARE AND MEDICAID PROGRAMS

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

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

4. APPOINTMENT CANCELLATION POLICY

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

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

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

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

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

_____ _____

Signature Date