UB|MD PEDIATRICS

THE PHYSICIANS AT
Oishei Children's Hospital

DIVISION OF ADOLESCENT MEDICINE

Welcome to the Division of Adolescent Medicine. Our diverse staff provides specialized and multidisciplinary services focused on the health and psychosocial needs of adolescents and young adults, ages 12-30.

Subspecialty Services:

- Evaluation and treatment of eating disorders including obesity
- Reproductive health care
- Testing and treatment for sexually transmitted diseases
- Evaluation, treatment and referral for alcohol and substance abuse
- Evaluation and treatment of gynecological problems
- Evaluation, 2nd opinions and treatment for complex multifactorial/chronic conditions
- Follow-up of post-sexual assault patients and management of post-exposure prophylaxis medications
- Care for adolescents with chronic disease
- Routine HIV testing and risk reduction counseling and access to an HIV treatment specialized program
- Medical management and care coordination of mental health conditions
- Immunizations
- Functional abdominal pain
- Gender dysphoria

Attending Physicians

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

Dalinda Condino, MD
Division Chief

Christina Padgett, DO, MHS

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	**716.323.0050** **716.323.0296** **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.

UB|MD PEDIATRICS

DIVISION OF ADOLESCENT MEDICINE
1001 MAIN STREET, 5TH FLOOR
BUFFALO, NY 14203
T: 716.323.0050 | F: 716.323.0296

EATING DISORDER INTAKE FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Weight Change History:

This information provided below will help us to understand you better as a patient. Please answer each item to the best of your ability, do not worry about being exact if you are unsure on certain questions.

1. Approximate weight now _____; 6 months ago _____; 1 year ago_____; 2 years ago _____; 3 years ago _____
2. Height _____ (feet) _____ (inches)
3. Do you think your body frame is □ Small □ Medium □ Large?
4. What is the most you've ever weighed? _____
   - When did you reach that weight? _____ (month and year)
   - When did you last reach that weight? _____ (month and year)
   - What is the longest of period time you stayed that weight? _____ months
5. Since childhood, what is the least you have ever weighed? _____
   - When did you reach that weight? _____ (month and year)
   - When did you last reach that weight? _____ (month and year)
   - What is the longest of period time you stayed that weight? _____ months
6. What is a normal weight for your height, and body frame? _____
7. What would you like to weigh? _____
8. Are you involved in activities that require you to control your weight? □ NO □ YES
   - Check all that apply: □ Work □ Sports □ Dance □ Other: _____
9. How often do you weigh yourself?
   □ Less than once a week
   □ Once a week
   □ 2-6x a week
   □ Once a day
   □ More than once a day
10. Does your weight go up and down, from day to day? □ NO □ YES
11. If I gained (or lost) 2 lbs., I would feel (check what applies):
    - Gained: □ Very Bad □ Bad □ No Different □ Very Good □ Good
    - Lost: □ Very Bad □ Bad □ No Different □ Very Good □ Good
12. How did you feel in grades 1-4, and how do you feel now? (check what applies)
    - 1-4: □ Very Thin □ Thin □ Normal Weight □ Fat □ Very Fat
    - Now: □ Very Thin □ Thin □ Normal Weight □ Fat □ Very Fat

Symptoms:

In the last 6 months, have you had any of the following symptoms? If YES, circle the number that best describes how often each occurs.

	Y / N	UNDER ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY
HEADACHE		1	2	3	4	5
DIZZINESS		1	2	3	4	5
FAINTING		1	2	3	4	5
COLD HANDS OR FEET		1	2	3	4	5
PUFFINESS		1	2	3	4	5
ENLARGED CHEEKS OR JAW		1	2	3	4	5
TROUBLE WITH TEETH OR GUMS		1	2	3	4	5
HAIR LOSS		1	2	3	4	5
HAIR GROWTH		1	2	3	4	5
HEAT OR COLD SENSITIVITY		1	2	3	4	5
CONSTIPATION		1	2	3	4	5
DIARRHEA		1	2	3	4	5
PAINFUL URINATION		1	2	3	4	5
STOMACH PAIN		1	2	3	4	5
MUSCLE CRAMPS		1	2	3	4	5
CHEST PAIN		1	2	3	4	5
BREAST DISCHARGE		1	2	3	4	5
BONE PAIN		1	2	3	4	5
JOINT PAIN		1	2	3	4	5
NAUSEA		1	2	3	4	5
BLOATING		1	2	3	4	5
LOSS OF APPETITE		1	2	3	4	5
WEAKNESS		1	2	3	4	5
FEELING IRRITABLE		1	2	3	4	5
FEELING DEPRESSED		1	2	3	4	5
TROUBLE SLEEPING		1	2	3	4	5
BEING AFRAID YOU CANT STOP EATING		1	2	3	4	5
THINKING ABOUT FOOD		1	2	3	4	5
DIFFICULTLY CONCENTRATING		1	2	3	4	5
DIFFICULTY MAKING DECISIONS		1	2	3	4	5
DIFFICULTY GETTING ALONG W/FAMILY		1	2	3	4	5
DIFFICULTY GETTING ALONG W/FRIENDS		1	2	3	4	5
FEEL BAD ABOUT YOURSELF		1	2	3	4	5
FEEL BAD AFTER EATING		1	2	3	4	5
OTHER: _____		1	2	3	4	5

Have you ever been treated for any of the symptoms listed above? □ NO □ YES

- If YES, when and by whom were you treated? _____
- If YES, have you been hospitalized or taken medication as part of your treatment? □ NO □ YES

Weight Control Activity:

1. In the last year, have you used any of the following methods to control your weight, or used them for other reasons?
   - If YES, circle how often you have used each method, on the average, approximately 6 months ago and circle how often you use each method, on the average, over the last 3 months.

LIMITING FOOD INTAKE

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

EXERCISE

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

VOMITING

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

IPECAC

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

LAXATIVES

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

DIURETICS

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

DIET PILLS

YES	NO	LESS THAN ONCE A WEEK	ONCE A WEEK	2-6X A WEEK	ONCE A DAY	MORE THAN ONCE A DAY

If you answered NO to all of the above, then you can move past questions #2-6.
If you have answered YES, please answer questions #2-6.

2. Limited food intake (dieting) to lose weight:
   - When did you first begin to diet? _____ (month and year)
   - What was your height and weight at that time? Height _____ Weight _____
   - What is the longest you've stayed on a diet? _____ months

3. Exercising how many hours per week? ____ hours

   Walking how many hours per week? ____ hours

   Running or Jogging how many hours per week? ____ hours

   Aerobics or Calisthenics how many hours per week? ____ hours

Weight Lifting how many hours per week? ____ hours

Dancing or Ballet how many hours per week? ____ hours

Swimming how many hours per week? ____ hours

Gymnastics how many hours per week? ____ hours

Team Sports how many hours per week? ____ hours

When did you begin your exercise program? _____ (month and year)

Has your exercise regimen changed in the last 24 months? □ NO □ YES, explain how?

_____

_____

4. Vomiting after eating: □ Small amounts □ Large amounts □ Both
   - Vomit how soon after finished eating? _____ minutes
   - How do you make yourself throw up? Circle all that apply.

Stick something in my throat	Take Ipecac	Put pressure on stomach	"It just happens."	Other: _____ _____ _____

   - How did you get the first idea to vomit? Circle all that apply.

Read about it	TV/Radio	Friend	Family member	Thought of it myself	Other: _____ _____ _____

5. Medications or Drugs in the past month to lose weight? Please list type, dose, and frequency.

	YES / NO	DOSE	FREQUENCY PER MONTH
IPECAC			
LAXATIVES			
DIURETICS			
DIET PILLS			

6. Rate on a chart with an "X" how other people and things have influenced your weight control? If a category has more than one possible answer, i.e. If you have two sisters or have read several different diet books, pick the most influential person or thing in the category.

	STRONGLY INFLUENCED WEIGHT LOSS	INFLUENCED WEIGHT LOSS	NEUTRAL / NO INFLUENCE	INFLUENCED WEIGHT GAIN	STRONGLY INFLUENCED WEIGHT GAIN	N/A
SISTER/BROTHER						
MOM/DAD						
FRIEND						
DOCTOR/NURSE						
BOY/GIRLFRIEND						
COACH						

OTHER: _____						
TELEVISION						
SOCIAL MEDIA						
RADIO						
MOVIE						
BOOK/MAGAZINE						
ADS						
OTHER: _____						

Eating History:

This history will help us to understand your eating habits. Please choose the one answer that best describes a typical day, or week.

1. On a scale of 0-5, how much do you now eat at each of the following times in a typical day?
   Nothing-0 Snack-1 Small Meal-2 Meal-3 Large Meal-4 Binge-5

   AT: Breakfast _____ Lunch _____ Dinner _____

   BETWEEN: Breakfast & Lunch _____ Lunch & Dinner _____ Dinner & Bedtime _____

   AFTER: Going to bed _____ Something Upsetting _____ Other (specify): _____

2. How many times a week do you eat the following meals? Please circle.

   Breakfast: 0 1 2 3 4 5 6 7

   Lunch: 0 1 2 3 4 5 6 7

   Dinner: 0 1 2 3 4 5 6 7

3. How many times a week do you eat the following meals with your family? Please circle.

   Breakfast: 0 1 2 3 4 5 6 7

   Lunch: 0 1 2 3 4 5 6 7

   Dinner: 0 1 2 3 4 5 6 7

4. Please rate your preference for eating the following food groups. (Look over the items in the list before you start answering.)

	EXTREME DISLIKE	DISLIKE	TAKE IT OR LEAVE IT	LIKE	FAVORITE FOOD
BREAD, CEREAL OR PASTA					
COOKIES, CAKE OR PIE					
FAST FOOD					
FISH					
FRUIT					
MILK, CHEESE OR YOGURT					
POULTRY					
RED MEAT					

SNACK FOODS					
SWEETS OR CANDY					
VEGETABLES					
OTHER: _____					
OTHER 2: _____					

5. How well do the following words describe your food choices and eating habits now?

	EXTREMELY	VERY MUCH	SOMEWHAT	SLIGHTLY	NOT AT ALL
IMPULSIVE	1	2	3	4	5
BORING	1	2	3	4	5
WELL PLANNED	1	2	3	4	5
FATTENING	1	2	3	4	5
NUTRITIOUS	1	2	3	4	5
FLEXIBLE	1	2	3	4	5

6. Please record what you typically eat and drink at BREAKFAST:
   Food/Drink Amount
   _____
   _____
   _____
   _____

7. Please record what you typically eat and drink at LUNCH:
   Food/Drink Amount
   _____
   _____
   _____
   _____

8. Please record what you typically eat and drink at DINNER:
   Food/Drink Amount
   _____
   _____
   _____
   _____

Binge Eating History:

1. Has there ever been a time when you were in the habit of eating a large amount of food in a short amount of time (binge eating): □ NO □ YES
   - IF YES, When did you start to binge? _____ (month and year)
   - What was your height and weight? Height _____ Weight _____
2. Have you binged in the last 3 months? □ NO □ YES, how often on average? (choose one)
   - □ Less than once a week
   - □ Once a week
   - □ 2-6x a week
   - □ Once a day
   - □ More than once a day

3. Was there a time in your past when your binging was worse than it is now? □ NO □ YES
   - IF YES, please rate your binge eating at its worst.
     □ Less than once a week
     □ Once a week
     □ 2-6x a week
     □ Once a day
     □ More than once a day
4. If you binge more than once a month, please answer a-e below.
   a. Do you prefer any particular food in a binge? □ NO □ YES
   - If YES, please rate the following using scale below.

	NEVER EAT THIS IN A BINGER	DISLIKE	TAKE IT OR LEAVE IT	LIKE	FAVORITE BINGE FOOD
BREAD, CEREAL OR PASTA					
COOKIES, CAKE OR PIE					
FAST FOOD					
VEGETABLES					
FRUIT					
MILK, CHEESE OR YOGURT					
POULTRY					
RED MEAT					
SNACK FOODS					
SWEETS OR CANDY					
NUTS/ PEANUT BUTTER					
OTHER: _____					
OTHER 2: _____					

   b. How many calories do you consume in a typical binge?
      □ <500 □ 2000-3000
      □ 500-1000 □ 3000-4000
      □ 1000-2000 □ >4000
   c. How long does your typical binge last? _____ minutes
   d. Do you ever binge in the presence of other people? □ NO □ YES
   e. Are your binges? □ Planned □ Spontaneous □ Both
5. Are there any foods or beverages that "trigger" a binge (when you eat or drink these items, you are likely to end up binging, even if you didn't plan to)? □ NO □ YES
   - If YES, what foods? _____

     _____
6. Do you know anyone else who binge eats? □ NO □ YES
   - If YES, who? _____

7. In what settings are you likely to binge?
   - □ At home alone
   - □ At home when others are home
   - □ Eating out
   - □ School
   - □ Work
   - □ Other
8. In what situations are you likely to binge? (check all that apply)
   - □ Sad, depressed
   - □ Angry
   - □ Anxious
   - □ Hungry
   - □ After an argument
   - □ Other
9. How do you feel after a binge? (check all that apply)
   - □ Sad, depressed
   - □ Angry
   - □ Anxious
   - □ Happy
   - □ Guilty
   - □ Hopeless
   - □ Other
10. What happens immediately after a binge?
    - □ Go back to what I was doing
    - □ Vomit
    - □ Laxative/Diuretic
    - □ Begin to fast
    - □ Exercise
    - □ Sleep
    - □ Other
11. Do you think that your pattern of binge eating is a problem for you? □ NO □ YES
    - If YES, what have you tried to do about it? _____

      _____
12. Who knows about your binge eating? _____
13. Is there anything else you would like us to know about your binge eating? □ NO □ YES
    - If YES, please explain: _____

      _____

Body Satisfaction:

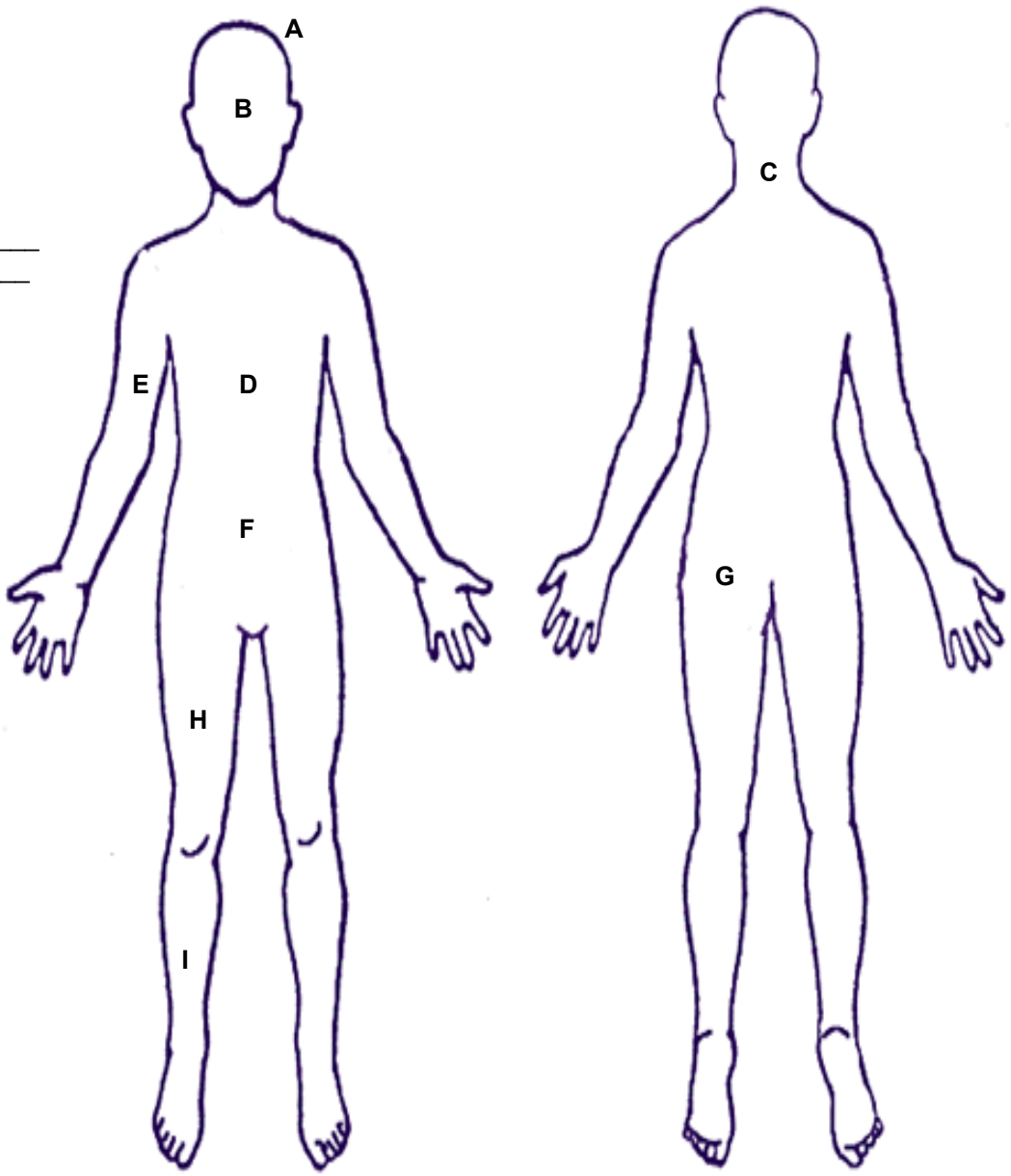
The purpose of this exercise is to help us understand how you feel about your body. Areas on the outline have been divided into segments. Each area is identified by a letter from A to I. For each of these areas please pick the number that best describes how you feel about that particular area of your body, from very satisfied to very dissatisfied.

SCALE: 1-VERY DISSATISFIED 2-DISSATISFIED 3-NEUTRAL 4-SATISFIED 5-VERY SATISFIED

BODY PART

A.) HAIR _____
B.) FACE _____
C.) NECK _____
D.) CHEST _____
E.) ARMS _____
F.) STOMACH/WAIST _____
G.) HIPS/BUTTOCKS _____
H.) THIGHS _____
I.) LOWER LEGS _____

TOTAL _____



Descriptions Form:

We all have a very complex thoughts and feelings about our bodies, and it is difficult to have to reduce our experience of ourselves to a single number on a 5 point scale. On this form, we'd like you to describe, in your own words how you feel about your body. Please be as detailed as possible.

1. How would you describe your feelings about your body?

(Continue on back if needed)

2. If you could change your body, what would you change and how would it change your life?

(Continue on back if needed)

Daily Schedule:

ACTIVITY

6:00 a.m. to 7:00 a.m. _____

7:00 a.m. to 8:00 a.m. _____

8:00 a.m. to 9:00 a.m. _____

9:00 a.m. to 10:00 a.m. _____

10:00 a.m. to 11:00 a.m. _____

11:00 a.m. to 12:00 noon _____

12:00 p.m. to 1:00 p.m. _____

1:00 p.m. to 2:00 p.m. _____

2:00 p.m. to 3:00 p.m. _____

3:00 p.m. to 4:00 p.m. _____

4:00 p.m. to 5:00 p.m. _____

5:00 p.m. to 6:00 p.m. _____

6:00 p.m. to 7:00 p.m. _____

7:00 p.m. to 8:00 p.m. _____

8:00 p.m. to 9:00 p.m. _____

9:00 p.m. to 10:00 p.m. _____

10:00 p.m. to 11:00 p.m. _____

11:00 p.m. to 12:00 a.m. _____

Parent History:

1. Please check all that apply to the infancy and early childhood of your daughter/son.
   Feeding:
   - □ Normal
   - □ Poor appetite
   - □ Vomiting
   - □ Colic
   - □ Diarrhea
   - □ Other

   Weight: □ Normal □ Underweight □ Overweight
2. Please check how you perceived your daughter's/son's weight in grades 1-4, compared to now.
   Grades 1-4: □ Very thin □ Thin □ Normal □ Heavy □Very heavy
   Now: □ Very thin □ Thin □ Normal □ Heavy □Very heavy
3. Does your daughter/son make negative remarks about his/her body? □ NO □ YES
   - If YES, how often? _____
4. How many times a week does your daughter/son eat the following meals?
   Breakfast _____

   Lunch _____

   Dinner _____
5. How many times a week does your daughter/son eat the following meals with family?
   Breakfast _____

   Lunch _____

   Dinner _____
6. How well do the following words describe your daughter's/son's food choices and eating habits?

	EXTREMELY	VERY MUCH	SOMEWHAT	SLIGHTLY	NOT AT ALL
IMPULSIVE	1	2	3	4	5
BORING	1	2	3	4	5
WELL PLANNED	1	2	3	4	5
FATTENING	1	2	3	4	5
NUTRITIOUS	1	2	3	4	5
FLEXIBLE	1	2	3	4	5

7. On a scale of 0-5, how much do YOU now eat at each of the following times in a typical day?
   Nothing-0 Snack-1 Small Meal-2 Meal-3 Large Meal-4 Binge-5

   AT: Breakfast _____ Lunch _____ Dinner _____

   BETWEEN: Breakfast & Lunch _____ Lunch & Dinner _____ Dinner & Bedtime _____

   AFTER: Going to bed _____ Something Upsetting _____ Other (specify): _____
8. When did you first notice a change in his/her eating habits?
   - □ 0-3 months ago
   - □ 3-6 months ago
   - □ 6-12 months ago
   - □ 12-24 months ago
   - □ >24 months ago
9. What changes did you notice then? Check all that apply.
   - □ Skipping meals
   - □ Exercising to lose weight
   - □ Talking about weight
   - □ Eating less at meals
   - □ Vomiting
   - □ Irritability when asked about eating
   - □ Overeating
   - □ Laxatives
   - □ Other (specify): _____

10. What changes do you notice now? Check all that apply.

- □ Skipping meals
- □ Exercising to lose weight
- □ Talking about weight
- □ Eating less at meals
- □ Vomiting
- □ Irritability when asked about eating
- □ Overeating
- □ Laxatives
- □ Other (specify): _____

11. How well do the following words describe family mealtimes at home now?

	EXTREMELY	VERY MUCH	SOMEWHAT	SLIGHTLY	NOT AT ALL
HAPPY					
TENSE					
ENJOYABLE					
FRUSTRATING					

12. Any family members with the following conditions? (only blood relatives, but including aunts, uncles and cousins along with immediate family members)

	NO	YES	IF YES, RELATIONSHIP TO PATIENT
ANOREXIA NERVOSA			
ARTHRITIS			
ASTHMA			
BACK PROBLEMS			
BLEEDING DISORDER			
BONE DISEASE			
BRONCHITIS/EMPYHSEMA			
OTHER LUNG DISEASE			
BULIMIA (BINGE EATING)			
CANCER			
COLITIS			
DEPRESSION			
DIABETES			
DRINKING PROBLEM			
DRUG ABUSE			
HEADACHES			
HEART ATTACK			
HIGH BLOOD PRESSURE			
CROHNS DISEASE			
IRRITABLE BOWEL SYNDROME			
KIDNEY DISEASE			
KIDNEY STONES			

MENTAL ILLNESS (SPECIFY): _____			
OBESITY			
OSTEOPOROSIS			
STROKE			
SUICIDE/ATTEMPT			
THYROID DISEASE			
ULCERS			
VOMITING (PERSISTENT)			
OTHER (SPECIFY): _____			

13. Is there any other family history you feel is important regarding your daughter/son?

_____

_____

_____

_____

14. Is there any other information that would be important for us to know about your daughter/son?

_____

_____

_____

_____

15. What are you most concerned about with respect to your daughter/son?

_____

_____

_____

_____

16. How would you like us to help your daughter/son and you or your family?

_____

_____

_____

_____

UB|MD PEDIATRICS

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