PEDIATRIC UROLOGY AT
THE UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK

Phone: (518) 262-3341 • **Fax:** (518) 262-6660 • **Albany:** 23 Hackett Blvd, Albany 12208
Malta: 5 Hemphill Place, Community Care Pediatrics, Building 5, Suite 123, Malta NY, 12020

Welcome to our practice!

All of us in Urology are dedicated to providing the best possible care for your child. We will do everything we can to help with that, but we do need your cooperation on several points.

- **By law, a parent and/or guardian must accompany your child at each visit**. If there are extenuating circumstances, please speak with our supervisor before the day of the appointment and we will try to make an exception if at all possible. If non-parents are caring for a child, custody papers should be faxed to our office when the appointment is made.

- In order for us to take the best care of your child, we must view the actual x-rays your child has undergone. P**lease bring a CD** with the actual x-rays (this is even more important than the report) to your child's appointment. The hospital/primary care physician may send us the report, but they will usually **not** send the actual pictures. .

- **CCP requires a copy your insurance card and the ID of the child's parent/guardian at the time of the visit. Please be sure to bring both. In addition, co-payments are due at the time of your visit.** If you do not have your co-payment you will be asked to reschedule your appointment. We accept cash, checks, and credit/debit cards.

Please understand that we are a teaching institution and we often have students and physicians getting advanced training working with us. We do not allow any of these trainees to practice on your child and indeed, studies have shown that the presence of trainees on our team actually enhances care.

We do our best to be prompt. We respect your time and will try to warn you as much as possible in advance about delays. Sometime delays are out of our control. We encourage you to bring reading material and/or your tablet/laptop. We have free wireless in our waiting area for your convenience and enjoyment.

We see patients at two locations. Our secretaries at 518-262-3341 schedule for both offices.

Appointment. _____ **Location:** __ **23 Hackett Blvd, Albany, NY**

__ **5 Hemphill Place, Malta, NY**

Barry Kogan, MD, FAAP, FACS
Professor, Surgery & Pediatrics

Jean Hollowell, MD, FACS
Associate Professor, Surgery & Pediatrics

Karla Giramonti, FNP
Instructor of Surgery

11/11/14

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Please Help Us By Filling Out This History Form And Bringing It To Your Child's Appointment

PLEASE BRING ALL CDs OF TESTS DONE BY ANY RADIOLOGY DEPARTMENT

Patient Name: _____ **Birthdate:** _____

Ethnic Background: _____

E-mail address: _____

Pharmacy name:_____

Pharmacy Phone #_____**Fax#**_____

Why is your child being seen? _____

Medications: (Please include dosages and times):

_____ _____ _____

Allergies to Medication _____ _____ _____

Does your child have a Latex Allergy? YES NO

Prenatal/Neonatal Development:

No Complications Yes Complications _____

Prenatal Alcohol Intake: None, Occasional, or Regular

Prenatal Smoking: None, < 1 pack/d, >1 pack/d

Delivery: (circle one) Spontaneous vaginal delivery Induced vaginal delivery

C-section Reason for C-Section _____

Was your child Premature? Y / N (# weeks of pregnancy at birth) _____

Was your child in the hospital for longer than 2-3 days after birth? Y / N If yes, for how long _____

Was your child breastfed? Y / N If yes, for how long? _____

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Past Medical History of your child: Circle all that applies (write in anything not listed)

Diabetes	Kidney disease	AIDS
Anemia	Diarrhea	Breathing problems
High blood pressure	Constipation	Overnight hospitalizations
Heart problems	Bleeding problem	Other_____
Cancer	Developmental concerns	

Has your child been on antibiotics? Y / N

If yes, please add an estimate of how many times or for how long _____

Operations your child has had: Circle all that apply (write in anything not listed).

Tonsils	Testicle surgery	Kidney surgery
Appendix	Bowel surgery	Circumcision
Hernia	Heart surgery	Other_____
No surgeries		

Social History:

1) Caregivers (circle) Single Parent Two Parents (circle whether one or two households)

Foster Parents Other Legal Guardian_____

Highest Degree of Caregivers: High School Technical School College Graduate School

Occupation of Caregivers _____

2) Child's Grade in School: _____ Doing well in school?_____

3) For teens: Tobacco Use: ____Packs per day started at age _____ 4) Drug Use: Marijuana or Other

Brothers/Sisters (and ages) _____

Family History: Mother/Father/Brothers/Sisters (list as M, F, B or S next to the diagnosis):

Kidney disease	Kidney stones	UTIs	Kidney reflux
Daytime wetting	Nighttime wetting	Testicular Problems	Constipation
Bleeding disorders	Diabetes	Epilepsy	Cardiovascular Dis
High blood pressure	Cancer	Alcoholism	

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Review of Systems:

Does your child have any of the following?

General Symptoms:	Yes	No
Fever	___	___
Chills	___	___
Other	___	___
Eyes:	___	___
Poor vision	___	___
Other	___	___
Respiratory:		
Asthma	___	___
Other	___	___
Gastrointestinal:		
Constipation	___	___
Diarrhea	___	___
Integumentary:		
Skin Problems	___	___
Rashes	___	___
Other	___	___
Neurological:		
Spine Problems	___	___
Seizures	___	___
Hydrocephalus		
Other	___	___
Ears, Nose, Throat:	Yes	No
Hearing Loss	___	___
Obstructive Sleep Apnea	___	___
Other	___	___

Musculoskeletal:	Yes	No
Any	___	___
Cardiovascular:		
High BP	___	___
Murmur	___	___
Other	___	___
Developmental:		
Delay	___	___
ADHD	___	___
Depression Anxiety	___	___
Other	___	___
Endocrine:		
Excessive Weight	___	___
Sugar (Diabetes)	___	___
Other	___	___
Hematological:		
Bruising/		
Bleeding Disorder	___	___
Sickle Cell	___	___
Other	___	___
Allergic/Immunologic:		
Any	___	___

Age Potty Trained _____

Age Menstruation Began: _____

Does your child have any type of syndrome? No Yes – please list. _____

Is your child seen by any other specialists? No Yes – please list. _____

Does your child have any other medical conditions that are not listed? No Yes – please list.

_____

THE UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK

Phone: (518) 262-3341 • **Fax:** (518) 262-6660 • **Albany:** 23 Hackett Blvd, Albany 12208

We are pleased you have selected our practice for your treatment. The Urological Institute of Northeastern New York is dedicated to be the leading provider of urological care in the Capital Region. Whether you are new to our practice or a returning patient, the following information is important for you to know in order for you to receive the best possible care.

Providers: We have several faculty physicians in our practice that provide care in general urology but also have expertise in specific areas of urology.
Specialty Areas
Urological Cancers: Dr. Hugh Fisher, Dr. Ronald Kaufman, Dr. Badar Mian, Dr. Rebecca O'Malley
Kidney Stones: Dr. Mark White
Pediatric Urology: Dr. Barry Kogan, Dr. Jean Hollowell
Female Urology: Dr. Laura Chang Kit, Dr. Elise De
Infertility and Men's Health: Dr. Andrew McCullough, Dr. Charles Welliver
General Urology: Dr. Donald Rivard, Dr. Donald Bentrovato

Nurse Practitioners/Physician's Assistants: Carl Diaz- Parker, Randi Daniels, Karla Giramonti
They see both new and follow-up patients under the guidance of our MDs.

RESIDENT PHYSICIANS: Because we are an academic medical center, one of our missions is to provide educational opportunities to the next generation of health care providers. The students and young physicians we work with are just beginning their careers. Their questions and input help to provide better patient care. They are always supervised by our faculty physicians.

PHONE CALLS: Our regular office hours are 8:30am-4:30pm, Monday through Friday. If you leave a message you can expect to receive a return call within 24 hours. If you believe that your call is urgent, please let the receptionist know this at the time of your call so that we can expedite your call.

REFERALS AND CO-PAYS: If your insurance requires a referral it will need to be obtained prior to your visit. **PLEASE BRING YOUR INSURANCE CARD AND ID AT EVERY VISIT** or we may not be able to see you. We collect your co-pay at the time you check in. It is illegal for us not to collect your co-pay.

WALK-IN APPOINTMENTS: We do not have walk- in appointments. If you feel you need to be seen immediately, please call our office and ask to speak to a nurse/medical assistant.

APPOINTMENT CANCELLATION/RESCHEDULING: If you are unable to keep this appointment, please call our office as soon as possible at (518) 262-3341 to reschedule. Cancellations must be made at least 24 hours in advance or you will be subject to a $25.00 fee.

PRESCRIPTIONS: Please give us a minimum of 48 hours advance notice. This will give adequate time for us to review your medical record and fill out the required forms. Also, please be aware that some prescriptions need insurance pre-authorization. This process takes at least 72 hours. When you phone in for a refill, be sure to have the pharmacy name and phone number.

TEST RESULTS: Test results are **NOT** given out over the phone. Results of any procedures done in our office will be discussed at your next scheduled office visit. Results of any tests or blood work ordered by your provider will be discussed at your next scheduled office visit.

EMERGENCY ROOM OR HOSPITAL ADMISSIONS: If you are seen in the ER of any hospital or are admitted to any hospital prior to your scheduled visit please let our office know so that appropriate records can be requested by our medical records staff.

PLEASE BRING THE REPORTS, PATHOLOGY SLIDES AND ANY X- RAY FILMS/CD's WITH YOU TO YOUR APPOINTMENT.

COPIES OF MEDICAL RECORDS: Medical record releases must be made in writing and signed by the patient or legal guardian of the patient. If you are requesting medical records be mailed a return address must be provided. If you are requesting medical records be faxed a fax number must be provided. Medical records may also be picked up in our office. **Please allow 7-10 days from the time your request is received by our office for your request to be processed and completed.**

FORMS: Disability forms, Social Security forms, insurance forms, etc., are very complex. In order for us to fill them out correctly, please allow 1-2 weeks turnaround. There is a $20.00 fee for form completions.

Thank you for your understanding, and cooperation with these issues. In our effort to ensure quality care for our patients, we welcome your opinions and suggestions. If you would like to comment or have concerns, please feel free to call the Practice Manager, Linda Hall at (518) 262-3341.

The Urological Institute of Northeastern New York

South Clinical Campus
23 Hackett Boulevard
Albany, New York 12208
Tel.: (518) 262-3341 • Fax: (518) 262-6660

Patient name (print)_____

Patient date of birth_____

Please list pharmacy name_____,

Telephone #_____and fax # _____

of pharmacy that is used for most refills.

Sincerely,

Medical Providers
The Urological Institute of Northeastern New York

COMMUNITY CARE PHYSICIANS, P.C.

Community Care Physicians, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians, P.C.'s
Print Patient Name

Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Guardian Date of Birth Date

_____ _____
Witness Date

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

Person or Entity to Receive the Information:

Dr. _____
Urological Institute of Northeast New York
23 Hackett Boulevard
Albany, New York 12208

This authorization permits the entity above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signed by: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____

Order # CCP Admin-40

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Community Care Physicians, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Please list other medical providers, family, friends, etc. whom, with your permission, may receive your medical information.	→	**Person or Entity to Receive the Information**
		_____
		_____
		_____

This authorization permits Community Care Physicians, P.C. to use and/or disclose the following individually identifiable health information about me. Please specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.:

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line below. In the event the health information described below includes any of these types of information, and I initial the line below, I specifically authorize release of such information to the person(s) indicated above.

Specific information to be released:

☐ Entire Medical Record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)

Only Include:		**Include:** *(Indicate by Initialing)*
☐ Prescriptions	☐ Office Notes	_____ **Alcohol/Drug Treatment**
☐ Lab Results	☐ Billing	_____ **Mental Health Information**
☐ Referrals	☐ Other _____	_____ **HIV-Related Information**

Reason for release of information: ☐ At request of individual ☐ Other: _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians, P.C.. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signed by: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____

COMMUNITY CARE PHYSICIANS, P.C.

PATIENT REQUEST FOR COPY OF MEDICAL RECORDS

COMMUNITY CARE PHYSICIANS, P.C.
www.communitycare.com

Patient Name: _____ DOB: _____ MRN: _____
(First) (Last)

Address: _____ _____
(Street Address) (City, State, Zip)

Phone: _____

HOW WOULD YOU LIKE TO OBTAIN YOUR RECORDS?

☐ **Paper Copy**

How would you like to receive them?

- ☐ Mail to the address above
- ☐ Pick up in office
- ☐ Mailed to the following address:

_____
(Name)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Relationship to the Patient)

☐ **Faxed to the following fax number:** _____

According to New York State law, you may be charged up to $0.75 per page for these requests.

☐ **Electronic Copy on a USB storage device supplied by CCP**

If you choose this option, you must provide an e-mail address here, so we can send you the password for the device:

_____
(E-mail Address)

How would you like to receive the device?

- ☐ Mail to the address above
- ☐ Pick up in office
- ☐ Mailed to the following address:

_____
(Name)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Relationship to the Patient)

The charge for this request is $20.00 payable in advance. Please be sure you have provided a valid e-mail address above. CCP will not be able to fulfill your request otherwise due to security concerns.

☐ **E-mail a Copy to the Following Address:** _____

The charge to e-mail your records is $5.00 payable in advance. Please note that your file may be too large to e-mail. If so, you will be notified and you will need to select an alternative option above. Additional charges may apply.

WHICH INFORMATION WOULD YOU LIKE TO RECEIVE?

- ☐ **Entire Record**
- ☐ Only the information in the time period _____ through _____.
- ☐ HIV/AIDS related information. (*Please note: this box must be checked in order to receive this information, even if you opted for your* ***Entire Record.***)
- ☐ Other (please be specific):

_____

_____

Specific criteria may include: laboratory results, provider orders, consultations, and imaging records.

IMPORTANT INFORMATION

a. I understand that the content of my file is not medical advice and is not to be used or relied on for diagnosis or treatment. The content does not take the place of instructions or advice from my doctor or health care provider. I will talk to my doctor or other health care provider before making any major health care decisions based on this electronic file.

b. I understand that the information disclosed pursuant to this request may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

c. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of CCP once it is in my possession. By requesting records in this format, I am knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.

I agree to pay $_____ to Community Care Physicians, P.C. for fees necessary to complete my request, including but not limited to: clerical work, processing, mailing, and storage devices.

_____ _____
Patient/ Legal Representative Signature **Date**

mycare DOT™

Community Care Physicians, PC

TERMS AND CONDITIONS

Terms and Conditions for email collection and patient portal mycareDOT™ communications:

Please follow the below guidelines when using email and portal communication with Community Care Physicians, PC (CCP).

1. You should never use email to communicate sensitive medical information with a Community Care Physicians' doctor/office. If you wish to connect with your doctor online, please use the mycareDOT™ patient portal and follow the below guidelines.

FOR MYCAREDOT™ Content:

A. The following types of information and content are acceptable for inclusion in communications using mycareDOT™:

   1. Prescription requests for non-controlled substances.
   2. Appointment requests.
   3. Medical reminders.
   4. Disclosure of some test results.
   5. Message your provider

B. mycareDOT™ cannot be used for emergencies or time-sensitive matters. It should be used with caution and on a limited basis. This communication should not replace your regularly scheduled office visits or times when your doctor suggests you come into the office for a visit. It is an additional option and not a replacement. Not all issues can be handled with mycareDOT™. Your doctor alone will decide which medical topics are appropriate for online communications and with whom we communicate with online. You may be directed to contact us via telephone or in person at any time.

2. Risk of Using Email

Transmitting patient information has a number of risks you should consider before using email, including:

a. Email can be circulated, forwarded, stored, and sent to unintended recipients

b. Email senders can easily misaddress an email

c. Backup copies of email may exist even after the original copy has been deleted

d. Employers have a right to inspect email transmitted through their system

e. Email can be intercepted, deleted, forwarded or used without authorization or detection

f. Email can be used to transmit viruses

g. Email can be used as evidence in court

h. Emails may not be secure and confidentiality of communications may be breached by a third party

****Using the secure patient portal helps to avoid the risks associated with emails.**

3. Community Care Physicians, P.C. will use reasonable means to maintain security and confidentiality with your email address and messages. Community Care Physicians, P.C. is not responsible for improper disclosure of confidential information that isn't caused by intentional misconduct.

4. Email is never appropriate for urgent situations or emergencies. Community Care Physicians, P.C. cannot guarantee any email will be read and responded to within a particular time.

5. When necessary, email will be printed and scanned into your medical record

6. It is the responsibility of the patient to follow-up and schedule an appointment if warranted

7. Inform your doctor's office of any changes to your email

A. The following types of information and content are NOT acceptable for inclusion in e-communications:

   1. Highly sensitive information such as mental health records.
   2. HIV or sexually transmitted disease information.
   3. Medical information related to pending legal claims or litigation including worker's compensation

Patient Acknowledgment and Agreement

By submitting your email address, you acknowledge that you have read and fully understand the terms described. CCP may use email to communicate company and health related news and announcements. Access to Community Care Physicians' web portal mycareDOT™ is an optional service and CCP may suspend or terminate access at any time and for any reason. If Community Care Physicians does terminate or suspend this service, you will be notified as promptly as possible. If you do not understand or do not agree to these terms, please do not enroll.

COMMUNITY CARE PHYSICIANS, P.C.

To Enroll in the Patient Portal mycareDOT™,

Complete this form and give it to the front desk.

Name (of patient): _____ Date of Birth (of patient): _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Parent/Guardian Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Signature: _____

Please read the terms and conditions in this brochure pertaining to the mycareDOT™ patient portal and email communications. By completing this form and submitting it to the front desk of your doctor's office, you are agreeing to the terms and allowing the office to invite you to join the patient portal via email invitation. You may also receive health and company news and announcements from Community Care Physicians, PC. If you do not understand or do not agree to comply with or do not consent to these policies or procedures, please do not complete this form to enroll in the patient portal.

A copy of this form will be scanned into your permanent medical record.