DANIELA ATANASSOVA - LINEVA M.D. FAAP, FSAM
NEW YORK

Daniela Atanassova-Lineva, M.D., Pediatrics, P.C.

63-95 Austin Street, Rego Park, NY 11374
Tel: 718.268.9100 Fax: 718.766.8236

NEW PATIENT REGISTRATION FORM

Date: ___/___/_____

Patients Name: _____
Date of Birth: _____ ( ) Male ( ) Female
Name of hospital patient was born in: _____
Newborns last name while in hospital: _____
Mothers Name _____ DOB: _____
Fathers Name _____ DOB: _____
Patients Address _____

Home Tel # _____
Patient lives with: ( ) Both Parents ( ) Mother ( ) Father ( ) Other
Address if different from above: _____
Mom's Cell # _____ Dad's Cell # _____
Mom's Work # _____Dad's Work # _____
Emergency Contact (other than parents): _____
Emergency Contact #_____ Relationship to patient: _____

E-mail: _____

Preferred Pharmacy: _____

Primary Insurance: _____
Policy #: _____ Group # _____
Primary Policy Holders Name: _____ DOB: _____
Relationship to patient: _____

Secondary Insurance: _____
Policy #: _____ Group # _____
Primary Policy Holders Name: _____ DOB: _____
Relationship to patient: _____

How did you hear about us: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) TO RECEPTIONIST

PLEASE PROVIDE YOUR CHILDS IMMUNUZATION RECORD CARD

Daniela Atanassova-Lineva, M.D., Pediatrics, PC
63-95 Austin Street, Rego Park, NY 11379

Phone: 718.268.9100
Fax: 718.766.8236

PATIENT INFORMATION CONSENT FORM/FINANCIAL AGREEMENT/RELEASE FORM
PATIENT INFORMATION CONSENT FORM

I have read and understand the Norm of Patient Information Practice. I understand that my Personal health information may be used for the proposes of carrying one treatment, obtaining payment evaluating the quality of services provided and any administrative operations related to treatment or payment I understand that I have the right to restrict how my personal health information is used and disclosed *for* treatment, payment and administrative operations if I notify you. I also understand that such requests for restriction will be considered on a case by case basis, but such requests for restrictions may not necessarily be accepted.

I hereby consent to the use and disclosure of my personal health Information for purposes as noted in the Patient Information Practices. I understand that I retain the right to revoke this consent by notification in writing at any time.

FINANCIAL AGREMENT/MEDICAL RELEASE

We participate with most Insurance Companies. Check your provider directory or contact your insurance to verify that this is a participating provider before members are rendered. Patient is responsible for the deductible, co-pay and co-insurance. When the insurance has processed your claim, they will send you an EOB (explanation of benefits). The EOB explains payment and patient responsibility. Patient payment Is required within 30 days of insurance payment Co-pays are required at the time service.
Patient are responsible for obtaining prescriptions and referrals from their Primary physician.
Self Pay accounts must be paid at the time of the service unless other arrangements have been made.

INSURANCE AND MEDICAL RELEASE FORM

I hereby authorize any insurance benefits to he paid directly to the physician providing services and recognize my responsibility to pay for all non covered services. I also authorize the physician to release any information necessary to process an insurance claim

A PARENT OR GUARDIAN WHO WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL AT THE TIME OF THE SERVICE MUST ACCOMPANY THE CHILD. WE CANNOT BE BOUND BY ANY DIVORCE OR OTHER FAMILY RELATIONSHIP CONTRACTS.

_____ _____

Patient Name **Date**

_____

Signature

Atanassova-Lineva,M.D.,Pediatrics,P.C.

Consent for Treatment of a Minor without Parent Present

I give permission for my child to be medically evaluated and treated at Atanassova-Lineva,Daniela pediatrics office in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:
1. complete physician check-up (including blood and urine samples)
2. hearing, vision, scoliosis, and blood pressure screening
3. immunizations
4. first aid and emergency care
5. prescription and treatment for illness
6. referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

If there are any services that you do not consent to in your absence, please list:
_____

_____

My child will be accompanied by:
[ ] himself/ herself
[ ] babysitter(name)_____
[ ] other (name, relationship)_____
I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Child's name Date

_____ _____
Parent or Guardian Signature Parent or Guardian Name

Phone number where parent or guardian can be reached

_____

Atanassova-Lineva, Daniela, M.D.,Pediatrics,P.C.
Adolescent Confidentiality Agreement

Parent

I, _____(parent or guardian), allow _____(patient), to enter a confidential patient-physician relationship. I understand that my son/daughter can make independent health care decisions.

_____(patient) has permission to schedule appointments and receive confidential reports from Atanassova-Lineva, Daniela Pediatrics office. I accept responsibility for physician charges and laboratory fees and give permission for diagnostic tests and procedures as required by the Doctor.

_____ _____
Parent or Guardian Date

_____ _____
Physician Date

Patient

I, _____(patient), am entering a confidential patient-physician relationship with _____(physician). I will make an effort to communicate with my parent(s) or guardian(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish.

_____ _____
Parent or Guardian Date

_____ _____
Physician Date

Daniela Atanassova-Lineva, M.D. Pediatrics, PC

Co-paymentPolicy: For all co-payments not paid at the time of visit there is a $10.00 surcharge that will be billed to your account.

Patient Name(s)_____

Financial Policy

We are committed to providing the best possible care to our patients and their families and feel that this goal is best achieved if everyone is aware of our financial policy. We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you.

Payment Procedures:

Fullpaymentisexpectedatthetimeofservice, regardless of who brings the child to the office. This includes applicable deductibles and co-payments.

We accept cash, personal checks and all major credit cards. Once your balance is settled, we can provide you with insurance claim forms if applicable. A receipt must be provided to you for all payment transactions. The accompanying parent or other adult is responsible for full payment at the time of service and for providing the proper insurance identification. If there should be a dispute about the financial responsibility, we will hold the accompanying parent responsible for payment.

Insurance Coverage

We participate with several insurance plans. As insurance benefit plans vary by employer, it is the policyholder/parent's responsibility to know the specific benefits of their plan. We will bill the insurance companies we participate with. If your carrier requests other information from you such as evidence of other insurance, they will not reimburse us until you provide it. If you do not do so, you will be billed for any outstanding charges.

Non-covered Services

We will always provide your child with, what we consider the best and most-up to date medical care. Some insurance plans limit procedures and services in order to control their costs. As a result, certain services we may provide for your child may not be reimbursed by your plan. Except as provided by your insurance contract or by state law, we will hold you responsible for all charges not covered by your policy. We do not bill co-payments.

Secondary Insurance

We are unable to process secondary claims for you. At your request, we will be happy to provide you with a complete claim form following our reimbursement by your primary carrier.

Newborn Enrollment

It is essential that you enroll your newborn on your policy within a few days of the date of birth. We can only bill newborn services under the mother's insurance for the first 30 days following the date of birth. If you have not enrolled your newborn within the 30 day period, you will be responsible for payment at the time of service.

Daniela Atanassova-Lineva, M.D. Pediatrics, PC

Mostofourparticipatinginsurancecontractscoverthesefees,butintheeventtheydonot youwill beresponsibleforthesefees.

Laboratoryservices
We will send your lab work to the appropriate laboratory based on the insurance information you have provided to our office. We are not liable for insurance billing and balances due from outside labs. There is a charge for specimen handling and transport.

Afterhours: There is an additional $60.00 fee charged for visits after routine office hours.

MedicalRecords: Upon your written consent, we will provide you with a copy of your child's medical record. There is a charge of $.75 per page for this service.

Camp/SchoolForms: There is a $10.00 fee for each camp/school form completed or provided. There is a $5.00 fee for each WIC form. For faster processing, we ask that you provide a self-addressed stamped envelope along with your form.

MissedAppointmentFee: There is a $25.00 fee charged for appointments that are not canceled. Please call ahead, preferably at least 24 hours in advance if you are unable to keep an appointment.

ReturnedChecks: There is a $25.00 charge for any check returned to us from the bank.

CollectionsAgency: Any charges remaining unpaid for more than 90 days from the date of service are considered delinquent and may be sent to a collection agency. In this situation, the responsible party will have to correspond with the collection agency regarding any financial arrangements and will be responsible for the original amount due in addition to any fees charged for the cost of collection.

Should you experience financial hardship, please contact our Billing Department for assistance with a payment plan. They are available Monday through Friday between 10:00am and 5:00pm.

I have read the above policy and agree to its terms;

_____ _____
Signature of parent, insured or authorized representative Date

_____
Relationship to patient

Daniela Atnassova-Lineva, M.D.,Pediatrics,P.C.
63-95 Austin Street
Rego Park, NY 11374
Phone 718.268.9100
Fax 718.766.8236
www.mdpeds.com

Personal Health Information/Medical Record Release Form
I authorize Daniela Atanassova-Lineva, M.D. Pediatrics, PC to release the following information
to:

_____

Patient's Name:_____**DOB:**_____
Address:_____
_____

Other: _____

Address:_____
Please check the information requested:
( ) Complete Medical Record
( ) Immunization Record
( ) Last Physical Examination
( ) Specialties Reports
( ) Other _____

Dr's. Signature _____

I understand and agree that I will be charged at the rate of **$.50 per page** for copying and any postage and handling to forward these records. Please allow at least 10 business days for processing.

_____ _____
Signature of Parent/Guardian Date of Request

_____
Print Name of Parent/Guardian

Effective date: September 23, 2013

Daniela Atanassova-Lineva MD Pediatrics PC
and Notice of Privacy Practices

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.

TDaniela Atanassova-Lineva MD Pediatrics PC [Pediatrics office]
is required under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to provide you with a description of the types of information that we gather about you, with whom that information may be shared, the safeguards that we have in place to protect it, and your rights to access and amend your health information. Because this notice only describes your privacy protections and other rights related to your medical information under HIPAA, you may be afforded additional protections and rights under other federal laws and/or State law that are not described in this notice. If the practices described in this notice meet your expectations, there is nothing further you need to do. If you prefer that we not share certain information, you may make a written request, as described below. If you have any questions regarding this Privacy Notice, or a complaint about our privacy practices, please contact our office manager at 718-268-9100.

Who Will Follow This Notice?

This notice describes Daniela Atanassova-Lineva MD Pediatrics PC's
privacy practices and that of:
•Any health care professional authorized to enter information into your medical chart.
•All departments and units of Pediatrics office its hospitals, clinics, community providers, and
affiliates working with Daniela Atanassova-Lineva MD Pediatrics PC's to provide health care at the Pediatrics office
• Any member of the Daniela Atanassova-Lineva MD Pediatrics PC's workforce including all employees, staff, volunteers,
and students,

All of these entities and facilities follow the terms of this notice. In addition, these individuals, entities, and locations may share medical information with each other for purposes of treatment, payment, health care operations, or research, as described in this notice.
A business associate may use or disclose your medical information only as permitted or required by its contract or other agreement with Daniela Atanassova-Lineva MD Pediatrics PC . A Daniela Atanassova-Lineva MD Pediatrics PC business associate is not a member of the workforce, but has a relationship with Daniela Atanassova-Lineva MD Pediatrics PC to perform, or assist in the performance of, a function or activity on behalf of NYCHHC. A business associate

for your health care services. For example, we may need to give your health plan information about surgery you received at Daniela Atanassova-Lineva MD Pediatrics PC so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. However, for services that you pay for out-of-pocket, and/or in full, you may request that we limit the information shared with your insurance company.

For Health Care Operations. We may use and disclose medical information about you as needed to run Daniela Atanassova-Lineva MD Pediatrics PC's operations on a daily basis and to make sure that all of our patients receive quality care. For example, we may use medical information to review the quality of our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Daniela Atanassova-Lineva MD Pediatrics PC should offer, what services are not needed, and whether 'certain new treatments are effective. When necessary, we may also disclose information to our accountants, consultants, and other professionals who help us operate the facility.

Appointment Reminders. We may use and disclose medical information to contact you with reminders that you have an appointment at the Pediatrics office .
Sale of Medical Information Daniela Atanassova-Lineva MD Pediatrics PC is generally prohibited from selling your medical information.
However, in most circumstances or activities for which we expect to receive financial payment for disclosing medical information, we must obtain your written authorization before we use or disclose the information, if the payment that we receive is not related to a medical treatment or service that we have provided.
Marketing. We must obtain your written authorization before we use your medical information to communicate with you about purchasing or using a product or service, unless the communication is: made face-to face between you and Pediatrics office or consists of a promotional gift of nominal value provided to you by Daniela Atanassova-Lineva MD Pediatrics PC . The following do not require prior authorization, unless NYCHHC receives payment from a third party in exchange for contacting you:
Drug Information. We may use and disclose medical information to provide refill reminders or to provide information about a drug that you have been prescribed.
Treatment Alternatives. We may use and disclose medical information to tell you about treatment options that may interest you including case management or care coordination, alternative treatments, therapies, health care providers, or care settings.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits, products and services including NYCHHC owned health plans, and events that may interest you.

Fundraising Activities. We may use information, including your name, address, age, date of birth, gender, treating physician, dates of treatment, the department in which you received services, and certain other information unrelated to your condition, to contact you to raise

money for our facilities and their health care operations.We may share that same information with a Pediatric office-related foundation or business associate for the same

-

Effective date: September 23, 2013

Workers' Compensation. We may release medical information about you to your employer's insurance carrier, to the Workers' Compensation Board or to similar programs.

Public Health Activities. We may share medical information about you for public health purposes with government organizations that are authorized to prevent the spread of disease, or to receive reports of certain medical conditions, births, deaths, abuse, neglect, and domestic violence. We will try to obtain your permission before releasing this information, except when we are required or authorized **to** act without your permission.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes (under federal law), and genetic information. If your care involves these special areas, please contact your health care providers or counselors for more information about these additional protections.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, and inspections.

Legal Proceedings. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your medical information for law enforcement purposes, including the following:
To respond to legal proceedings
To identify or locate a suspect, fugitive, material witness, or missing person In circumstances pertaining to victims of a crime
In the case of deaths we believe may be the result of criminal conduct In the case of crimes occurring at the facility
To report a crime in an emergency; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
Death. In the event of your death, Daniela Atanassova-Lineva MD Pediatrics PC may use and disclose your protected health information in order to notify or assist in locating your family member, next-of-kin, personal representative, or other person involved in your care about your death, unless doing so would be inconsistent with any prior preference or instruction that you have expressed in writing to Daniela Atanassova-Lineva MD Pediatrics PC . In making any such disclosure, Daniela Atanassova-Lineva MD Pediatrics PC personnel will ensure that only the protected health information that is relevant and necessary for notification or location purposes is used. Otherwise, Daniela Atanassova-Lineva MD Pediatrics PC may only disclose your protected health information to a surviving relative or facility. All amendment requests must be in writing. To request an amendment, complete a *NYCHHC Request for Amendment* form or submit a written request to the facility's Health Information Management Department. You must provide a reason to support your request for amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
Was not created by us, unless you provide us with a reason to believe that the person who created the information is no longer available to act on the amendment. Is not part of the information that may be used to make decisions about you. Is not part of the information that you would be permitted to inspect and copy Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures that Daniela Atanassova-Lineva MD Pediatrics PC has made of medical information about you. The list will not include certain information, such as information we have shared for your treatment, payment, or Daniela Atanassova-Lineva MD Pediatrics PC health care operations, or those disclosures we have made with your permission. To request this list, please submit your request in writing to the facility's Health Information Management Department. Your request must include a time period that may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list(i.e., on paper or electronic format). The first list you request within a 12-month period will be free. For additional lists, we may charge a reasonable cost-based fee to cover the cost of providing the information. We will notify you of the cost involved and you may choose to cancel or change your request at that time before you've been charged.

Right to Request Restrictions. You have the right to request a restriction on the medical information that we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information that we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a medical procedure that you had. To request restrictions, please complete a Daniela Atanassova-Lineva MD Pediatrics PC *Request for Additional Privacy Protections* form. You may also submit a written request to the facility's Director of Admitting or the Director of Registration. In your request, please tell us:

What information you want to limit

Whether you want to limit our use, disclosure or both

To whom you want the limits to apply (for example, disclosures to your spouse)

We are not required to agree to your restriction request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, please submit your request in writing to the facility's Medical Correspondence Unit. We will not ask you the reason for your request. We will accommodate

Effective date: September 23, 2013

Acknowledgement
By signing and dating the form below, I acknowledge that I have received a copy of the Daniela Atanassova-Lineva MD Pediatrics PC's Privacy Notice.

_____
Patient's Name

_____
Patient's Signature

_____
Date

If executed by a patient's personal representative, please print your name in the space below:

Personal Representative's Name : Signature :_____

Daniela Atanassova-Lineva MD Pediatrics PC's STAFF ONLY:

❑Patient refused to sign

❑ Patient unable to sign

Daniela Atanassova-Lineva MD Pediatrics PC's Employee's Initials:

Medicine for Fever or Pain Relief

Acetaminophen
Acetaminophen (*Tylenol, Feverall, Paracetamol*) is available without a prescription. Children over 2 months of age can be given acetaminophen. Give the correct dosage for your child's weight every 4-6 hours, as needed for fever or pain. No more than 5 doses in 24hours.
Suppositories: Acetaminophen is also available as a rectal suppository in 120-mg, 325-mg, and 650-mg dosages. Suppositories are useful if a child with a fever is unable to take oral medication.

	May Give Every	Upto11 pounds	12-17 pounds	18-23 pounds	24-35 pounds	36-47 pounds	48-59 pounds	60-71 pounds	72-95 pounds	96+ pounds
Drops (80mg/0.8ml)	4-6 hours	Call Your Doctor	0.8ml	1.2ml	1.6ml	2.4ml				
Syrup (160mg/5ml)	4-6 hours		½ teaspoon	¾ teaspoon	1 teaspoon	1 ½ teaspoon	2 teaspoon	2 ½ teaspoon	3 teaspoon	4 teaspoon
Chewable tablets (80mg)	4-6 hours			1 ½ tablet	2 tablets	3 tablets	4 tablets	5 tablets	6 tablets	8 tablets
Chewable tablets (160mg)	4-6 hours				1 tablet	1 ½ tablets	2 tablets	2 ½ tablets	3 tablets	4 tablets
Adult tablets (325mg)	4-6 hours							1 tablet	1 to 1 ½ tablets	2 tablets
Suppository	4-6 hours		80mg	120mg	160mg	240mg	325mg	325mg	325-445mg	650mg

Ibuprofen
Ibuprofen (*Advil, Motrin*) is available without a prescription. Children over 6 months of age can be given ibuprofen. Give the correct dosage for your child's weight every 6-8 hours, as needed.

	May Give Every	Upto11 pounds	12-17 pounds	18-23 pounds	24-35 pounds	36-47 Pounds	48-59 pounds	60-71 pounds	72-95 pounds	96+ pounds
Drops (50mg/1.25ml)	6-8 hours	Call your Doctor	1.25ml	1.875ml	2.5ml					
Syrup (100mg/5ml)	6-8 hours			¾ teaspoon	1 teaspoon	1 ½ teaspoon	2 teaspoon	2 ½ teaspoon	3 teaspoon	4 teaspoon
Chewable tablets (50mg)	6-8 hours			1 ½ tablet	2 tablets	3 tablets	4 tablets	5 tablets	6 tablets	8 tablets
Chewable tablets (100mg)	6-8 hours				1 tablet	1 ½ tablets	2 tablets	2 ½ tablets	3 tablets	4 tablets
Adult tablets (200)	6-8 hours								1 ½ tablets	2 tablets

Alternating or Combining Acetaminophen and Ibuprofen
Combining acetaminophen and ibuprofen is not recommended. Combining can cause confusion, dosage errors, and poisoning. Also, it is usually not important to control a fever that closely. However, if instructed by your health care provider to alternate acetaminophen and ibuprofen, do it as follows:

- Alternate doses of acetaminophen and ibuprofen every 4 hours
- Alternate medicines for only 24 hours or less, then return to a single product.

Avoid Aspirin
Children (through age 21 years) should not take aspirin if they have chickenpox or influenza (any cold, cough, or sore throat symptoms). This recommendation is based on several studies that have linked aspirin to Reye's Syndrome, a severe encephalitis-like illness. Most pediatricians have stopped using aspirin for fevers associated with any illnesses.

KEEP ALL MEDICATIONS OUT OF THE REACH OF CHILDREN
In case of accidental ingestion call **POISON CONTROL 212-POISONS**, or our office at 718.268.9100