VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

PATIENT INFORMATION FORM

Patient's Name _____ Male ☐ Female ☐ DOB _____
(First) (M. I.) (Last)

Home Address _____

City _____ State _____ Zip Code _____

Mother _____ DOB _____

Maiden Name _____

Father _____ DOB _____

Mother's Cell # _____ Mother's Work # _____

Father's Cell # _____ Father's Work # _____

NAMES OF OTHER CHILDREN SEEN HERE

NAME	DOB	INSURANCE SUFFIX

Emergency Contact Name _____

Relationship to Patient _____ Phone # _____

Referred By (Rheumatology only) _____

PCP Name _____ PCP Phone # _____

VILLAGE
Pediatrics & Rheumatology

PATIENT DEMOGRAPHICS

Race ☐ White ☐ Black/African America ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Patient Declined

Ethnicity ☐ Spanish/Hispanic Origin ☐ Not of Spanish/Hispanic Origin ☐ Patient Declined

Language ☐ English ☐ Spanish ☐ Declined ☐ Other _____

PRIMARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Primary Pharmacy _____ (Name) Location _____ (Street, Town)

SECONDARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Case Manager _____ Phone # _____

Social Worker _____ Phone # _____

VILLAGE
Pediatrics & Rheumatology

AUTHORIZATION FOR INSURANCE BILLING

I hereby authorize Joan G. Calkins, MD to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Dr. Calkins. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

RECORD RELEASE AUTHORIZATION

I hereby authorize you to release to Joan G. Calkins, MD, at the aove address, any and all information, including diagnosis and records of any treatment or examination rendered. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

Dr. Calkins occasionally has students working with her. If you prefer that the students not assist with your child please let a staff member know. Thank you for your understanding and help in this matter. Our students appreciate the opportunity to learn from you!

How did you learn about our Practice?

_____

_____

_____

_____

_____

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Family History

Patient Name _____ **DOB** _____

	No	Yes	Relationship (Parent, Grand Parent, etc)
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Bleeding Disorders	☐	☐	_____
Genetic Disorders	☐	☐	_____
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Seizures	☐	☐	_____
Intellectual & Development Disabilities	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
ADD/ADHD	☐	☐	_____
Learning Disability	☐	☐	_____
Depression	☐	☐	_____
Addiction	☐	☐	_____
Other	☐	☐	_____

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Authorization & Acknowledgement of Practices Financial & Privacy Policies

In general, the HIPAA Privacy Rule (Health Insurance Portability & Accountability Act of 1996- a federal law) gives individuals the right to request a restriction of uses and disclosures of their Protected Heath Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office. In order to protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for Treatment, Payment, Operation (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purposes.

AUTHORIZATION

I authorize the release of any PHI necessary to determine liability for payment & to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including, but not limited to, Medicaid, Medicaire, private insurances, and other health managment organizaton to the practice named on this form.

The assignments of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I also give permisssion to the providers & nurses of Village Pediatrics & Rheumatology, LLC to treat, perform any diagnostic procedures, and to administer vaccines in the medical care of my child(ren).

I authorize Dr. Joan Calkins, and the practice staff to leave medical information pertaining to my care by the following methods; and I will assume the responsibility of notifying the office whenever this information changes.

Please indicate below how you would like our office to handle communicaitons with you.

APPOINTMENT INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Mobile Text (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

MEDICAL INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

CONTACTS: OK to contact (Name, Relationship, Phone Number)

_____ _____ _____

_____ _____ _____

_____ _____ _____

I agree to the insurance assignments & financial responsibilities as indicated by Village Pediatrics & Rheumatology, LLC. I am also aware of my rights and practice's responsibilities with respect to Private Health Information (PHI) as outlined in Village Pediatrics & Rheumatology's Notice of Privacy Practices.

_____ _____ _____

Patient Name (Please Print) | Signature (Patient or Parent if Minor) | Date

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

New Rheumatology Patients of Dr. Joan Calkins

Patient Name _____ **DOB** _____

Thank you for considering Dr. Joan Calkins as your child's Rheumatologist. She has over 30 years' experience treating children with Rheumatologic issues as well as other complex medical concerns your child may be faced with.

Dr. Calkins has found that the best road to successfully treating children with these medical issues is through a team approach with your child's Primary Care Provider(PCP) and any other specialist that may be involved. A consultation for your child with Dr. Calkins begins with a referral(letter) from your PCP stating why he/she is requesting Dr. Calkins to see you child. In addition, we require all medical records related to your child's medical condition. These should include any relevant office visit notes, labs conducted, x-rays performed along with any consults from other specialists that are or have been involved with your child's care. Dr. Calkins will review all of these records and recommend the best course of action to pursue. This could be as simple as scheduling your child's first appointment with her office. However, Dr. Calkins may require additional specialized labs to be ordered by your child's PCP or an appointment with another specialist to rule out some specific concerns.

As with any specialist, your insurance company may require a referral to see us and any other specialist we might recommend that your child see. You, in conjunction with your PCP, are responsible for securing these referrals and keeping them up to date. It is your responsibility to understand the rules of your insurance company and provide the appropriate referrals when needed as they will expire. Please contact your Primary Care Provider for assistance.

Your child's initial appointment will most likely take up to an hour with a possible follow-up appointment within the next couple of weeks. Following each visit with Dr. Calkins, she will send a letter informing the primary of the visit and a brief synopsis of what occurred together with future plans for your child's treatment. Labs are an extremely important element of Dr Calkins' management plan for your child, if you are given a script for labs, or any other testing, it is your responsibility to ensure that they are completed with enough time to review the results prior to the next scheduled appointment.

Dr. Calkins will only begin a relationship with patients that have not reached the age of 16. An established patient reaching that age or when we have stabilized their situation, we will advise you to seek care with an Adult Rheumatologist.

After you have read and understood the policies mentioned above, please sign and return to us keeping a copy for your records.
Joan G Calkins, M.D.

_____ Date_____

Parent or Guardian Signature