Burlington Pediatrics LLC

QUALITY PEDIATRIC CARE SINCE 1959

NEW PATIENT REGISTRATION

Patient Name: _____

Date of Birth (MM/DD/YYYY): _____ Gender (circle one): M F

Address: _____ Phone numbers:

Home: _____

_____ Cell: _____

Email: _____

Parent/Guardian Name: _____ Date of Birth: _____

Guarantor Name*: _____ Date of Birth: _____

Guarantor Address (if different from patient): _____

_____

Name of Insurance Plan: _____

Insurance Member ID#: _____ Insurance Group #: _____

Insurance-Subscriber Name: _____

*Guarantor is the person who is financially responsible for anything not covered by insurance

BURLINGTON PEDIATRICS, LLC
281 Cambridge Street
Burlington, MA 01803

It is my intent to transition my healthcare from this pediatric practice to an adult medical provider. My signature and elections below authorize disclosure by this office to the provider/practice indicated. While I understand that full disclosure provides the best opportunity for safe ongoing care, please observe my preferences as noted.

AUTHORIZATION TO RELEASE and / or RECEIVE HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
First Middle Last

ADDRESS _____ APT# ___ CITY _____ STATE __ ZIP _____

PATIENT'S PHONE # _____

I authorize [Practice Name] to (please √) [ ] release information to and/or [ ] receive information from:
NAME OF PRACTICE _____

ADDRESS _____ SUITE# ___ CITY _____ STATE __ ZIP _____

PURPOSE FOR THIS REQUEST: (Check one)
[ ] Treatment [ ]Transfer of Care [ ] Other _____

TYPE OF RECORDS TO BE DISCLOSED: (Check one)

- ☐ Entire Medical Record
- ☐ Billing Records
- ☐ Immunization History
- ☐ Laboratory Test Results
- ☐ X-Ray Reports
- ☐ Treatment Summary (includes history/physical, laboratory tests and x-ray reports, operative reports and pathology)
- ☐ Other (Please specify):

_____
_____
_____

SENSITIVE INFORMATION: Please read carefully. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. I hereby consent to the release of the following types of information if such information is contained in my medical record:

☐ HIV/AIDS information ☐ Genetic information ☐ Sexually transmitted disease information
☐ Mental/behavioral health information, including ADD/ADHD
☐ Substance use disorder information (drugs/alcohol)

I understand that:

- My right to treatment, payment or my eligibility for healthcare benefits is not conditioned on this authorization.
- I may revoke this authorization at any time by submitting a written request to the address provided at the top of this form, however, I understand that any previously disclosed information would not be subject to my revocation request and that once the information is released by my health care provider it may be re-released by the recipient and no longer protected under federal law.
- If I have any questions about my medical record I should contact my physician.
- I will not hold [xxxx] liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
- There may be a charge for the requested records.
- This authorization will expire two (2) years from the date signed below or until written notice of revocation is received.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____
NAME & RELATIONSHIP TO PATIENT (if requestor is not patient): _____

This form has been provided only as an aid to Highland IPA pediatricians for the process of transferring patients to adult providers of care. It remains the responsibility of the practice to ensure this form complies with applicable federal and/or state laws and regulations, and to maintain and update this form as necessary.

Burlington Pediatrics LLC

281 Cambridge Street

Burlington, MA 01803

www.burlingtonpediatrics.org

781 272 2210

Thank you for choosing Burlington Pediatrics LLC as your Primary Care pediatrician for your child. We are honored that you have chose our practice as your healthcare partner. Please keep this letter for future reference.

Burlington Pediatrics LLC is committed to providing high quality health care in a convenient and in cost-efficient setting. In furtherance of our commitment to you, our physicians are proudly member so the Highland Healthcare Associates Independent Physicians Association, which is affiliated with Tufts Medicine Integrated Network. This membership provides us with enhanced access to many talented and skilled specialists in the community as well as in Boston, when complex specialty services are necessary and appropriate for your child's care.

To lean more about Highland Healthcare Associates IPA, visit www.ipaconnect.com
To learn more about Tufts Medicine Integrated Network visit www.tuftsmedicine.org

We would like to take this opportunity to share some important information about our practice to help improve your experience with us:

Office Hours:

Monday, Tuesday, Wednesday, Thursday 8 AM to 6 PM. Friday 8 AM to 4 PM. Saturday 8 AM to 11:30 AM

After Hours Coverage:

For a life threatening emergency contact 911.

For non-life threatening emergencies after our normal hours, please call 781 272 2210 and follow the prompts to contact our answering service. There is a provider on call to provide urgent medical advice after hours. In some cases, you may be directed to either schedule an appointment the next business day or seek care at one of our preferred urgent care centers or emergency room if needed.

Preferred care centers for after hours:

PM Pediatrics Woburn, MA. Wilmington Family Medical Center, Wilmington, MA. Winchester Hospital Emergency Room.

Appointments and Scheduling:

Routine Wellness Check Ups: As an active partner in your child's healthcare, we expect to your child to visit our office at least once a year so we can be proactive about any medical questions or concerns.

Same Day appointments: We offer same day sick appointments. Call early in the day for availability.

Specialty Care:

As your primary care physicians, we strive to provide care for most of our patients' medical needs in our office. We make referrals for specialty care based on what is in the best interest of the patient, and in consideration of the quality, convenience, and cost to you. When specialty care is necessary, we will work you to determine which community based specialist is most appropriate for your child. When more complex care is needed, we refer to Tufts Medical Center or Boston Childrens Hospital.

Prescription Refills

Request may be made by calling our office or through our patient portal. We may decline a request for a refill if we have not seen the patient in our office within a year.

Patient portal

Patient medical records are available at any time by accessing our secure patient portal. Here you can find access to test results, billing information, and health records. We encourage you to use this self-service tool to communicate with us. You can access the patient portal through our website at www.burlingtonpediatrics.org

Welcome to our practices,

The physicians and staff of Burlington Pediatrics LLC