WATCHUNG Pediatrics

The Bridge to Adulthood

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THE BRIDGE TO ADULTHOOD

Becoming an adult is a rite of passage that many people look forward to, but with this new sense of independence also comes a new set of responsibilities. Through the following information and tips, we hope to give you the jump start necessary to begin taking your healthcare into your own hands.

For parents

If you need access to your child's records, your son or daughter must consent in writing to provide you access. Under HIPAA, medical providers no longer are permitted to discuss health issues with you without expressed consent from your young adult. This is important to keep in mind when trying to call a health care provider with questions when your young adult is away at college. Your child will need to call himself or herself.

CHECKLIST FOR TURNING 18

___ Maintain insurance coverage.
___ Obtain a copy of your immunization records.
___ Get a pre-college health exam.
___ Make sure you are up to date with immunizations.
___ Record and evaluate your prescriptions.
___ Complete a consent form designating what information we can discuss with anyone other than you

SEEKING MEDICAL CARE

When you turn 18, seeking medical care on your own is a new responsibility. Your parents can help guide you through seeking medical care. However, as an adult, you have the right and responsibility for your own medical care. This means that you now may seek medical care without your parents' consent and call to make your own appointments, as needed.

Here are a few things you need to know about being responsible for your own medical care:

• Watchung Pediatrics can continue to provide medical care for you until you turn 22. Consider talking with your provider about when it may be best for you to find an adult provider who is more knowledgeable about adult health issues. (See also "Interview questions for finding the right provider for you.")

• When calling for an appointment, let the receptionist know who your provider is, why you need to see him or her and when you need the appointment. Be sure to provide the most honest description of why you need to be seen so that an appropriate amount of time is scheduled.

Script for scheduling an appointment

Here is a sample of what you can say when you call to schedule an appointment:

"Hello, my name is _____ **(use your legal first and last name – not your nickname)**. I need an appointment to see _____ **(provider's name)** because _____ **(reason why – example, "I need a physical, I'm going to college.")**. I am wondering when you have an appointment available."

• Your parents may come to the appointment with you, but you will need to check in and sign any forms yourself. You will be asked to sign forms to verify your contact information, financial responsibility and medical treatment consent.
• You will need to provide insurance information (such as a card) that shows you have insurance. You will be required to sign a copy of your insurance card at each visit. This indicates what insurance you would like us to bill. If you do not have insurance, you may be asked to sign a specific financial responsibility form.
• You will be financially responsible for your account. This means you will need to pay any co-payments or billing portions required. If you would like us to discuss your account with your parents, you will need to provide consent.
• You will sign for any medical treatment consents including vaccinations. Your parents may help you understand what you are signing, but they no longer can sign for you.
• You have the right to be informed of your medical care and treatment. You also have the right to refuse medical treatment.
• Please provider us with the best phone number to contact you directly.

MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

For young adults

Under the federal Health Information Portability and Accountability Act, or HIPAA, medical records are private information that is kept between you and your health care provider. Access to your health records and any discussion about your health is only provided to people you consent to, including your college and your parents. If you would like your parents to discuss your health on your behalf, you must provide consent to your health care provider. You will be asked to complete a form to document your consent. These forms are called the "Consent to Discuss Medical Information and Protected Health Information."

Once you turn 18, your parent become unable to access your records online. If you would like to grant them access it must be submitted, in writing, to the office.

TALKING TO YOUR PROVIDER

When you were little, your parents talked to your provider about your medical needs, picked up your prescriptions and made sure you took your medicine. Now that you're getting older, your health care is your responsibility. As you mature, the issues you face may become more complicated and personal. It's important to find someone to talk to who is both knowledgeable and who you can trust. That's where your provider can help you out.

Providers are trained to help you with your health and emotional concerns. You can talk with them, they can answer your questions and they can check out what worries you. Even if you feel embarrassed at first about discussing personal subjects (such as physical development or sexual health), it's helpful to know that providers deal with those concerns – and all sorts of things – every day.

A few things to keep in mind when talking with your provider:

• **Be honest**. It's your job to openly discuss your symptoms and concerns. A provider can't help you unless you tell the whole story. Even if you're uncomfortable, being open and honest will only benefit you. Most providers realize that people can feel uncomfortable about raising sensitive issues, and they try to be good listeners.

• **Provide complete and truthful information.** Providers make decisions about what needs to be done and how to answer your questions and concerns based upon the information you provide. Providing all of the information helps the provider help you. Your provider will know which information is relevant to any medical decisions.

• **Do not be embarrassed.** It's perfectly normal to feel nervous when talking with your provider about personal issues. You should be able to talk to your provider about everything. Keep in mind that most experienced providers have cared for many patients. No matter what the issue is, it probably won't surprise your provider.

•**Write things down.** It may help to show up for your appointment with a written list of questions and concerns to give to the provider. It also can include your problems and symptoms. This list can jump-start the communication process and help put you at ease to openly and comfortably discuss your issues with your provider.

• **Your provider is interested in keeping you healthy, not judging you.**
If you are concerned about a sensitive topic, you shouldn't avoid going to the provider because you are worried about what the provider might think. A provider's role is to listen respectfully, examine, educate and treat people, not criticize them.

HOW TO GET PRESCRIPTION MEDICATIONS AND REFILLS

If you have been on medication and are used to your parents taking care of getting the prescription for you, the process of refilling your medication may be new to you. We have some helpful tips on how to get your prescription medications for the first time and then refilled.

First-time prescriptions
You will need to select a pharmacy for your prescriptions. You can choose one that is close to home, school or work. You also can base your selection on a pharmacy that has a nationwide option, so you don't have to transfer your prescription when you go to school.

When your provider wants you to take medication, you will be given a written prescription. You will need to take it to the pharmacy to get it filled. When dropping prescriptions off, there may be a wait time, so plan accordingly. When picking up your prescription, remember to take your insurance card with you. You also might need to pay a co-pay charge at the time you pick up your prescription.

Refills
The most important thing to remember about medication refills is plan ahead. Do not wait until the last dose is taken to call for a refill. Most providers will not call in refill prescriptions after normal clinic or business hours. To ensure that the medication is on-hand and that you are taking it according to the directions, call at least 5 days in advance.

If your medication indicates refills (your provider would need to order that), you may call the pharmacy directly for refills. Have your medication nearby when you request a refill. You will need information on the label to fill the request.

Script for calling your pharmacy/provider for a medication renewal

Make sure you have your prescription in front of you for the information.

"Hello, my name is _____**(use your legal first and last name – not your nickname)**. I need a refill on a prescription.
My provider is _____.
The prescription number is _____.
The name of the medication is _____.
The strength/dose is _____.
(If contacting your provider) My pharmacy name and number is _____.
My telephone number is: _____.

(Provide a telephone number such as a cell, home or work phone number where you are available and can be reached.)
Thank you."

Make sure you understand how and when to take your medication, and any possible side effects and what to do if you experience them. You will get written information along with your medication, but be sure to ask the pharmacist or your provider if you have any questions. Ask your pharmacist or provider if you have any questions at any time while taking a medication. Finally, take your medication according to your provider's directions.

WHAT IS NJIIS (NEW JERSEY IMMUNIZATION INFORMATION SYSTEM)?

- The NJIIS is a secure, computerized, statewide immunization registry that can help keep track of your immunizations. It can only be accessed by health care providers, hospitals, schools, health insurance plans, and local and state health departments. It cannot be accessed by the general public. This means if you need medical treatment by someone other than your regular doctor, they can log in the system and have access to your immunizations. For instance, if you went to an emergency room for a cut, the hospital would be able to look to see when your last Tetanus booster was given.
- NJIIS can provide a complete and current record of your immunizations even if you move or switch health care providers or insurance companies.
  ONLY authorized users who have signed a confidentiality agreement can access the registry information.
- If for any reason you wish to withdraw at a later time, there is a "NJIIS Registrant Withdrawal" form that you may obtain from this office or at http://njiis.nj.gov/njiis/html/forms.html and it can be mailed to the address listed on the form.
- If you have any additional questions, please ask our office staff.

FINANCIAL RESPONSIBILITY

Another result of becoming an adult is your parents may not be responsible for your bills. The debt you incur is important because it may affect your ability to get loans, credit cards or make future purchases.

When seeking medical care, you ultimately are financially responsible for any bills or invoices regardless of whether you are on your parents insurance or not. In addition, your parents are not able to discuss your personal finances without your expressed consent even though they may still have access to any joint accounts you've set up.

CONGRATULATIONS ON BECOMING AN ADULT

This is quite an exciting time. We hope that you have found this booklet helpful. If you have any questions about the information in this booklet, or other information you have received, **please contact your provider in Warren: (908) 755-KIDS (5437).**

Fanwood: (908) 889-TOTS (8087).

Millburn: (973) 376-PEDS (7337).

ADDITIONAL RESOURCES

Books and Websites

- The New Teenage Body Book by Kathy McCoy and Charles Wibbelsman
- http://www.TeenHealthFX.com
- http://www.youngwomenshealth.org/03/2012Version
- www.mypyramid.org

What can you do to stay healthy?

- **Don't smoke.** If you do smoke, talk to your provider about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your provider or nurse can help you. You also can help yourself. For tips on how to quit, visit "You Can Quit Smoking Now" at smokefree.gov. To talk to someone about how to quit, call the National Quit line at (800) QUIT-NOW. For more stop smoking resources, visit healthfinder.gov and search for "smoking."

- **Be physically active.** Walking briskly, mowing the lawn, dancing, swimming and bicycling are just a few examples of moderate physical activity. If you are not already physically active, start small and work up to 30 minutes or more of moderate physical activity most days of the week.

- **Eat a healthy diet.** Emphasize fruits, vegetables, whole grains and fat-free or low-fat milk and milk products. Remember to include lean meats, poultry, fish, beans, eggs and nuts. Eat foods low in saturated fats, trans fats, cholesterol, salt (sodium) and added sugars.

- **Stay at a healthy weight.** Balance calories from foods and beverages with calories you burn off by your activities. To prevent gradual weight gain over time, make small decreases in food and beverage calories and increase physical activity.

Emergency Medical Information Card

Name: _____ Date of Birth: _____
Address: _____
Allergies (to latex or other medications): _____
Other allergies (i.e. food, bees, seasonal, etc.): _____
Phone:(_____) _____
School contact: _____
Emergency contacts:
1. Name: _____ Relationship: _____
Phone:(_____) _____ Primary provider: _____
2. Name: _____ Relationship: _____
Phone: (_____) _____ Primary provider: _____
3. Name: _____ Relationship: _____
Phone:(_____) _____ Primary provider: _____
Health care contacts:
Provider: _____ Phone: _____
Hospital/clinic: _____ Phone: _____
Insurance company: _____
Insurance card #: _____ Insurance company phone: _____
Claims address: _____
Medications: _____
_____

Pharmacy name: _____ Phone: _____
Past Medical History (i.e. asthma, Celiac disease, diabetes, etc.): _____
_____
Other medical information: _____
_____

P E D I A T R I C S

Transfer to an Adult Physician

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient.

Patient (s) Name(s) and Dates of Birth: _____

Organization Providing the Information: Watchung Pediatrics, 76 Stirling Rd, Ste 201, Warren, NJ 07059

Organization or Provider Receiving the Information: _____

_____

_____

Specific Description of Information Disc1osed:
- □ Medical History Summary and Immunization Record (no cost)
- □ Complete Medical Record
- □ Other:_____

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information purposes indicated below by initialing before each category:

Initials: _____ HIV/AIDS testing, test results; treatment and related information including high risk behavior documented:

Initials: _____ drug and/or alcohol diagnosis. treatment, test results and reports and referral information;

Initials: _____ mental health treatment information. test results and reports including psychological and psychological and psychiatric studies, reports, evaluations and referral information; and/or

Initials: _____ information regarding sexually transmitted diseases;

Initials: _____ genetic testing, test results, counseling reports, treatment, and referral information.

Purpose of Discloser: Transfer adult physician

You must read and initial the following statements:

1. I understand this Authorization will expire one year from date below OR on __ /__ /___ This allows the disclosing office to forward any information received to my new provider without requiring a new authorization form to be completed. **Initials:** _____

2. I understand that I may revoke this Authorization at any time by notifying the disclosing office's Privacy Officer in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. **Initials:** _____

Charge:
As per NJ Statute, Watchung Pediatrics charges a medical record transfer fee of $1 per page, with a maximum $100, *per child*.

When records are copied and mailed directly to a physician, the maximum charge is $25 *per child*, payable at the time the request is submitted.

Patients may have a Medical Summary and immunization record ***free of charge.***

Please allow 30 business days for your request to be processed.

_____ _____

Signature of Patient or Representative and Relationship Date

You may refuse to sign this authorization. We cannot condition treatment on your signing this Authorization.

CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT OVER 18 YEARS

Patient Name (please print): _____ Date of Birth: _____
First, M.I., Last Name

I authorize Watchung Pediatrics and its staff to discuss my medical information as follows (initial below all that apply):

- For financial purposes, I allow my parent(s) to access to my diagnosis and treatment information and to discuss my account: _____
- I allow my immunization records to be released by fax or mail to: _____ **school** _____ **parents**
- I allow my treatment plans (i.e.: medication, asthma, epi-pens, etc.) to be disclosed to: _____ **school** _____ **parents**
- I allow my office visits to be accessed by: _____ **school** _____**parents**
- I allow my labs to be released to: _____**school** _____**parents**
- With my prior consent, I allow any "confidential information" to be shared with: _____ **school** _____ **parents**
- I allow my parent to have access to my online medical records. I understand that I cannot limit access to my online records. _____ **yes** **or** _____**no**
- Other: _____

_____
Parent/Guardian 1 Relationship

_____
Parent/Guardian 2 Relationship

_____
Name of School

I am requesting online access to my medical records. The email address to send my registration is _____

I understand that I am financially responsible for all charges unless my parents agree, in writing, to continue financial responsibility. _____
(Initials)

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____
Signature **Date**

I understand that I may revoke this consent at any time and I must notify Watchung Pediatrics in order to revoke the consent.

(Signature of Patient) (Date Signed)

_____ _____
(Printed name of signature above) (Phone Number)

REVOKE CONSENT

(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

(Signature e of Patient) (Date Signed) *Revised 10.2016*

New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -