Children's Community Practices

An Affiliate of Nationwide Children's Hospital

Patient Information Form:

Please Print and fully complete

Patient Information:
First Name _____ Middle Initial _____ Last Name _____
Address _____ City _____ State _____ ZIP _____
DOB _____ Sex: ☐ Male ☐ Female Phone# _____

Parent or Legal Guardian Information:
First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____
Child lives with ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Legal Guardian ☐ Other

Parent or Legal Guardian Information:
First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Please list all children in your family who come to this practice:
_____ DOB _____ _____ DOB _____ _____ DOB _____
_____ DOB _____ _____ DOB _____ _____ DOB _____
Preferred E-Mail for the patient portal: _____
Preferred Pharmacy: _____ Address _____ Phone _____

Emergency Contact: Name _____ Relationship _____ Phone _____

How were you referred to this practice? ☐ Existing patient ☐ Physician Name of patient/physician _____
☐ Newspaper ☐ Telephone ☐ Internet ☐ Website ☐ Insurance company ☐ Other _____

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

_____
Printed name of patient or parent/guardian Signature Date

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Welcome to Hand In Hand Pediatrics! Please fill out this form as much as possible.

Patient Name _____ Birth Date _____

Person completing this form _____ Relationship _____

Birth History

Is the child yours by: birth ☐ adoption ☐ stepchild ☐ other ☐

Gestational age at birth _____ Birth weight _____ Birth Length _____

Birth Hospital _____ Hepatitis B vaccine? Yes No Date _____

Apgars score _____ Newborn hearing screen pass ☐ not pass ☐

Delivered by vaginal ☐ c-section ☐ Reason for c-section _____

Complications during newborn hospitalization _____

_____

Family History

Please check all categories that apply and which family member has had the diagnosis. Please include parents, grandparents, siblings, and parents' brothers and sisters. Please mark all that apply.

Condition	None	Biological Mother	Biological Father	Sibling	Grandparent	Other
Asthma	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Bleeding/Clotting Disorder _____	☐	☐	☐	☐	☐	☐
Cancer Type _____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Gastrointestinal	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐
Heart Attach <50 years	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Psychological ADHD, autism, anxiety _____	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐

Please explain all positives _____

_____

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Patient Name_____ Birth Date_____

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	Yes	No	
Asthma/wheezing/pneumonia	☐	☐	_____
Allergies- food/pets/seasonal	☐	☐	_____
Anemia/blood disorder	☐	☐	_____
Diabetes	☐	☐	_____
Ear infections/strep throat	☐	☐	_____
Genetic disorder	☐	☐	_____
Heart disease/defects	☐	☐	_____
Intestinal problems	☐	☐	_____
Neurological (headaches/seizures)	☐	☐	_____
Psychological (ADHD, autism, anxiety)	☐	☐	_____
Urinary tract infections/disorders	☐	☐	_____
Other chronic conditions	☐	☐	_____

Has your child ever been hospitalized overnight? ☐ Yes ☐ No Please explain and give dates _____

_____

Please list any specialist(s) your child is seeing _____

_____

Medications

Allergies to medications and reactions _____

Current medications and dose _____

_____

Vitamins, herbal supplements, over the counter medications _____

_____

Surgical History

Type of surgery and date of surgery _____

Social History

Who lives in the household with your child? ☐ Parent (Mom) ☐ Parent (Dad) ☐ Siblings #_____ ☐ Other _____

Parent(s) ☐ Married ☐ Single ☐ Divorced ☐ Remarried Name of Step-parent_____

☐ Custody (Please bring in custody papers if other than shared)

Smokers ☐ Yes ☐ No Pets ☐ Yes ☐ No What Kind? _____ Age of home_____

Does your child stay home with you? ☐ Yes ☐ No Does your child attend daycare/preschool/babysitter? ☐ Yes ☐ No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school _____

Patients Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Hispanic ☐ Black or African American

☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Decline to report

Patients Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other _____

Patients Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Decline to report

General Consent Agreement

Patient: _____ Date of birth: _____

Consent for Medical Treatment:

I consent to let the clinical providers and employees of **Hand In Hand Pediatrics** (the practice) do all things that may be needed to diagnose, treat and care for the needs of the patient referenced below to include any necessary examination, immunizations, medical diagnosis, surgery, treatment and/or hospital care to be rendered to the minor child named below under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio.

I authorize the practice to take photos, video or audio recording of me/my child for diagnostic and identification purposes.

I understand that the practice is not responsible for personal belongings lost during my visit.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the result of my examination or treatment.

Patient Rights and Responsibilities:

I understand I have the right to take part in decisions about the health care and plan for treatment. I have received a copy of the Patient Rights and Responsibilities and my questions have been answered.

Consent to Release Medical Information:

I consent to let the practice share/release/exchange information such as clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, health care provider, and/or to any insurance company or organization that helps pay my bill. The practice may also give information to any welfare organization to which I have applied or may apply for aid.

Assignment of Insurance Benefits:

I assign to the practice, my physician and other healthcare professionals involved in the patient's care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs I identify for which benefits may be available to pay the practice for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Practice Price Disclosure:

I have a right to see a list of prices for services provided.

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Patient: _____ Date of birth: _____

Financial Responsibility:

I (or my guarantor, if appropriate) will pay all bills for care including bills that insurance benefits do not pay. This includes bills from the practice, physicians or any other entities that provided services during my care.

Removal from the practice:

If I decide to stop medical care against the advice of doctors, I understand that the practice and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices which sets forth the ways in which protected health information may be used or disclosed by the practice and outlines my rights with respect to such information.

Consent for Automated Calls and Texts:

I authorize the practice, its affiliated entities, and third-party service providers to call or text me at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from the practice.

I **do not** wish to receive text messages or automated appointment reminders. _____**initial**

Acknowledgement of Receipt of Children's Community Practice Patient Policies:

I hereby acknowledge that I was offered or received a copy of the Children's Community Practice Patient Policies, which set forth the responsibilities a patient must abide by as part of this physician practice.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Patient Name(s) _____

Signed _____ Signed _____
PATIENT, IF 18 YEARS OR OLDER DATE TIME PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE/TIME

_____ (_____)_____
STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

Signed _____ _____
WITNESS DATE TIME PRINT NAME OF PARENT/GUARDIAN

Children's Community Practices

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Patient Policies

Missed Patient Appointments

Our office will do it's best to make reminder calls and text messages 7 days and twenty-four (24) hours prior to your scheduled appointment. If you are unable to make your scheduled appointment, you must call and cancel that appointment at least twenty-four (24) hours in advance of your appointment. If your appointment is on Monday, you may leave a message. If appropriate notification is not given, or you do not show up for your appointment, you may be charged a fee.

Forms

Forms for physicals, daycare, simple school forms, work permits, medication, etc. when presented at the time of your child's appointment the provider will complete and sign without a charge. If presented later outside of an appointment, there may be a $25 charge. For FMLA forms, a $25 will always be charged. Please allow up to five (5) working days for these forms.

Prescription refill

Please allow forty-eight (48) business hours (i.e. not Saturday, Sunday or holidays) when calling for a prescription refill.

Insurance Information

At each appointment, you will be asked to verify your insurance information and effective date. Please make sure you bring your child's up to date insurance card to each appointment. If your insurance is no longer in effect, you will be responsible for the visit charge.

Non-emergent after hour calls

Our office provides after hour coverage for emergent sick calls that cannot wait until the next business day. Please leave a reliable phone number where you can be reached, so your child may receive immediate care.

Patient Portal Access:

The practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Someone who knows the right password or pass- phrase to log in to the portal site can only read secure messages and information. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

1. Please make sure we have your correct email address and inform us if it ever changes.
2. Also, keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

You may receive bills from Nationwide Children's Hospital for services received by Children's Community Practices.

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Designation of another Person to Consent for Treatment of Minor Child

In the event I, _____, cannot accompany my child, _____, _____,
(parent/legal guardian) (child's name) (date of birth)

to his/her appointment(s). I give permission to the following person(s) to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above-named minor child under the general or special supervision and on the advice of any provider of the practice.

1. _____
(name of designee) (relationship to patient)

2. _____
(name of designee) (relationship to patient)

3. _____
(name of designee) (relationship to patient)

4. _____
(name of designee) (relationship to patient)

Expiration of Permission (check one):

_____ This form will remain in effect until revoked by written notice.

_____ This form is VALID ONLY during the following time frame:

Effective date: _____/Expiration date: _____

_____
Parent or legal guardian (Please print name)

_____
Signature of parent or legal guardian Date

_____
Witness (Please print name)-MUST be 18 years or older and NOT the person receiving consent to treat

_____
Signature of witness Date

Instructions: Please provide your child's health insurance card and copay as applicable at each appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation may be scheduled.

Hand In Hand Pediatrics
HIPAA Notice of Privacy Practices

Effective date of this notice – Updated 6/1/18

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION AS A PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The privacy of your child's medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI is information that identifies you and relates to health care services, the payment of health care services or your physical or mental health or condition, in the past, present or future. This notice describes your rights to access and control your child's PHI.

Our Responsibilities

Federal law requires that we maintain the privacy of your child's PHI and provide to you this Notice of our legal duties and privacy practices. We are required to notify affected individuals following a breach of unsecured PHI. We are required to abide by the terms of this Notice, which may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our duties, or other practices stated in this Notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new notice in which the material change is reflected.

Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations

- Federal law provides that we may use your child's PHI **for your treatment**, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to a specialist involved with your child's care.
- Federal law provides that we may use your child's medical information to **obtain payment** for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your child's visit and a description of the services rendered.
- Federal law provides that we may use your child's medical information for **health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.

Uses and Disclosures of PHI for Appointment Reminders, Treatment Alternatives, or Fundraising Activities

- We may use and disclose your child's PHI to contact you as a reminder that your child has an appointment for a home visit. We may use and disclose your child's PHI to advise you or recommend possible service options or alternatives that may be of interest to you. We may contact you for fundraising activities. However, you will be provided the opportunity to opt out of receiving such fundraising communications.

Disclosures You May Authorize Us to Make

- We will not disclose your child's PHI without authorization, except as described in this Notice. Most uses and disclosures of psychotherapy notes, as applicable, require your authorization. Subject to certain limited exceptions, we may not use or disclose PHI for marketing without your authorization. We may not sell PHI without your authorization. You may give us written authorization to use and/or disclose health information to anyone for any purpose. If you authorize us to use or disclose such information, you may revoke that authorization in writing at any time.

Health Information Exchanges.

- We may participate in one or more health information exchanges (HIEs) and may electronically share your child's health information for treatment, payment, and healthcare operations purposes with other participants in the HIEs. HIEs allow your health care providers to efficiently access and use your child's pertinent medical information necessary for treatment and other lawful purposes. Depending on State law requirements, you may be asked to "opt-in" in order to share your child's information with HIEs, or you may be provided with the opportunity to "opt-out" of HIE participation. If you opt-in to the HIE (or do not opt-out depending upon state law requirements), we may provide your child's health information to the HIEs in which we participate in accordance with applicable law. Patients who opt-in will be required to provide written authorization and may revoke their authorization at any time.

Other Specific Uses or Disclosures

When Legally Required. We will disclose your child's PHI when required by any Federal, State or local law.

In the Event of a Serious Threat to Life, Health or Safety. We may, consistent with applicable law and ethical standards of conduct, disclose your child's PHI if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your life, health, or safety, or to the health and safety of the public.

When There Are Risks to Public Health. We may disclose your child's PHI for public activities and purposes allowed by law in order to prevent or control disease, injury or disability; report disease, injury, and vital events such as birth or death; conduct public health surveillance, investigations, and interventions; or notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

To Report Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe a child is the victim of abuse, neglect or domestic violence. We will make this disclosure only when required or authorized by law, or when the child's personal representative agrees to the disclosure.

To Conduct Health Oversight Activities. We may disclose your child's PHI to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your child's PHI if you are the subject of an investigation and your child's PHI is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. We may disclose your child's PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order, or, in response to a subpoena, discovery request or other lawful process, if we determine that reasonable efforts have been made by the party seeking the information to either notify you about the request or to secure a qualified protective order the release of any confidential medical information.

For Law Enforcement regarding your health information. Under Ohio law, some requests may require a court order. As permitted or required by law, we may disclose specific and limited PHI about you for certain law enforcement purposes.

For Research Purposes. We may, under very select circumstances, use your PHI for research. Before we disclose any of your child's PHI for such research purposes in a way that you could be identified, the project will be subject to an extensive review and approval process, unless otherwise prohibited as with Medicaid.

For Specified Government Functions. Federal regulations may require or authorize us to use or disclose your child's PHI to facilitate specified government functions relating to military and veterans; national security and intelligence activities; protective services for the President and others; medical suitability determinations; and inmates and law enforcement custody.

For Workers' Compensation. We may use or disclose your child's PHI for workers' compensation or similar programs.

Transfer of Information at Death. In certain circumstances, we may disclose your child's PHI to funeral directors, medical examiners, and coroners to carry out their duties consistent with applicable law.

Organ Procurement Organizations. Consistent with applicable law, we may disclose your child's PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purposes of tissue donation and transplant.

Minors

- For divorced or separated parents: each parent has equal access to health information about their un-emancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.

Your Rights with Respect to PHI

You have the following rights regarding PHI that we maintain:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your child's health information. You have the right to request a limit on our disclosure of your child's PHI to someone who is involved in your child's care or the payment of your child's care. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it unless the request concerns a disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full. To request such restrictions, please contact Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.**

Right to Receive Confidential Communications. You have the right to request that we communicate with you in a confidential manner. For example, you may ask us to conduct communications pertaining to your child's health information only with you privately, with no other family members present. If you wish to receive confidential communications, please contact Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.** We may not require that you provide an explanation for your request and will attempt to honor any reasonable requests.

Right to Inspect and Copy Your PHI. Unless your access to your child's records is restricted for clear and documented treatment reasons, you have a right to see your child's PHI upon request. You have the right to inspect and copy such health information, including billing records, at a reasonable time and place. A request to inspect and copy records containing your child's PHI may be made to Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.** If you request a copy of such health information, we may charge reasonable copying, processing, and personnel fees. If the PHI that is the subject of a request is maintained in one or more designated record sets electronically and if you request an electronic copy of such information, we will provide you with access to the PHI in the electronic form and format requested if readily producible in such form and format; or, if not, in a readable electronic form and format as agreed upon by us and you.

Right to Amend Your PHI. You have the right to request that we amend your child's records, if you believe that your PHI is incorrect or incomplete. That request may be made as long as we maintain the information. A request for an amendment of records must be made in writing to Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.** We may deny the request if it is not in writing, or does not include a reason for the amendment. The request also may be denied if your child's health information records were not created by us, if the records you are requesting are not part of our records, if the health information you wish to amend is not part of the health information you are permitted to inspect and copy, or if, in our opinion, the records containing your child's health information are accurate and complete. We take the position that amendments may take the form of including a written statement from you and may not include changing, defacing or destroying any necessary information related to your child's health care.

Right to Know What Disclosures Have Been Made. You have the right to request an accounting of disclosures of your child's PHI made by us for certain reasons, including reasons related to public purposes authorized by law, and certain research. The request for an accounting must be made in writing to Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.** The request must specify the time period for the accounting, and may not be made for periods of time in excess of six (6) years prior to the date on which the accounting is requested. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable, cost-based fee.

Right to a Paper Copy of This Notice. You have a right to receive paper copy of this Notice at any time, even if you have received this Notice previously. To obtain a paper copy, please contact Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.**

Where to File a Complaint

You have the right to complain to us if you believe that your child's privacy rights have been violated, including the denial of any rights set forth in this Notice. Any complaints to us shall be made in writing to Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.** We encourage you to express any concerns you may have regarding the privacy of your child's information. You will not be retaliated against in any way for filing a complaint.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C., 20201 or call toll-free (877) 696-6775, by e-mail to OCRComplaint@hhs.gov, or to Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, Ill, 60601, Voice Phone (312) 886-2359, FAX (312) 886-1807, or TDD (312) 353-5693.

Contact Persons

We have designated the Privacy Official as our contact point for all issues regarding consumer privacy and your rights under this Notice. If you have any questions regarding this Notice, please contact Clinical Leadership at **Hand In Hand Pediatrics, 6051 Memorial Drive, Dublin, OH 43017; (614) 799-6044.**

Effective Date

This Notice is effective June 1st, 2018.

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Mother's Name _____ Baby's Name_____
Mother's DOB _____ Baby's DOB _____
Street Address _____ City _____State ____ Zip _____
Phone Number _____

As you have recently had a baby, we would like to know how you are feeling. Please place an X on the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example already completed
I have felt happy:
___ Yes, all the time
_X_ Yes, most of the time This would mean "I have felt happy most of the time" during the past 7 days
___ No, not very often
___ No, not at all

Please complete the other questions in the same way. In the past 7 days

1. I have been able to laugh and see the funny side of things.

___ As much as I always could
___ Not quite so much now
___ Definitely not so much now
___ Not at all

2. I have looked forward with enjoyment to things.

___ As much as I ever did
___ Rather less than I used to
___ Definitely less than I used to
___ Hardly at all

3. *I have blamed myself unnecessarily when things went wrong

___ Yes, most of the time
___ Yes, some of the time
___ Not very often
___ No, never

4. I have been anxious or worried for no good reason

___No, not at all
___ Hardly ever
___ Yes, sometimes
___Yes, very often

5. * I have felt scared or panicky for not very good reasons

___ Yes, quite a lot
___ Yes, sometimes
___ No, not much
___ No, not at all

6. Things have been getting on top of me.

___Yes, most of the time I haven't been able to cope at all
___ Yes, sometimes I haven't been coping as well as usual
___ No, most of the time I have coped quite well
___ No, I have been coping as well as ever

7. *I have been so unhappy that I have had difficulty sleeping

___ Yes, most of the time
___ Yes, sometimes
___ Not very often
___ No, not all

8. *I have felt sad or miserable

___ Yes, most of the time
___ Yes, quite often
___ Not very often
___ No, not at all

9. *I have been so unhappy that I have been crying

___ Yes, most of the time
___ Yes, quite often
___ Only occasionally
___ No, never

10. *The thought of harming myself has occurred to me

___ Yes, quite often
___ Sometimes
___ Hardly ever
___ Never

Administered/Reviewed by _____ Date _____