PEDIATRIC AND NEONATAL OF SOUTH FLORIDA, LLC

PATIENT'S INFORMATION

DATE: ____________

PATIENT'S NAME: ____

BIRTHDAY: __________ SEX _____ HOSPITAL WHERE BORN: ____________________

EMAIL: ______________________________ PHONE: ______________________

ADDRESS: ____

PARENT'S INFORMATION

MOTHER NAME: ______________________________ CELL: ________________

FATHER NAME: ______________________________ CELL: ________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ______________________________

INSURANCE ID#: ______________________________

PERMISSON

OUR OFFICE ASKS THAT EVERY EFFORT BE MADE FOR A PARENT TO ACCOMPANY THEIR CHILD FOR CHECK –UP/WELL APPOINTMENTS, WHICH ARE SCHEDULED IN ADVANCE. HOWEVER, WE UNDERSTAND THAT SOMETIMES IT IS NOT POSSIBLE FOR A PARENT TO ACCOMPANY THEIR CHILD FOR SICK VISITS OR BE AVAILABLE TO SPEAK WITH OUR OFFICE IF THEIR CHILS IS SICK OR TO CONTACT THE OFFICE WITH MEDICAL QUESTIONS. PARENTS MAY ELECT TO ASSIGN A FAMILY MEMBER OR FRIEND TO EITHER BRING CHILD TO THE OFFICE OR CONTACT OUR OFFICE FOR MEDICAL ADVICE.

HENCE, PLEASE LIST BELOW THE PERSONS WHOM YOU ELECT MAY ACCOMPANY YOUR CHILD TO OUR OFFICE.

NAME: ____________________ RELATIONSHIP: ____________________

NAME: ____________________ RELATIONSHIP: ____________________

PATIENT/GUARDIAN SIGNATURE: ____________________ DATE: __________

PEDIATRIC AND NEONATAL OF SOUTH FLORIDA, LLC

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY ACT (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDDING MY PROTECTED HEALTH INSURANCE, I ACKNOWLEDGE THAT I HAVE RECEIVED OR HAVE BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF YOUR NOTICE OF PRIVACY PRATICES, I ALSO UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRATICES, I ALSO UNDERSTAND THAT THIS PRATICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRATICES AND THAT I MAY CONTACT THE PRATICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTIES.

______________________________________ ________________________

PATIENT NAME OR LEGAL GUARDIAN (PRINT) **DATE**

____

SIGNATURE

NO SHOW POLICY

THIS POLICY HAS BEEN ESTABLISHED TO HELP SERVE YOU BETTER.

IT IS NECESSARY FOR US TO MAKE APPOINTMENTS IN ORDER TO SEE OUR PATIENTS AS EFFICIENTLY AS POSSIBLE. NO- SHOW CAUSE PROBLEMS THAT GO BEYOND A FINANCIAL IMPACT ON OUR PRACTICE. WHEN AN APPOINMENT IS MADE, IT TAKES AND AVAILABLE TIME SLOT AWAY FROM ANOTHER PATIENT. NO- SHOW DELAY THE DELIVERY OF HEALTH CARE TO OTHER PATIENTS, SOME WHO ARE QUITE ILL. A NO-SHOW IS A MISSING A SCHEDULE APPOINMENT.

A CHARGE OF $20.00 WILL BE ASSESSED FOR EACH NO- SHOW APPOINTMENT

PATIENT/GUARDIAN SIGNATURE: ______________________ DATE: ____________

Pediatric and Neonatal of South Florida, LLC
10621 N. Kendall Drive Suite 113, Miami, FL, 33176,
Telephone: (305) 670-6006 ~ Fax: (305) 670-6007

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________ ID Number: __________________

Date of Birth: ______________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_______________________________________ ____________________

Signature of Patient or Legal Representative Date

_______________________________________ ____________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

CHILD HEALTH HISTORY

Allergies: Home Phone#: Cell Phone #:

DATE:	NAME PARENT/GUARDIAN:	SIBLINGS:	CARETAKERS:

MEDICAL HISTORY

Y = Yes, N = No, ? = Unknown	Patient	Family
Stroke/Hypertension	Y / N / ?	Y / N / ?
Heart Dz / Rheumatic Fever	Y / N / ?	Y / N / ?
Diabetes	Y / N / ?	Y / N / ?
Cancer	Y / N / ?	Y / N / ?
Congenital / Genetic Disorders	Y / N / ?	Y / N / ?
Blood Disorders / Sickle Cell / Rh	Y / N / ?	Y / N / ?
Lung / Tuberculosis / Asthma	Y / N / ?	Y / N / ?
Headaches / Seizures	Y / N / ?	Y / N / ?
Neuro / Mental / Emotional Heath	Y / N / ?	Y / N / ?
Breast Disease	Y / N / ?	Y / N / ?
Gall Bladder / Liver	Y / N / ?	Y / N / ?
Kidney / UTI	Y / N / ?	Y / N / ?
GI Disease	Y / N / ?	Y / N / ?
Substance Abuse	Y / N / ?	Y / N / ?
HIV	Y / N / ?	Y / N / ?
Skin / Skeletal	Y / N / ?	Y / N / ?
Thyroid / Endocrine	Y / N / ?	Y / N / ?

FOR PATIENT ONLY

	Patient	Date
Blood Transfusion	Y / N / ?	
Blood Type:	A / B / AB / O	Rh + / -
Rubella	Y / N / ?	
Measles	Y / N / ?	
Mumps	Y / N / ?	
Hepatitis B	Y / N / ?	
STD (specify)	Y / N / ?	
Past vaccine Rxn	Y / N / ?	
Chickenpox	Y / N / ?	
Other		

Delivery History(as applicable)

Mother's Prenatal History

☐SVD

☐C/S Reason: ______

Diabetes ☐yes ☐no controlled: ☐diet ☐insulin

Hypertension ☐yes ☐no

HIV Tested ☐yes ☐no results: ☐pos(+) ☐neg(-)

PPD Tested ☐yes ☐no results: ☐pos(+) ☐neg(-)

ETOH / Tobacco / Drugs ☐yes ☐no

STD ______

RPR ☐pos (+) ☐neg (-)

HBsAg ☐pos (+) ☐neg (-)

Weeks Gestation: ______

Birth Weight: ______

APGAR: ______ / ______ / ______

Length: ______

Head Circ: ______

Where Delivered: ______

Hearing Screen: ______

NEONATAL PROBLEMS & CONDITIONS

☐Birth Defects ______

☐Jaundice ______

☐Feeding ______

☐Respiratory ______

☐Cardiac ______

☐Sepsis work-up results: ☐pos(+) ☐neg(-)

☐Other: ______

SERIOUS ILLNESS, ACCIDENT, HOSPITALIZATION (S):

MEDICATIONS:

FREQUENT EPISODES OF MINOR ILLNESS:

VITAMINS:

CULTURAL / ALTERNATIVE MEDCINES:

SOCIAL HISTORY

Pool: ______ Gun: ______

ETOH / Tobacco / Drugs: ______

Domestic Violence: ______ Pets: ______

Religion: ______ Language: ______

Family dynamics: ______

PHYSICAL HISTORY (as applicable)

Menarche: ______

Puberty: ______

Acne: ______

Sexual Activity: ______

Signature: ______

Patient Name: ______ **DOB:** ______ **F M Language: E S Other**

Pediatric and Neonatal of South Florida LLC

Vaccination Policy

Patient's Name: ______________________________ Date: ______________

DOB: ____________

Effective January 1st , 2015 Pediatric And Neonatal of South Florida, LLC will no longer accept patients who are unvaccinated, on an alternative vaccine schedule or those with religion exemptions from the Florida Department of Health.

For any current patient with unvaccinated or those with a religious exemption from the Florida Department of Health, we will give 30 days to begin catch-up immunization schedule or enroll with a different Primary Care Physician.

The providers in Pediatric and Neonatal of South Florida, LLC care deeply about the health and safety of the children in our office. Our practice believes that vaccinating children and young adult is a crucial step to promoting healthy lives in the future.

Our office follows the recommendations and schedule of the American Academy of Pediatrics and the Centers of Disease Control and Preventing regarding lives and futures.

Unvaccinated children are at higher risk for becoming ill with a host of preventable diseases that can have serious and sometimes devastating consequences, in addition, unvaccinated children can potentially spread a preventable disease to another child who may be too young to be vaccinated or who is immune compromised. The vaccines our patients have receive have been thoroughly tested for safety and efficacy.

If you need assistance in locating a provider that does accept religious exemptions, please contact your insurance carrier.

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:__________________________ DOB:__________________

I understand and agree that I will be financially responsible for any and all charges for services rendered or not paid by my insurance. This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has been terminated/inactive or if any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may results in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied and I understand this and agree to be financially responsible and make full payment.

I hereby authorize payment of medical benefits directly to Pediatric and Neonatal of South Florida, LLC for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Signature:__________________________ Date:__________________

Print Responsible Party Name:____________________________________

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

(X) a female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

(X) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

(X) Other procedures as listed ____________________

(X) Examination of external genitalia___________________________

This examination will be performed by any provider from **Pediatric and Neonatal of South Florida, LLC.**

The consent will remain active until I withdraw my consent in writing.

Name of Patient

____

Signature of Patient or Patient's Representative if under 18

____

Date ________________

Pediatric & Neonatal of South Florida, LLC
HIPPA
Policy & Procedures

Privacy Officer: ____________

Our office will make every effort to ensure that protected health information (PHI) is secure and used or disclosed in accordance with HIPAA guidelines as well as other applicable federal and state laws.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal legislation conceived to guarantee that health insurance coverage is available to workers and their families when they change or lose their jobs. It has been extended to include:

A. **Standardizing** the data content and format for electronic transactions (EDI) rules:
   Defines how health care information can be transmitted electronically
B. **Privacy** of confidential personal health care information:
   Defines what health care information needs to be protected
C. **Secure** physical access to records
   Defines how health care information should be protected
D. **National identifiers** for providers, employers, and health plans.
   Tax ID number or EIN

The act empowers patients by guaranteeing them access to their medical records, giving them more control over how their protected health information (PHI) is used and disclosed, and provides a clear avenue of recourse if their medical privacy is compromised.

A. **Standards** for Transactions (EDI):

   * Mandates the use of ANSI (American National Standard Institute) formats for EDI transactions, including
     minimum requirements for electronic signature.
   * Mandates for standardized transactions for claims, remittance, eligibility inquires, claims status inquires
     and referral.
   * Mandates issuing of unique identifiers for providers, employers, health plans and patients. (No standard yet)
   * Madates Code Sets such as ICD-9, CPT, HCPC

   What Standard transactions are covered:

   - Claims
   - Claims Status
   - Eligibility

- Referral/Authorizations
- Enrollment and Disenrollment in a Health Plan
- Health Care Payment and Remittance Advice (EOB)
- Health Care Payment
- COB
- Name
- Address
- Telephone number
- Social Security number
- E-Mail Address
- URL (Web site information)

- IP Address
- Dates
- Medical Record Number
- Health insurance information, including policy #.
- Internal Account Number
- Certificate number
- Vehicle identifier
- Facial photos
- Device identifiers
- Geographic Units
- Any other unique identifier or code
-

B. **Privacy** Standards

Any protected health information (PHI) that identifies the patient and relates to his or her health status (or payment of health Services).

Six rules apply:

- PHI may be written or oral
- PHI may be recorded on paper, computer, or other media
- PHI is information that reveals a person's health status
- PHI may be information that is "individually identifiable".
- PHI may be "individually identifiable" if it gives a reasonable basis for determining a patient's identity.
- PHI may be information you create or receive.

There are 18 "identifiers":

Name, Geographic (street, city, county, zip code – except for the first three digits of a zip code),
All elements of dates (except year) –date of birth, admission or discharge dates
Telephone and fax numbers, E-Mail address, social security numbers, medical record numbers, health plan
beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers, web universal
resource (URL), internet protocol address numbers, biometric identifiers – including finger and voice prints,
Full face photographic images, any other unique identifying number, characteristic, or code.

Disclosing PHI

There are two instances in which we can disclose PHI; if the disclosure is required, or if the disclosure is
permitted.

Required Disclosure:

The Privacy Rule permits our office to comply with laws requiring the use or disclosure of PHI, provided the use or disclosure meets and is limited to the relevant requirements of such other laws. Such as, victims of abuse, neglect, or domestic violence, for judicial purposes.

There are three categories when we are required to disclose PHI; 1) when the parent requests access to their child's PHI, 2) when required by the Health & Human Services Secretary, 3) or when required by law.

Steps to Take Before Disclosing Required PHI:

1. Verifying the Legitimacy of the Request verify signature on request.

2. Verifying the legitimacy of Requestor. Take reasonable steps to verify requestor: check & copy
driver's license or other form of ID, if request is made @ our office, or by letterhead from other
entity if request by mail or fax

3. Documenting the disclosure include date, what was disclosed, and to whom (all should be on release form)

4. Notify parent of disclosure: Ex; abuse. Exception if determination is made that notification would cause further harm to patient.

Permitted Disclosures

PHI may be disclosed to a parent/guardian or other entity upon written request from parent/guardian. The request must contain the following:

Patient name
Date of birth
Parent/guardian name
Reason for request
Part of medical record being requested
Signature
Date
Copy of drivers license

C. Secure Physical Access to PHI/Medical Records

All medical records are stored in a secure room where only staff members have access.
Computers are not left unattended on any portion that may contain PHI.
Data back-up of computer
Only employees of our office are allowed to view PHI
    Secretaries : for the purposes of making appointment, registering patients, updating patient demographic information, preparing charts for office visits, referrals.
    Medical Assistants: for the purposes of obtaining and reviewing information to assist the physician in the care of the patient.
Utilize care when disposing of material which may contain PHI - utilize a shredder
Destroy zip discs or other discs that may contain PHI when no longer of use.
Utilize the utmost care when discussing patient information within the office setting by:
    Using soft voice in and around patient areas thereby preventing other patients/visitors from overhearing PHI.
    Do not discuss PHI in and around waiting room, triage areas in a manner where other patients/visitors may overhear.. Have parents come directly to the window when registering, updating, or discharging patients, or discussing accounts.

PHI may only be discussed with patient, parents, or legal guardian. We must have written authorization from

arent or legal guardian in order for our office to communicate PHI with family members, etc.

D. National Identifier

Tax ID numbers