Pediatric Kidney Center of South Florida

7800 SW 57th Ave, Suite 305
Miami, FL 33143
Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

PATIENT INFORMATION:

Patient Name:_____ Social Security#: ____/____/____
Date of Birth: _____/____/_____ Sex ☐ Male ☐ Female Race:_____
Address:_____City_____State_____Zip Code_____
Telephone (Home):_____(Mobile):_____(Work):_____
E-mail Address:_____
Preferred Language: (Spanish) or (English)
Pharmacy Name:_____ Pharmacy Address/Telephone:_____
Referring Physician/Pediatrician:_____Phone:_____
****How did you hear about our practice?**_____

PARENT / LEGAL GUARDIAN INFORMATION:

Mother:_____Date of Birth:_____
Social Security Number:_____/_____/_____Employer/Occupation:_____
Mobile Phone:_____Work Phone:_____
Father:_____Date of Birth:_____
Social Security Number:_____/_____/_____Employer/Occupation:_____
Mobile Phone:_____Work Phone:_____

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Company Name:_____	Company Name:_____
Policy ID Number:_____	Policy ID Number:_____
Group Number:_____	Group Number:_____
Policy Holder:_____	Policy Holder:_____
Policy Holder SS#:_____	Policy Holder SS#:_____
Policy Holder Date of Birth:_____	Policy Holder Date of Birth:_____
Relationship to Patient:_____	Relationship to Patient:_____

*****If your insurance requires a referral for you to see Dr. Fanny González, it is your responsibility to provide our office with the referral. If your insurance company denies payment (due to no referral) you, the patient, agree to pay Pediatric Kidney Center of South Florida in full for any charges incurred during your visit.**

Patient/ Guardian Signature: _____ Date: _____

Insurance Release Information

I hereby authorize the office Pediatric Kidney Center of South Florida, to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Pediatric Kidney Center of South Florida. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Guardian Signature: _____ Date: _____

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Notice to All Patients

Your health plan has specific regulations you must follow in order for you to avoid liability from full payment on service rendered by our physician.

Referrals: We participate with many health plans. It is your responsibility as a patient to provide us with an updated referral on the day of your scheduled appointment. Our office cannot be held responsible for obtaining referrals. If we do not have a referral on file on the date of your scheduled appointment, we will reschedule you for a future date. To avoid this problem, we suggest you contact your primary care physician in advance.

Payment Policy: Please be prepared to present your insurance card and Identification card at every visit to enusre that our doctor actively participates with your insurance carrier. Be aware of your insurnace policy benefits and limitiations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to pay in full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service. We accept cash, personal checks, Visa, MasterCard, and Discover.

Patients may receive and are responsible for bills for services sent to another facility such as laboratory or diagnostic center which may not be covered by your insurance. Patients will be responsbile for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statemens will be mailed for unpaid services. Balances must be paid in 30 days. If a balance is due over 90 days and we have not been contacted to arrange payments, the accounte may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan.

Non-Cancellation Policy: Please be courteous and call us if you cannot make your shceduled appointment 24 hours in advance. This allows us to see other patients who may be in need of our services. There is a $25 fee for missed appointments or appointments not cancelled 24 hours in advance.

Forms: There is a $20 fee for school forms and copy of all medical records.

Test Results: Test results require a follow-up visit to review and discuss any diagnostic testing.

Finally, this is your information plan. Please familiarize yourself with every rule of the health plan you are enrolled in. Your insurance company will mail a summary of charges, payments, denials, or requests for your further information. Please review all insurance correspondence.

Please sing and return to the front desk after reading. If you have nay questions, feel free to speak to one of our office personnel.

I have read and understand the above information.

Parent Name: _____

Signature: _____ Date: _____

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COMMUNICATION AUTHORIZATION

Pediatric Kidney Center of South Florida would like to communicate with you in the ways you prefer. By signing below, you allow us to disclose your Protected Health Information (PH) as described on this form. PHI includes all information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

Patient Name: _____

Date of Birth: _____ **Today's Date:** _____

			Initials
1	**Telephone messages:** We may leave messages on answering machines or with individuals answering the phone at numbers written in this section, including referral information, prescription refill reminders, appointment reminders, test results, and other information the Practice determines to be appropriate to leave on voicemail.	Phone numbers:	
2	**Email Communications:** We may send email messages to your listed email address including referral information, test results, and other information.	Email:	

PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN:

_____ Yes, my child may be treated when accompanied by:

Name	Relationship

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

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Notice of Privacy Acknowledgement

Pediatric Kidney Center of South Florida

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name (print) Patient Date of Birth

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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MEDICAL RECORD RELEASE FORM

Telephone: 305-856-7005
Fax: 786-577-2117

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to Pediatric Kidney Center of South Florida:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films (X-ray, Ultrasound, CT, MRI, etc.)

_____ _____
Signature of Patient or Parent/Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosedmay, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time

unless the facility, which is to make the disclosure of information, has already done so in reliance of the consent.

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Patient Name: _____

DOB: _____

Acknowledgements/Authorizations/Consent to Treatment

I hereby consent to any and all diagnostic procedures, tests, and medical treatments required in the diagnosis of my illness and course of treatment by the physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

I hereby authorize the physician designated to release all necessary information (via Fax Transmittal, e-mail or hard copy) acquired in the course of my examination and treatment to secure payment. I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I hereby authorize my consent for medication release.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein. I agree that this authorization shall be valid until rescinded in writing or replaced by of a later date.

_____ _____

Signature of Patient, Parent or Guardian Date

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NEW PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Nickname: _____

Sex: _____ Age: _____ Date of Birth: _____

What problem brings you today? _____

How long has this problem been going on for? _____

SOCIAL HISTORY:

	Name	Age	Medical Problem	Medications
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

If mother and father don't live together, or child doesn't live at home, what is the child's custody status? _____

Is patient in daycare/school? ☐ Yes ☐ No; If yes: Name of school and grade? _____

BIRTH HISTORY:

Birth Weight: _____ Full term? ☐ Yes ☐ No; If early/late, how many weeks gestation? _____

Any problems with the pregnancy (high blood pressure, blood or protein in urine, etc)? ☐ Yes ☐ No _____

Was the delivery ☐ vaginal OR ☐ C-section ; If ceasarian, why? _____

Did the patient have any problems at birth? ☐ Yes ☐ No _____

Was the patient on a ventilator? ☐ Yes ☐ No; If yes, how long? _____

MEDICAL HISTORY:

Does the patient have any serious illnesses or medical conditions? ☐ Yes ☐ No EXPLAIN: _____

Has the patient had any surgeries (When/Type)? ☐ Yes ☐ No EXPLAIN: _____

Has the patient ever been hospitalized? ☐ Yes ☐ No EXPLAIN: _____

Is the patient allergic to any medicines or drugs? ☐ Yes ☐ No EXPLAIN: _____

What medications (including over the counter) is the patient currently taking? _____

_____

Immunizations up to date? ☐ Yes ☐ No

FAMILY HISTORY:

Has any family member had any of the following?

Kidney disease	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney stones	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney failure	☐ Yes ☐ No	Who: _____	Comments: _____
Dialysis (kidney treatments)	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney transplant	☐ Yes ☐ No	Who: _____	Comments: _____
High blood pressure	☐ Yes ☐ No	Who: _____	Comments: _____
Deafness	☐ Yes ☐ No	Who: _____	Comments: _____
Vesicoureteral reflux	☐ Yes ☐ No	Who: _____	Comments: _____

Additional Family History: _____

PAST MEDICAL HISTORY:

Does the patient have/ever had any of the following:

Fever	☐ Yes ☐ No	Explain: _____
Fatigue	☐ Yes ☐ No	Explain: _____
Headaches	☐ Yes ☐ No	Explain: _____
Dizziness	☐ Yes ☐ No	Explain: _____
Vision problems	☐ Yes ☐ No	Explain: _____
Nose bleeds	☐ Yes ☐ No	Explain: _____
Sore throats/throat infections	☐ Yes ☐ No	Explain: _____
Heart problems (murmur)	☐ Yes ☐ No	Explain: _____
High blood pressure	☐ Yes ☐ No	Explain: _____
Asthma, Bronchiolitis, Pneumonia	☐ Yes ☐ No	Explain: _____
Blood transfusions	☐ Yes ☐ No	Explain: _____
Vomiting	☐ Yes ☐ No	Explain: _____
Diarrhea	☐ Yes ☐ No	Explain: _____
Blood in urine	☐ Yes ☐ No	Explain: _____
Protein in urine	☐ Yes ☐ No	Explain: _____
Urine, bladder, and/or kidney infection	☐ Yes ☐ No	Explain: _____
Pain when urinates	☐ Yes ☐ No	Explain: _____
Urinating more often	☐ Yes ☐ No	Explain: _____
Urinating less often	☐ Yes ☐ No	Explain: _____
Accidents or bedwetting	☐ Yes ☐ No	Explain:_____
Joint pain or swelling	☐ Yes ☐ No	Explain: _____
Muscle problems	☐ Yes ☐ No	Explain: _____
Rashes	☐ Yes ☐ No	Explain: _____
Neurologic problems (Seizures)	☐ Yes ☐ No	Explain: _____