

PATIENT INFORMATION

Date _____ Name _____
Date of birth _____ Sex _____ Home # _____ Cell # _____
Street Address _____ City _____ Zip _____
Parent/Guardian Email Address _____
Social Security # _____ Number of brothers and sisters _____
Patient Allergies _____
Primary Language _____ Race _____
Ethnicity: Hispanic or Latino, Yes _____ No _____ Referred by: _____

Father's or Guardian's Name _____
Relationship, if not father _____
Street Address _____ City _____ Zip _____
Phone # _____ Employer _____
Social Security # _____ Driver's License # _____
Date of birth _____ Race _____ Height _____

Mother's or Guardian's Name _____
Relationship, if not mother _____
Street Address _____ City _____ Zip _____
Phone # _____ Employer _____
Social Security # _____ Driver's License # _____
Date of birth _____ Race _____ Height _____

●Email address for patient reminders: _____

Person responsible for this account: _____

Primary Insurance: _____
Policy Holder _____ Policy Holder's DOB _____
Policy Number _____ Policy phone # _____

Secondary Insurance: _____
Policy Holder _____ Policy Holder's DOB _____
Policy Number _____ Policy phone # _____

Name of relative not living with you _____
Address _____ Phone # _____

●PHARMACY NAME _____ Location _____

Will visits require special need services, such as services for the hearing impaired, during office visits? _____ If yes, explain _____

●I understand that Plant City Pediatrics will no longer accept new patients who do not follow the recommended routine childhood immunizations.

Parent/Guardian Signature _____

**Plant City Pediatrics
Initial History Questionnaire**

Name: _____ Sex: _____ DOB: _____ Age: _____
Date: _____ Previous Physician: _____

CHILD'S BIRTH HISTORY

Birth Weight: _____ Birth Length: _____ Maternal Smoking: Y / N
Weeks Gestation: _____ Term / Pre Term / Post Term Maternal Alcohol/Drugs Y / N
Delivery: Vaginal or Cesarean If Cesarean why? _____ Hospital: _____
Maternal Problems: Prenatal: Y / N Post Natal: Y / N
Infant Problems: Y / N
Breast Feeding: Y / N Every _____ Hours _____ minutes on each side for _____ Months
Formula: _____ every _____ hours, _____ ounces.

I understand that my child is required to come in for regular routine child check-ups in order to remain a patient at Plant City Pediatrics.

Parent or Guardian Signature

CHILD'S MEDICAL HISTORY

| | | | |
|-------------------------|-------|------------------------------------|-------|
| Healthy | Y / N | Blood Transfusions | Y / N |
| Medical Problems | Y / N | Frequent Abdominal Pain | Y / N |
| Hospitalizations | Y / N | Vision Problems | Y / N |
| Chicken Pox | Y / N | Pneumonia/Bronchitis/Bronchiolitis | Y / N |
| Frequent Ear Infections | Y / N | Heart Problems | Y / N |
| Accidents/Injuries | Y / N | Seizures | Y / N |
| Asthma | Y / N | Diabetes | Y / N |
| Anemia | Y / N | Bladder or Kidney Infections | Y / N |
| Frequent Headaches | Y / N | Thyroid Problems | Y / N |
| Chronic Skin Problems | Y / N | Fractures | Y / N |

Allergies: _____ Immunizations: _____
Past Surgical History: _____
Developmental History: _____
Grade in School: _____ Behind? Y / N Grades: _____ Problems: _____
Concern's about child's physical development? Y / N
Concern's about child's mental or emotional development? Y / N

FAMILY MEDICAL HISTORY

| | | | |
|----------------------|-------|---------------------------------------|-------|
| Mental Retardation | Y / N | Asthma | Y / N |
| Mental Illness | Y / N | Tuberculosis | Y / N |
| Seizure Disorder | Y / N | Heart Disease (<50 yrs of age) | Y / N |
| Drug/Alcohol Abuse | Y / N | High Blood Pressure (<50 yrs of age) | Y / N |
| Deafness | Y / N | High Cholesterol | Y / N |
| Allergic Rhinitis | Y / N | Liver Disease | Y / N |
| Cataracts / Glaucoma | Y / N | Kidney Disease | Y / N |
| Anemia | Y / N | Diabetes (<50 yrs of age) | Y / N |
| Bleeding Disorders | Y / N | Immune Problems, HIV, Aids | Y / N |

Provider Signature

Date

***** Important Information Regarding Your Account *****

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that some services performed by Plant City Pediatrics may be 'non-covered' by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses

(For patients with "UCR" coverage) I acknowledge that the fees charged by Plant City Pediatrics for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered 'usual, customary and reasonable', due to specialized services and staff. However, I agree to pay Plant City Pediatrics fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions

Commercial Insurance

(Initials) I hereby authorize and request Plant City Pediatrics to bill my insurance company/Medicaid for services rendered to my child/children. I request payment of benefits to be made to Plant City Pediatrics for services rendered.

Office Policies

It is our policy that office visits, co-pays and deductibles be paid in full at the time of service. I fully understand that if my account should need to be turned over to a collection agency for non-payment, that I will be charged an additional percentage of the amount to cover the agency's fees. I agree to pay any and all charges that exceed, or are not covered by my insurance.

Signature

Permission for Treatment

Permission is hereby granted for physicians, employees, or agents of Plant City Pediatrics to render the patient named below such medical and surgical treatment as deemed necessary.

Permission to Release Medical Information

I authorize Plant City Pediatrics to release information from my medical record, or from the medical record or the person for whom I am legally responsible, to my/their insurance company, other third-payors or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Plant City Pediatrics until written notice revoking it is provided. I release Plant City Pediatrics of all responsibilities for loss of confidentiality through access and/or copies made of records released in compliance to this authorization. I have read all of the above and understand/agree to all provisions therein regarding responsibility for payment, release of information, and permission for treatment.

Patient Name:

Parent or Legal Guardian Signature:

If Legal Guardian, Relationship to Patient:

PLANT CITY PEDIATRICS
511 W. Alexander St. ste. 2 Plant City FL 33563
Phone: 813-659-9800 Fax: 813-659-9807
MEDICAL RECORD REQUEST

Patient Name: _____ Birth Date: _____ Social Security Number: _____

Address: Telephone Number: _____ (____) _____

I hereby authorize: _____

To release information (by fax or mail) from the medical record of the above mentioned patient.
To: _____

For the following purpose or treatment: _____

Type of Access Requested: _____ Copies of Record _____ Inspection of Record

**This authorization expires 90 days from the date signed below and covers only
treatment for the dates or diagnosis specified above.**

H&P Immunization Record Other
 Progress Notes Consultation Reports Current Information
 Labs **All Records Changing Primary Physician**

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol,
drug abuse, psychiatric, HIV testing, HIV results, and AIDS information.

Initials _____

_____ I, the undersigned, have read the above and authorized the staff of Plant City Pediatrics to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

Date: _____

Parent or Guardian's Signature: _____

Witness Signature _____

FOR OFFICE USE ONLY:

Date Received _____ **Processed By:** _____

**PLANT CITY PEDIATRICS
PRIVACY AGREEMENT**

Date: _____

Patient's Name: _____

Person Bringing Child: _____

Relationship to Child: _____

Person Bringing Child: _____

Relationship to Child: _____

Person Bringing Child: _____

Relationship to Child: _____

I give permission to the above person/persons to bring my child to their doctor's visit. I give my full consent for your office to provide medical care and release all medical information pertaining to my child to this individual. I understand that I am able to revoke this authorization at any time in writing.

Signature of Parent/Guardian

Relationship to Child

I, the parent/guardian of the above patient give consent for the following individuals to receive medical information and when necessary pick-up prescriptions, referrals, etc.:

- 1) _____ **Relationship:** _____
- 2) _____ **Relationship:** _____
- 3) _____ **Relationship:** _____
- 4) _____ **Relationship:** _____
- 5) _____ **Relationship:** _____
- 6) _____ **Relationship:** _____

I, the parent/guardian of the above patient, give consent for Plant City Pediatrics to leave phone messages and medical information regarding this child on my answering machine if I am not available.

Signature of Parent/Guardian

Date

**HIPPA POLICY AND PROCEDURES
SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES
PLANT CITY PEDIATRICS**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact our Privacy Officer at (813) 659-9800.

Who will follow this notice:

- Plant City Pediatrics

This notice describes our privacy practices. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information identifying you is kept private.
- Give you notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization. There are also various other ways in which we may use or disclose your information:

- **Appointment reminders**
- **To allow oversight of the quality of healthcare we provide**
- **To allow Worker's Compensation claims**
- **As required by Subpoena in lawsuits and disputes**
- **Various uses as required by law or to avert a serious threat to health or safety**

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to inspect and copy**
- **Right to amend**
- **Right to an accounting of disclosures**

- **Right to request restrictions**
- **Right to request confidential communications**

- **Right to a paper copy of this notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from our Privacy Officer at (813) 659-9800.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our practice's Compliance Committee Chair. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosure of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you make revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**PLANT CITY PEDIATRICS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

NAME OF CHILD: _____ **DOB:** _____

I, _____, (Print name), have received the Notice of Privacy Practices from Plant City Pediatrics.

Patient/Parent or Guardian Signature: _____ **Date:** _____

In lieu of patient signature, I _____, a staff member of Plant City Pediatrics state that _____ has been given our current Notice of Privacy Practices.

Staff Signature: _____ **Date:** _____

DECLINE

I, _____ (print name), was offered the Notice of Privacy Practices from Plant City Pediatrics and have decided not to accept a copy.

Patient/Parent or Guardian Signature: _____ **Date:** _____

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

LEAD POISONING RISK ASSESSMENT

| | | | |
|--|---|---|---|
| Does your child live in or regularly visit (once a week or more) any house built before 1978? | Y | N | U |
| Does your child live or regularly visit any house or building that has vinyl mini-blinds, lead pipes, pipes with lead solder joints, or had metal pipes replaced or repaired within the last 5 years? | Y | N | U |
| Does your child have a mother, sibling or play mate, who has, or did have, lead poisoning? | Y | N | U |
| Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? Some examples are employment in building renovation, an auto battery factory, auto or radiator repair shop, highway bridge sandblasting or painting, welding metal structures, wire cable cutting or hobbies such as refinishing furniture, casting bullets, making stained glass, toy soldiers, dive weights or fishing weights? | Y | N | U |
| Does your child eat food that has been stored in metal cans, from leaded crystal, ceramic or pewter dishes, or have contact with cosmetics, candies, spices, and home or folk remedies not made or sold in the United States? Have you ever seen your child eat dirt or paint chips? | Y | N | U |
| Does your child play in loose soil, near a busy road or near any industrial sites such as a battery recycling plant, junk yard or lead smelter? | Y | N | U |
| Has your child lived in a foster care home or in a country other than the U. S.? | Y | N | U |
| Place date at the top of the column. Indicate response by "Y" for yes, "N" for no, or "U" for unknown. Sign name and relationship at the bottom of the page. A yes or unknown response to any question indicates the child is at risk for lead poisoning. The child should receive blood lead testing and appropriate follow-up. See Risk Assessment, Screening, and Follow-up of Children for Elevated Blood Lead Levels. | | | |

TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE

| | | | |
|---|---|---|---|
| Has your child had contact with a parent, relative or other caretaker with either active tuberculosis, abnormal chest x-ray suggestive of tuberculosis, or history of positive PPD skin test? | Y | N | U |
| Are any parents, relatives or caretakers of your child from a region with high incidence of tuberculosis (i.e., Latin America, Asia, Africa and Eastern Europe)? | Y | N | U |
| Has your child been exposed to any adult who is HIV positive, homeless, a drug user, a migrant worker, indigent, resident from a nursing home, prisoner or other institution? | Y | N | U |
| Has your child ever been institutionalized? (i.e., imprisoned, detention home, foster care, mental hospital or orphanage). | Y | N | U |
| Does your child have cancer, diabetes, renal failure, malnutrition or an immunosuppressive condition? | Y | N | U |

Parent/Guardian Signature: _____

Relationship to Patient: _____

Physician/Provider Signature: _____