PEDIATRICS PLUS

1200 Sligh Boulevard, Orlando, FL
Phone: 407-859-7239 Fax: 407-850-9185
www.pedsplus.org

W. David Carr, MD Kellie Cordovano, ARNP Vanetta Anderson, ARNP

Patient Information

Date filled out: _____

Patient's full name: _____ Nickname: _____

Street address: _____ City/St/Zip: _____

Date of birth: _____ Age: _____ Sex(M/F): _____ SS# (optional): _____

Father's (or legal guardian's) name: _____ DOB: _____

Street address: _____ City/St/Zip: _____

Phone # (Home): _____(Cell): _____ (Work): _____

SS#: _____ Occupation: _____

DL#: _____ Employer's name: _____

Address: _____

Is patient covered by insurance through father's employment? Yes/No Is this the primary ins.? Yes/No:

If yes, name and address of Insurance Co. _____

_____ Policy #: _____

Group #: _____ Deductible: _____ Co-payment: _____

Mother's (or legal guardian's) name: _____ DOB: _____

Street address: _____ City/St/Zip: _____

Phone # (Home): _____(Cell): _____ (Work): _____

SS#: _____ Occupation: _____

DL#: _____ Employer's name: _____

Address: _____

Is patient covered by insurance through mother's employment? Yes/No Is this the primary ins.? Yes/No

If yes, name and address of Insurance Co. _____

_____ Policy #: _____

Group #: _____ Deductible: _____ Co-payment: _____

If mother and father are divorced, who has legal custody of the patient? Mother ___ Father ___

Grandparent ___ Other ___ (give name and relationship to patient)_____

Upon request, who may legally obtain medical information on your child? Mother ___ Father ___

Grandparent ___ Other ___ (give name and relationship to patient)_____

Note: You must have legal papers documenting this fact on file in this office if we are to honor this statement.

Person(s) to contact in case of emergency (other than parents):

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

Assignment of Insurance Benefits and Release of Medical Records

I hereby authorize payment of the benefits to which I may be entitled under the medical/surgical provisions of my policy to be paid directly to Pediatrics Plus. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for knowing what is covered by my policy and for all charges that are not covered by my policy. I will assist in the collection of my insurance benefits should there be any delay in payment. I hereby authorize the release of any information, including medical and billing information, by Pediatrics Plus to my insurance company necessary to expedite payment of any claim(s).

Signature of insured: _____ Date: _____

I have received a copy of Pediatrics Plus' office financial policy. I have read it, and I understand it.

Signature of responsible party: _____ Date: _____

It is very important that you fill in all of the blanks on this form and that you sign and date it in all appropriate places.

Pediatrics Plus
New Patient Questionnaire

Date filled out: _____

Patient Name: _____ DOB: _____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Guardian's Name: _____ Age: _____ Occupation: _____

Mother's age at child's birth: ____ yrs. Were there any significant illnesses during pregnancy? ___ Yes ___ No

If yes, briefly describe: _____

Child's birth weight: _____ lb. _____ oz. Was child born prematurely? ___ Yes ___ No

If yes, gestational age at birth: _____ wks.

Was mother on medications (or drugs) during pregnancy other than vitamins and/or iron? ___ Yes ___ No

If yes, give name(s) of medications or drugs: _____

Did this child have any medical problems during birth hospitalization? ___ Yes ___ No

If yes, briefly describe: _____

Child's last previous doctor: _____ City of practice: _____

Age at last well check-up: _____ Age at last dental check-up: _____

Does this patient have allergies to any medications, foods, insect bites, or other? ___ Yes ___ No

If yes to any allergies, list: _____

Has patient been hospitalized other than for birth? ___ Yes ___ No If yes, give diagnosis: _____

Has this patient had any severe reactions to any immunizations? ___ Yes ___ No

If yes, give vaccine(s): _____

Any serious injuries? ___ Yes ___ No If yes, be specific: _____

Current medications: _____

Below, list age, sex, and general health condition of all of patient's siblings.

AGE	SEX	GENERAL HEALTH DESCRIPTION

Have any of your children suffered from a major illness? ___ Yes ___ No. If yes, give name or description of illness:

_____

Please check any medical conditions below that any immediate family member(s) of this patient have/have had.

☐ Anemia ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Mental illness ☐ Heart Disease ☐ High Blood Pressure

☐ Cancer ☐ Genetic illness ☐ ADHD ☐ Drug/alcohol problems ☐ Other: _____

During this child's first 6 months of life, was he/she fed predominantly via ___ breast milk or ___ formula?

If this child is still on formula, give name: _____

Does your child take supplemental vitamins? ___ Yes ___ No

Does your child have any food allergies? ___ Yes ___ No If yes, to what? _____

Safety Checklist

Have you adjusted the water temperature in your hot water heater?
Do you have functioning smoke alarms in several areas of your home?
Do you always use car restraints for all children?
Are there smokers in the household?
Is there a swimming pool or other body of water on or near your property?
Have you had each of your children water survival trained?
Has your house been painted with lead based paint?
Does your child wear a bicycle helmet when riding on any wheeled vehicle?
Do you know CPR?
Do you have a trampoline?
Have you "childproofed" your home?

Does this child have, or has he/she ever had, any of the following problems? If so, please inform your practitioner.

Frequent ear infections: ___ yes ___ no	Heart problems: ___ yes ___ no	Seizures: ___ yes ___ no
Eye problems: ___ yes ___ no	Neurological problems: ___ yes ___ no	Anemia: ___ yes ___ no
Sinus problems: ___ yes ___ no	Hyperactivity: ___ yes ___ no	Asthma: ___ yes ___ no
Tooth problems: ___ yes ___ no	Problems with urination: ___ yes ___ no	Eczema: ___ yes ___ no
Recurrent sore throats: ___ yes ___ no	Diarrhea/constipation: ___ yes ___ no	Pneumonia: ___ yes ___ no
Sleep problems: ___ yes ___ no	School problems: ___ yes ___ no	Speech: ___ yes ___ no

Other: ___ yes ___ no Describe: _____

Development:

At what age did your child first sit alone without support? _____

At what age did your child first walk? _____

At what age did your child first say 1-2 words? _____

At what age did your child first put 2 words together? _____

Has your child done reasonably well in school? ___ Yes ___ No

PEDIATRICS PLUS
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003

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

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this **Notice of Privacy Practices** from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment, and health care operations. However, we reserve the right not to agree to the requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment, and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. Revoke your authorization to use or disclose health information except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice,. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Karen Miceli, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Pediatrics Plus or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257 Toll Free: 1-800-696-6775
http:/www.hhs.gov/contacts

Pediatrics Plus
Karen Miceli, Privacy Officer
1200 Sligh Boulevard
Orlando, Florida 32806
Tel: (407) 859-7239
Fax: (407) 850-9185

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a copy to read at your visit. Thereafter, you may obtain a copy upon request, or the notice will be maintained on the organization's Web site at www.pedsplus.org for downloading.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition, or health.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work-related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example, in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury, or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Research (in-patient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

PEDIATRICS PLUS

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient I.D.# _____

I hereby acknowledge that I have read or have received a copy of PEDIATRICS PLUS'S Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

X _____

Signature of Patient or Legal Representative DATE

X _____

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

___ Parent or guardian of unemancipated minor
___ Court appointed guardian
___ Executor or administrator of decedents' estate
___ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained because:

___ Patient/Representative refused to sign
___ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date
___ Communication barriers prohibited acknowledgement (Explain)

_____

_____

_____

___ Other (Specify)

_____

_____

Witness signature: _____

Witness printed name: _____

W. David Carr, M.D.
Kellie Cordovano, A.R.N.P.
Vanetta Anderson, A.R.N.P.

PEDIATRICSPLUS
"We Love Our Kids"

PEDIATRICS PLUS OFFICE POLICY

1. **Please turn off all cell phones and pagers during the exam.**
2. **Patients must be accompanied by a legal parent or guardian.**
3. **Patients who do NOT have a scheduled appointment will be charged a $30.00 Walk-in fee. This includes unscheduled siblings. Please inform us at check-in, NOT when you see the doctor.**
4. **There is a $35.00 fee for all missed regular appointments. The fee for missing an ADHD or Consultation appointment with Dr. Carr is $50.00. Please call to cancel your appointment 24 hours in advance.**
5. **The fee for ALL copied records is $1.00 per page. There is a $5.00 charge for ALL form(s) that require the doctor's signature (this includes HRS forms) if there is no appointment the day you bring in the forms.**
6. **Ear piercing is $30.00.**
7. **Due to the increased cost, all after hours calls will now incur a $20.00 charge for all calls made to the office after NORMAL BUSINESS HOURS.**
8. **Please have a current copy of your insurance card at every appointment.**
9. **ALL CO-PAYS are due at the time of service. These fees can not be waived. All co-payments not collected at the time of service will incur a $5.00 billing charge!!**
10. **Please, no DOO-DOO diapers in the trash cans. Please ask a nurse to assist you with the disposal.**
11. **OSHA prohibits food and drink in the office. Please do not bring any food or drink into the building.**
12. **BUT MOST IMPORTANT *****REMEMBER HOW MUCH WE CARE FOR YOU AND YOUR CHILDREN HERE AT PEDIATRICS PLUS!!!!!**

PRINT PATIENT NAME	PARENT SIGNATURE	DATE

W. David Carr, M.D.
Kellie Cordovano, A.R.N.P.
Vanetta Anderson, A.R.N.P.

PEDIATRICSPLUS
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PEDIATRICS PLUS FINANCIAL POLICY

Thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you. As you may know, our office and physicians try to get insurance companies to pay us in a timely manner, however, this is not always the case. In order just to stay in business, we find ourselves having to make some hard decisions. As a result, we implemented a new Financial Policy as of November 2011.

PATIENT PAYMENTS: Payment is due at the time of service. You may use cash, check, or a credit card to pay on your account. In the event that you would like to be billed, there is an additional $15.00 billing fee that will be added to your account.

INSURANCE PAYMENTS: Your insurance policy is a contract between YOU and your insurance company. We are not a party to that contract! We require certain co-payments or payments depending on the type of insurance and insurance carrier. Our office works diligently to obtain payment from your insurance company, HOWEVER...IF WE HAVE FILED YOUR CLAIM AND YOUR INSURANCE HAS NOT PAID WITHIN 60 DAYS, you will be responsible for the balance.

INSURANCE COVERAGE: While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what is and IS NOT covered.

THIRD PARTY INSURANCE: We do not bill third party insurance or VISITOR insurance.

MISSED/LATE CANCELLED APPOINTMENTS: Please give us at least 24 hours notification if you can not keep your appointment. Although we do reminder calls for the following day's appointments, THESE ARE COURTESY CALLS and not to be used as an excuse for a missed appointment. All regular visit NO-SHOWS will be charged a $35.00 fee and ALL CONSULTS AND MEDICINE CHECKS no-shows will be charged a $50.00 fee.

RETURNED CHECKS: Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, ANY returned check will be charged a $35.00 NSF fee. All future visits will be cash or credit card only.

Thank you for your support.

Office Management

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407-859-7239 + Fax 407-850-9185 + www.pedsplus.org