ACCOUNT NUMBER

ORANGE PEDIATRICS

251 Maitland Ave Ste 104 Altamonte Springs FL 32701

PATIENT INFORMATION

PATIENT'S NAME-LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH
PATIENT SOC. SEC. NO	CHILD LIVES WITH:		PERSON TO BILL:	
SIBLING'S NAME-LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH
SIBLING'S SOC. SEC. NO.	CHILD LIVES WITH:			

FAMILY INFORMATION

FATHER'S NAME-LAST	FIRST	MIDDLE	EMPLOYER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	DATE OF BIRTH	SOC. SEC. #	
MOTHER'S NAME-LAST	FIRST	MIDDLE	EMPLOYER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	DATE OF BIRTH	SOC. SEC. #	

How did you find us? **Email:**

INSURANCE INFORMATION

INSURANCE COMPANY NAME:		
SUBSCRIBER'S NAME	POLICY NUMBER	GROUP NUMBER

OTHER INFORMATION

NAME and PHONE NUMBER OF RELATIVE,FRIEND OR NEIGHBOR WHO CAN BE REACHED IN CASE OF EMERGENCY:

METHOD OF PAYMENT:	YOUR DRIVER'S LICENSE NO.	COPY OF DRIVER'S LICENSE & INSURANCE CARD IS REQUIRED.
NAME OF PERSON BRINGING IN CHILD:		RELATIONSHIP:

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. Parent or the legal guardian will be responsible for all services not covered by their insurance. Any services not paid by parent or the responsible party will be forwarded to collections and will include collection fee.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Devyani Belsare, M.D. to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for any amount not covered by my insurance.

Signature of parent / legal guardian **Date**

ORANGE PEDIATRICS
251 Maitland Ave Ste 104 Altamonte Springs FL 32701
Ph: 407-557-2165 Fax: 407-369-4612

Your Child's Health History

This is Protected Health Information and is kept in strict confidence as per HIPPA regulations.
Please check pertinent boxes and describe as needed.

Patient's Name _____Patient's Date of Birth: ____/____/____

Your Name _____ Your Relationship to Patient_____

Reason For Your Visit Today_____
Does your child have a fever today or had fever in the past few days? □ No □ Yes _____ degrees
Did your child receive any medications today? □ No □ Yes _____ at_____ AM/PM

CHILD'S BIRTH HISTORY

□ Name of Hospital of Birth_____
□ Birth weight _____ □ Full term □ Premature □ Pregnancy weeks_____
□ Vaginal delivery □ Cesarean section
□ Received hepatitis B vaccine birth? □ Yes □ No □ Passed hearing screen at birth? □ Yes □ No
□ Jaundice □ No □ Yes
□ Newborn intensive care □ Breathing difficulties □ Feeding difficulties □ Other_____
□ Specify any drugs or ANY form of alcohol that mom took during pregnancy_____
Pregnancy complications: □ Maternal Infection/s: □ No □ Yes, name_____
□ Gestational diabetes □ Pre-term labor □ Pre-eclampsia

CHILD"S MEDICAL HISTORY (Write NA if Not Applicable)

1. At what approximate age did your child
Roll over _____ Sit _____ Stand_____
Walk _____ Start Talking _____ Become toilet Trained_____

2. Has your child had more than 4 consecutive ear infections in the past 1 year ? □ No □ Yes
3. Does you child usually have more than 3- 5 sore throats each year □ No □ Yes
4. Does your child seem to have a continuous stuffy nose or constant cold ?. . □ No □ Yes

Cardiology □ Heart murmur □ Congenital heart defect □ Irregular heart beat □ Fainting □ Blue spells

Nervous system □ Migraines □ Headache □ Seizures □ Meningitis □ Cerebral Palsy □ Down Syndrome
□ Developmental delay □ Mental Retardation

Respiratory □ Asthma □ Pneumonia □ BPD □ Bronchiolitis □ Croup □ Bronchitis □ Sinusitis

Gastrointestinal □ Constipation □ Diarrhea □ GERD/Reflux □ Liver disease □ Weight loss
□ Feeding difficulties □ Jaundice □ Vomiting □ Bed wetting/soiling

Endocrine □ Diabetes □ Obesity □ Thyroid disease □ High cholesterol □ Short stature

Hematology □ Anemia □ Sickle Cell □ Bleeding disorder □ Blood transfusion □ Hemophilia □ Other

Dermatology □ Acne □ Eczema □ Diaper rash □ Warts □ □ Ringworm □ Lice □ Scabies □ Impetigo□ MRSA

Behavioral: □ Bed wetting □ ADHD □ Depression □ Sexual/physical abuse □ Defiant behavior
□ Developmental delay □ Drug abuse □ Eating disorder □ Learning disability □ School problems

PRIOR HOSPITALIZATIONS □ None □ Yes, please specify _____
PRIOR ACCIDENTS/INJURIES □ None □ Yes, please specify _____
PRIOR SURGERIES □ None □ Yes, please specify _____

CHILD's MEDICATION LIST if any_____

YOUR PREFERRED PHARMACY IS (name, address or phone)_____
YOUR PREFERRED LABORATORY IS : □ **QUEST** □ **LABCORP** □ **OTHER**_____

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Health History (continued--- Patient's Name_____

ALLERGY TO MEDICATIONS:
□ None
□ Yes, please describe_____
Allergy to Neomycin ? □ Yes □ No
Allergy to Latex ? □ Yes □ No

ALLERGIES TO FOOD / ENVIRONMENT
□ None
□ Yes, please specify_____

□ Allergy to **EGGS**? □ Yes □ No

IMMUNIZATIONS

□ Up to Date □ Delayed
□ Did your child have any problems after taking immunizations? □ No □ yes_____
□ Opted for no immunization (please specify why) _____
□ RELIGIOUS EXEMPTION □ No □ Yes
(includes strong moral or ethical conviction similar to a religious belief and requires a written statement from parent/guardian)
□MEDICAL EXEMPTION □ No □ Yes
(physical condition of child is such that the immunization would endanger life or health)

NUTRITION

□ Regular diet _____ □ Special diet_____ WIC ? □Yes □ No
□ Food history for infants (Birth to 12 months age): □ Breast Milk Name of formula _____

FAMILY HISTORY

Any illnesses affecting children	□ No	□ Yes, specify_____
SIDS/Sudden Infant deaths in family	□ No	□ Yes, specify_____
Heart attacks/disease at age less than 55 yrs ?	□ No	□ Yes, who_____
Deaths in family at age <55 yrs due to heart disease	□ No	□ Yes, who_____
High Cholesterol	□ No	□ Yes, who_____
Obesity	□ No	□ Yes, who_____
Asthma	□ No	□ Yes, who_____
Diabetes	□ No	□ Yes, who_____
Thyroid problems	□ No	□ Yes, who_____
Liver disease	□ No	□ Yes, who_____
Cancer/leukemia	□ No	□ Yes, who_____
Cystic fibrosis	□ No	□ Yes, who_____
AIDS/ HIV + test	□ No	□ Yes, who_____
Tuberculosis or anyone with positive TB skin test	□ No	□ Yes, who_____
Anemia	□ No	□ Yes, who_____
Hemophilia or other bleeding disorders	□ No	□ Yes, who_____
Migraines	□ No	□ Yes, who_____
Allergies/hay fever	□ No	□ Yes, who_____
Sinus problems	□ No	□ Yes, who_____
Inherited disorders	□ No	□ Yes, who_____
Lupus	□ No	□ Yes, who_____
Mental/psychiatric illness	□ No	□ Yes, who_____
Depression	□ No	□ Yes, who_____

Does your child go to school ? □ No □ Yes
□ Grade at school _____ □ Name of school/daycare _____

Do you have pets? □ Yes _____□ None

Anybody smokes in the family (indoor or outside)? □ None □ Yes, Who?_____

Disclaimer: I acknowledge that my child's information is up to date and correct to the best of my knowledge.
I shall update Orange Pediatrics about any changes to the above history at each future health visit.

Signature of Parent/ Guardian_____ **Today's Date:** _____

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AUTHORIZATION FOR MEDICAL TREATMENT

Child's Name: _____
Child's date of birth:_____

Your name:_____

Your relationship to child:
□ Biological Mom □ Biological Dad □ Foster Parent □ Legal Guardian □ Other (Please Specify)

1. I, _____hereby, give consent to examinations, treatments, and procedures, including emergency treatments which may be deemed necessary by Dr. Devyani Belsare and her Associates at Orange Pediatrics.

2. In the event of an **EMERGENCY**, I authorize the staff of Orange Pediatrics to contact the following persons for information and authorization of medical care.

1st	Name	Relationship	Phone
2nd	Name	Relationship	Phone
3rd	Name	Relationship	Phone

In the event of such an emergency, I can be reached at:
Home Phone #: _____Work/Other: Phone #: _____

3. In my **ABSENCE**, I authorize the following individuals to accompany my child to the office of Orange Pediatrics or any medical facility serviced by their staff, and to seek medical care and to authorize treatment.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Parent/Guardian signature_____ Today's Date: _____

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PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S CURRENT ADDRESS: _____

I am requesting a copy of the following sections of my child's medical file :

FROM: Name: _____
Address:_____
Phone:_____
Fax: _____

(X) PREFERABLY BY MAIL TO ORANGE PEDIATRICS
251 Maitland Ave Suite 104, Altamonte Springs, FL 32701

OR Fax: 407 369 4612

( ) Request for medical records from Orange Pediatrics to authorized entity, parent/ legal guardian
(may include Clinical Summary within 72 hrs of any office visit if requested by parent or legal guardian or any Continuity of Care Document)

Please forward:

(X) 1. We need COPY OF **LAST** WELL CHILD PHYSICAL ONLY
(X) 2. Problem list
(X) 3. Complete immunization record
(**X**) 4. Growth charts
(**X**) 5. Laboratory reports and Radiology reports
( ) 6. Psychiatric / Behavioral health reports / history, if any
( ) 7. NEWBORN Hospital records MOM's NAME: _____
( ) 8. Newborn screen record

Reason : ____Continuity of care ____ New Physician ____ Other

Disclaimer: This release of medical information may include diagnosis, treatment and/or examination related to mental health, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases. I understand that you will not use or disclose my child's health information, except as provided in our Notice of Privacy Practice, without my authorization. This authorization will remain in effect for one (1) year or until revoked in writing, except to the extent that action has been taken in reliance on this authorization. I hereby release Devyani Belsare MD and Orange Pediatrics, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the above information. I understand that Orange Pediatrics assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Orange Pediatrics from all legal liability that may arise from this authorization.

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Authorized Staff **Date**

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

We may use and disclose you medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family member, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Dept. of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attn: Privacy Officer". For more information about HIPAA or to file a complaint: The U.S. Dept of Health & Human Services, Office of Civil Rights, 200 Independence Ave., S.W., Washington, S.C. 20201, (202)619-0257 or Toll Free: 1-877-696-6775/

Name of patient: _____ Patient's Date of Birth _____

_____ _____
Signature of Parent/ legal guardian Date

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OFFICE PROCEDURES

To be signed by all guarantors

COLLECTION POLICY: I understand that any portion of fees determined to be my responsibility will be due before patient is seen by the doctor. If I have a new insurance policy with a preexisting clause in effect, I will pay the allowable charge at the time of service, as my claim will be delayed for several months. If the claim is paid to the physician, I will be reimbursed. Any amounts which are 90 days past due will be eligible to be turned over to a collection agency. Collection agency fees are at 33 1/3% and recognized to be my responsibility. There will be a $35.00 charge for any returned check.

RESPONSIBILITY FOR ACCOUNT: I agree that should the amount of insurance benefits be insufficient to cover the expenses, less any required managed care adjustments, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my insurance policy. I understand that if my account has been referred to collections for lack of payment, my child will automatically be dismissed.

PARTICIPATING REFERRALS: It is the patient's responsibility to know the laboratories, hospitals, radiology centers, and any other facilities or physicians, which are participants of their insurance. It is the patient's responsibility to obtain referrals from their primary care physician as required by his/her insurance plan. It is the patient's responsibility to pay any out of network charges that may be incurred.

CANCELLATIONS: I understand that failure to contact Orange Pediatrics (Dr. Belsare's office) within 24 hours of a scheduled appointment time to cancel will result in a $50.00 no show fee for a physical, and a $35.00 no show fee for any other type of appointment. Also be advised that our "courtesy calls" are just that, a courtesy- not a requirement.

PATIENT'S NAME: _____

GUARANTOR'S SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT:_____