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:			
FAMILY INFORMATION				
FATHER'S NAME – Last, First	Date of Birth	Social Security #	EMPLOYER	
Father's **PHONE #**	HOME ADDRESS	CITY	STATE	ZIP CODE
MOTHER'S NAME – Last, First	Date of Birth	Social Security #	EMPLOYER	
Mother's **PHONE #**	HOME ADDRESS	CITY	STATE	ZIP CODE
Your Email for Patient Portal:		**How did you find us?**		
INSURANCE INFORMATION				
INSURANCE NAME	SUBSCRIBER'S NAME	POLICY NUMBER	GROUP NUMBER	

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient/guarantor. 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. 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.

_____ _____

Parent or Guardian Signature Date

AUTHORIZATION FOR MEDICAL TREATMENT

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.

Name: _____ Relationship: _____ Phone: _____
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: _____

_____ _____

Parent or Guardian Signature Date

ORANGE PEDIATRICS
251 Maitland Ave Ste 104 Altamonte Springs FL 32701
Ph: 407-557-2165 Fax: 407-550-6409

Patient's Name: _____

PATIENT'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
□ Food history for infants (Birth to 12 months age): □ Breast Milk Name of formula _____

Pregnancy complications: □ Newborn intensive care □ Breathing difficulties □ Feeding difficulties
Jaundice □ No □ Yes □ Other_____ □ Gestational diabetes □ Pre-term labor
□ Pre-eclampsia Maternal Infection/s: □ No □ Yes, Is your child on WIC? □ Yes □ No
Specify any drugs or ANY form of alcohol that mom took during pregnancy_____

PATIENT'S HEALTH HISTORY

1. At what approximate age did your child
Roll over _____Sit _____ Stand_____ Walk _____ Start Talking _____ Become toilet Trained_____
2. Specific nutritional needs □ Regular diet □ Special diet_____
3. Prior hospitalizations/surgeries □ No □ Yes, _____
4. Previous accidents/injuries □ No □ Yes, _____
5. Does your child go to school/daycare? □ No □ Yes, _____

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

ALLERGY TO FOOD/ENVIROMENT:
□ None □ Yes, please specify _____
Allergy to **EGGS**? □ No □ Yes

IMMUNIZATIONS: Did your child have any problems after taking immunizations? □No □ Yes_____
□ Up to Date □ Delayed □ 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)

FAMILY HISTORY

Anybody smokes in family?	□ No □ Yes, who_____
SIDS/Sudden Infant deaths in family	□ No □ Yes, specify_____
Heart attacks/disease at age less than 55 yrs?	□ 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	□ 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_____
Allergies/hay fever/sinus problems	□ No □ Yes, who_____
Inherited disorders	□ No □ Yes, who_____
Mental/psychiatric illness	□ No □ Yes, who_____

CHILD'S MEDICAL HISTORY

Cardiology:	□ Heart murmur □ Congenital heart defect □ irregular heart beat
Nervous system:	□ Migraines □ Headache □ Seizures □ Meningitis □ Cerebral Palsy □ Down Syndrome □ Developmental delay □ Mental Retardation
Respiratory:	□ Asthma □ Pneumonia □ Bronchiolitis □ Croup □ Bronchitis □ Sinusitis
Gastrointestinal:	□ Constipation □ Diarrhea □ GERD/Reflux □ Bed wetting/soiling
Endocrine :	□ Diabetes □ Obesity □ Thyroid disease □ High cholesterol □ Short stature
Hematology:	□ Anemia □ Sickle Cell □ Bleeding disorder □ Blood transfusion □ Hemophilia
Behavioral:	□ ADD/ADHD □ Depression □ Sexual/physical abuse □ Defiant behavior □ Developmental delay □ Eating disorder □ Learning disability □ School problems
Dermatology:	□ Acne □ Eczema □ Diaper rash □ Warts □ Ringworm □ Lice □ Scabies □ Impetigo□ MRSA

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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: 407 550 6409

( ) 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

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.

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.

Please sign acknowledging that you have been provided information on HIPAA by Orange Pediatrics.

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

_____ _____
Signature of Parent/ legal guardian Date

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.

Name of Patient: _____ Your Relationship to Patient: _____

_____ _____
Signature of Guarantor Date