

ORANGE PEDIATRICS
761 Ciara Creek Cv, Longwood, FL 32750

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

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

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: _____

Please send the medical records as specified below:

BY MAIL or FAX to ORANGE PEDIATRICS

761 Ciara Creek Cv, Longwood FL 32750

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:

- 1. We need COPY OF **LAST** WELL CHILD PHYSICAL ONLY
- 2. Problem list
- 3. Complete immunization record
- 4. Growth charts
- 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

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 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