| NEW PATIENT INFORMATION | | | |
|---|---|---|---|
| **Full Name:** | **Date of Birth** | ☐ **Male**<br>☐ **Female** | **Social Security #** |
| **Address** | | **State** | **Zip Code** |
| **Phone Number** | | **E-mail Address** | |
| **EMPLOYMENT INFORMATION** | | | |
| **Patient's Employer:** | | **Phone Number:** | |
| **Spouse's Employer:** | | **Phone Number:** | |
| **IN CASE OF EMERGENCY** | | | |
| **Name:** | **Phone Number:** | **Relation:** | |
| **Name:** | **Phone Number:** | **Relation:** | |
| **INSURANCE INFORMATION** | | | |
| **Insurance Company Name:** | | **ID Number:** | |
| **Secondary Insurance (if applicable):** | | **ID Number:** | |

**Preferred Pharmacy:** (circle

CVS Walgreens Publix Target Wal-Mart Other:

Phone Number: _____ Address:_____

# Health Questionnaire

Patient Name: _____ Date of Birth: _____

**Chief Complaint/ Why you are here today:**

_____

**Please indicate each of your chronic medical problems by checking the appropriate area below:**

___ High Blood Pressure ___ Asthma ___ Cancer ___ Heart Disease ___ Emphysema/Lung Disease ___ High Cholesterol ___ Diabetes ___ Kidney Problems ___ Thyroid ___ Smoke ___ Anemia ___ Glaucoma ___ Mental Health ___ Substance Abuse

**Please list all medications that you are currently taking along with strength and how often. Please include Non-prescription medications as well:**

Medication Strength How often

_____
_____
_____
_____
_____
_____
_____
_____

**Are you allergic to any medications? ___No ___Yes, if yes please list them**:

_____

**Social History:**

Tobacco _____ a day Number of years _____ Year Quit _____Alcohol _____ drinks per week Caffeine _____ per day Street drugs: __ No__ Yes, if yes explain: _____Exercise: __ No __Yes ; Times a week _____

**Family History:**

__ Heart Disease __ Diabetes __ Stroke __ High Blood Pressure__ Asthma __ Kidney Problems __ Anemia __ Cancer __ Thyroid __ Glaucoma __ Mental Health __ High Cholesterol __ Emphysema/ Lung Disease __ Substance Abuse

**Please list any prior surgeries/ hospitalizations (including the year):**

_____

_____

_____

_____

**Are you currently receiving care from another professional for an ongoing medical condition?**
__ No __ Yes, if so whom and what medical condition is it?

_____

_____

_____

**Women only:**

Date of last menstrual period___/___/___
Flushing/Menopausal symptoms? Yes or No
Number of: ___ Pregnancies __ Live births ___Miscarriages ___ Abortions Date of last Pap:___/___/___ Mammogram: ___/___/___ Osteoporosis Scan: ___/___/___

**Men only:**

Date of last prostate exam ___/___/___ Last PSA (Prostate Blood Test) ___/___/___

**Please place a checkmark next to any symptoms that you are currently having and indicate the year *if* the symptoms occurred in the past:**

- ☐ **General**: __ Fever __ Night Sweats __Unexplained Weight loss or Gain __ Fatigue
- ☐ **Skin**: __ Rashes __Cancers __ Change in Hair, Skin, or nails
- ☐ **Eyes**: __ Glasses __ Contact Lenses __Pain __ Change in Vision __ Discharge
- ☐ **Ear/Nose**: __Ear Pain __Change in Hearing __Persistent Runny Nose
- ☐ **Throat**: __ Sore Throat __ Change in Voice __ Sinus Trouble
- ☐ **Heart**: __Chest Pain __Swelling of the ankles __ Palpitations __Heart Murmur
- ☐ **Lungs**: __Cough __Shortness of Breath __Wheezing
- ☐ **Gastro**: __ Nausea __Blood in Stool __ Change in Bowel Movements __Ulcers __Heartburn
- ☐ **Women**: __ Vaginal Discharge __Change in Menstrual Cycle or Sexual Function
- ☐ **Men**: __Testicular Pain __ Decreased Urinary Stream __Pineal Discharge __ Change in Sexual Function
- ☐ **Orthopedic**: __ Painful Joints __Muscle Weakness
- ☐ **Neuro/Psych**: __ Seizures __Tremor __Paralysis __Frequent Headaches
- ☐ **Allergy**: __ Hives __Hay Fever
- ☐ **Circulation**: __Leg swelling __Blood Clots

# HIPPA Privacy Act Patient Consent Form/ Family Members

The Health Insurance Portable and Protection Act, H.I.P.A.A requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. Our office requests that each patient sign this consent form which allows us to share protected health information with other physicians' offices, your hospital, and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except when we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient: _____ Date of Birth:_____

Patient Signature:_____ Date:_____

**AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS**

Name:_____ Relation: _____

Signature Patient/Guardian: _____ Date:_____

# Kidz and Family Care
# Stephen Nimbargi, M.D.

## MEDICAL RECORDS RELEASE AUTHORIZATION

**Patient Name**: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip: _____

Cell/Home Phone: _____

**PLEASE CHECK ONE:**

**( ) Obtaining Records from** **( ) Sending Records to**

**Physician/Facility Name:** _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Information to be sent or received **(Check all that apply)**

**( ) Standard Record Release** (All records within the last 2 years including all immunization records.)
**( ) All Immunizations records**
**( ) X-Ray Reports** (within the last 2 years)
**( ) Laboratory Reports** (within the last 2 years)
**( ) Other Specify:** _____

**Initial: _____**I understand that this authorization will expire on _____. If a date is not specified, this authorization will expire in 12 months

**Initial: _____**I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the potential for the disclosed information to be re-disclosed by the recipient and no longer protected.

**Initial: _____**I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.

**Initial: _____**I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

Signature of Patient or Patient's Representative: _____ Date: _____

Relationship to Patient: _____

( ) 1091 Port Malabar Blvd NE Suite 3 Palm Bay, Florida 32905 Phone: 321-724-1200 Fax: 321-951-0675

( ) 517 Buena Vista Street Lakeland, Florida 33805 Phone: 863-688-3674 Fax: 863-616-9902
( ) 321 Maitland Ave Suite 1000 Altamonte Springs, Florida 32701 Phone: 407-331-6236 Fax: 407-331-6953
( ) 1081 Town Center Drive Suite 200 Orange City, Florida 32763 Phone: 386-218-6860 Fax: 386-218-6861

# APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Kidz and Family Care. When you schedule an appointment with Kidz and Family Care we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective ***January 1, 2021*** any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least ***24 hours notice*** will be considered a No Show and charged a ***$25.00 fee.***
  - 
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a ***SECOND*** time will be charged a ***$50.00 fee***.
  - 
- If a ***THIRD*** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be ***dismissed*** from Kidz and Family Care.
  - 
- Any new patient who fails to show for their initial visit will not be rescheduled.
  - 
- The fee is charged to the patient, not the insurance company, and is ***due at the time of the patient's next office visit***.
  - 
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Kidz and Family Care 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left at any location are acceptable.

- **Kidz and Family Care Orange City (386) 218-6860**
- **Kidz and Family Care Lakeland (863) 688-3674**
- **Kidz and Family Care Altamonte (407) 331-6236**
- **Kidz and Family Care Palm Bay (321) 724-1200**

**I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.**

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

# Email/Texting Informed Consent Form

## 1. Risk of using email/texting:

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company Systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or Detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

## 2. Conditions for the use of email and texts:

Therapists cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Kidz and Family Care is not liable for improper disclosure of confidential information that is not caused by Kidz and Family Care's intentional misconduct. Patient's/parents/Legal Guardians must acknowledge and consent to the following conditions:

- Email and texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- All email will usually be printed and filed into the patient's medical record. Texts may be printed and filed as well.
- Providers will not forward patient's/parent's/legal guardian's identifiable emails and/or texts without the patient's/parent's/legal guardian's written consent, except as authorized by law.
- Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
- Kidz and Family Care is not liable for breaches of confidentiality caused by the patient or any third party.
- It is the patient's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

## 3. Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between Kidz and Family Care and me, and consent to the conditions and instructions outlined, as well as any other instructions that Kidz and Family Care may impose to communicate with me by email or text.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____