

Kidz & Family Care
321 Maitland Avenue, Ste 1000
 Phone: 407-331-6236 Fax: 386-218-6861



NEW PATIENT INFORMATION			
Patient Last name, First name:		Date of Birth	Male Female
			Social Security #
Address		State	Zip Code
Phone Number		E-mail Address	
PARENT/GUARDIAN INFORMATION			
Mother's Name:		Date of Birth	Social Security #
Phone Number		Work Number	Place of Employment/ Occupation
Father's Name:		Date of Birth	Social Security #
Phone Number		Work Number	Place of Employment/ Occupation
INSURANCE INFORMATION			
Insurance Name			
Policy Holder Name (If Medicaid, write self)		Policy Holder Relationship to Patient (please circle)	
		Parent/ Self/ Other: _____	
ID#/ Policy #		Group #	
Who, if anyone other than the parent or legal guardian, has permission to access your child's medical records (PHI), make medical decisions for his/ her treatment, obtain lab results, and can bring your child/ren to Kidz & Family Care without your presence?		N/A	Yes, to the following individuals:
Name:		Relationship:	
Name:		Relationship:	
Name:		Relationship:	

I certify that above information is correct to the best of my knowledge. I release to Kidz & Family Care and its employees and clinicians from all liabilities for any adverse results caused by my authority to treat, release, and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian's Signature: _____

Date: _____

Authorization to Release Records
Kidz & Family Care
Phone: 386-218-6860 Fax: 386-218-6861

Parent/ Legal Guardian Name: _____

Parent/Legal Guardian Address: _____

Parent/ Legal Guardian Phone number: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

The Parent/Legal Guardian authorizes and requests Kidz and Family Care to obtain from:

(Name of previous doctor or facility)

For the purpose of releasing this information:

Changing Insurance Moving Dissatisfaction with Physicians/Staff

Changing Physicians Other Over 21

My signature below indicates that I understand what information will be released. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV/AIDS. In addition, information related to drug and alcohol abuse in my child's records are protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2.

I understand that I may revoke this consent in writing at any time, but that it will remain valid to the extent that this action has already occurred based on authorization. This consent will expire 90 days from date of signature.

Parent/Legal Guardian Signature

Relationship

Date

PATIENT HISTORY

Family Medical History (Please mark 'X' in the box to all that apply)

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Thyroid Disease								
Heart Disease								
High Blood Pressure								
Cancer (any type)								
Epilepsy								
Diabetes								
Depression								

Language Spoken:

- English
- Spanish
- Portuguese
- French
- Creole
- Urdu
- Chinese
- Other(s) _____

Ethnicity:

- Asian
- American/Indian/Alaskan Native
- African American
- White
- Hawaiian Native
- Pacific Islander
- Prefer not to sa

Allergies: (list type of reaction)

Medication:

Food:

Other(s):

Birth History

Where was the patient born? (Hospital and city?) _____

Birth Wt: _____ Birth Ht: _____ Gestational Age (How many weeks?): _____

- Cesarean Section
- NVSD (Vaginal delivery)
- Problem/ complication (list): _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child (as a patient of this practice) or you (as a patient of this practice) may be used and disclosed and how you have the access to this information. Please review this notice carefully. Our practice does not tolerate discrimination by its employees when they are serving individuals who are eligible for its programs based on any non-merit factor, including race, national origin, color, religion, sex, sexual orientation, gender identity, disability (physical or mental), age, status as a parent, or genetic information.

Our Commitment to Privacy

Kidz and Family Care is dedicated to maintaining the privacy of its patients' protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend our notice. By federal and state law we must follow the term of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI

Our practice may use and disclose PHI for the purpose of treatment, payment, and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes.

- Treatment
- Payment
- Health care Operations
- Release or Sharing of Information
- The Rights of Minors and Personal Representatives
- Release of Information to Business Associates
- Release of Information Required by Law
- Research Purposes
- Marketing Purposes

Your Health Information Rights

You have the following rights regarding the PHI that we maintain about your child or you.

- Requesting Restrictions on PHI
- Inspection and Copies of PHI
- Amendment of PHI
- Accounting of Disclosure
- Right to a Paper Copy of This Notice
- Right to File a Complaint
- Right to Provide an Authorization of Other Uses and Disclosures

I have read this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient (Print)

Date

Signature of Patient or Patient Representative
(Representative's signature is required if patient is a minor)

Relationship to Patient

PATIENT'S PAST MEDICAL HISTORY

Has your child ever had any of the following: (check as many as apply)

- ADD/ADHD
- Allergic Rhinitis (Allergies)
- Anemia, Hemophilia
- Asthma
- Atopic Dermatitis (Eczema)
- Autism
- Frequent Ear Infections
- Hay Fever/ Allergy
- Heart Murmur
- High Blood Pressure
- High Cholesterol/Obesity
- Bronchitis
- Cancer
- Cerebral Palsy
- Developmental Delay
- Diabetes
- Pneumonia
- Sinusitis
- Epilepsy/Seizures
- Varicella(Chickenpox) Date: _____
- Other(s): _____

Past Surgical History:

- Tonsils Removed
- Adenoids Removed
- Inguinal Hernia Repair
- Ear Tube Repair
- Heart Surgery _____
- Broken Bone (surgical repair) _____
- Other(s): _____

Hospitalizations:

- Yes
- No

Reason (if any): _____ Date(s): _____

Medications:

Daily Medications or Vitamins (include dosage): _____

Medications taken today: _____

Social History:

- Daycare
- School (Grade: _____)
- Pets: Dog(s): _____ Cat(s): _____ Other(s): _____
- Smoker(s) in home (includes inside and outside): _____

Patient's Habits (if >13 yrs old):

- Non-Smoker
 - Smoker: Tobacco
 - Other:
-

Preferred pharmacy:

- CVS
- Walgreens
- Publix
- Target
- Wal-Mart
- Other:

Phone Number: _____

Address: _____

FINANCIAL AND INSURANCE POLICIES

PLEASE INITIAL BELOW INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

____ I hereby authorize direct payment of medical benefits to Kidz and Family Care for services rendered by the physicians or the organization; I understand that I am responsible for any balances not covered by insurance.

____ Claims not paid within a timely manner (60 days) by my insurance company, fully become my responsibility.

____ Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment. All other payment arrangements must be made with our billing department 24 hours prior to the appointment time.

____ A returned check penalty fee of 25\$ will be charged to a patient's account for any check dishonored by the drawee bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid in cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the 25\$ returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately.

____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible these requests should be made 2 days prior to the appointment date with the specialist. It is up to the discretion of a Kidz and Family Care provider whether or not to issue a referral request after the appointment or procedure date.

____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to your insurance carrier.

____ I hereby authorize Kidz and Family Care to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

____ I certify that the information given by me in the applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about myself to release to the Social Security Administration or the Intermediaries of Carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

Date

Signature of Parent/Legal Guardian

Print Name of Parent/Legal Guardian

Print Name of Patient

NO CALL NO SHOW STATEMENT

We ask that you show consideration by notifying our office at least **24 hours in advance** if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor.

By signing below, I _____, am acknowledging that I have been advised that there is a **\$25.00 NO CALL NO SHOW FEE** for appointments that are not canceled within a 24 hours' notice. For specific procedures the **NO CALL NO SHOW FEE** is **\$50.00**. We will make every effort to call and remind you of your appointments, so please be considerate and call us if you are unable to make it.

It is your appointment therefore it is YOUR responsibility!

Thank you in advance.

Patient Signature

Kidz & Family Care

HIPPA Notice of Privacy and Confidentiality Patient's Rights

Patient's rights under HIPPA are described in the "Notice of Privacy Practices". These rights include:

- 1. Right to receive the "Notice of Privacy Practices"**- This informs patients of their rights and how to exercise them. By law, this notice is to be made available to patients and a good faith effort to obtain the patient's acknowledgement of receipts is required.
- 2. Right of Access-** Patient's may request to inspect their normal medical record and may request copies. There may be a fee to produce the copies. The process to follow and how to request copies is explained in the "Notice of Privacy Practices".
- 3. Right to Request an Amendment or Addendum-** The Notice describes how to file a request for an amendment or addendum.
- 4. Right to Accounting of Disclosures-** Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.
- 5. Right to Request Restrictions-** Patients have the right to request restrictions on how they will be communicating with or how their PHI is released. Generally, every effort to try to accommodate reasonable request for restrictions where of information could be harmful to the patient.
- 6. Right to Complain-** Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

Exceptions to the rules

Under HIPPA, there are certain expectations to these general rules. These expectations are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.