NEW PATIENTS

Patient Name:_____

In order for us to be able to best serve your child and obtain all medical history possible, we require that **Custodial and/or Biological** parents or **Legal Guardian** attend your child's first appointment with us.

The forms attached will allow you to be able to let us know whom you would like to be able to bring your child to any future appointments.

We apologize for any inconvenience this may cause and greatly appreciate your cooperation.

Sincerely,
Davenport Pediatrics

****

We are very glad you have chosen Davenport Pediatrics for your child(s) new medical home. Kindly take a moment and let us know how you heard about us.

_____ Drive-by

_____ Friend: Whom can we thank for referring you?_____

Hospital: Heart of Florida _____ Nemours_____ Celebration___

Other:_____

_____ Advertisement: Please Specify_____

_____ Other Medical Practice: Whom can we thank for referring you?_____

Internet: Google Search _____ Yelp Search _____

Other:_____

_____ Insurance Directory

☼ *Welcome* ☼

DAVENPORT PEDIATRICS

PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ NICKNAME: _____
Last Name First Name MI

ETHNICITY/ RACE: _____ PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other_____

SOCIAL SECURITY #: _____-_____-_____ SCHOOL: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

HOME ADDRESS: _____ DATE OF BIRTH: ____/____/_____ AGE: ____
MM DD YYYY

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____ SEX: M / F

MAILING ADDRESS IF DIFFERENT: _____

HOW DO YOU PREFER TO RECEIVE YOUR APPOINTMENT REMINDERS?: ☐ **HOME PHONE** ☐ **CELL PHONE - CALL** ☐ **CELL PHONE - TEXT** ☐ **EMAIL**
FOR TELEPHONE REMINDERS TO HOME OR CELL #'S, A MESSAGE WILL BE LEFT IF THERE IS NO ANSWER

PARENT OR GUARDIAN INFORMATION

NAME OF RESPONSIBLE PARTY/
PARENT OR GUARDIAN ACCOMPANYING CHILD: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____-_____-_____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____ SEX: M F MM DD YYYY
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____
PATIENT LIVES WITH: _____ RELATIONSHIP TO PATIENT: _____	

NAME OF OTHER PARENT/ GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____-_____-_____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____ SEX: M F MM DD YYYY
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PERSONS LISTED ABOVE)

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ OTHER: _____

PREFERRED PHARMACY NAME/ LOCATION: _____ PHONE: (_____) _____-_____

CONSENT FOR TREATMENT

I certify that the information I have provided above is current and correct. I hereby authorize DAVENPORT PEDIATRICS, P.A., its physicians and support staff to provide medical care to the patient named above. I voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any examination or treatment received from DAVENPORT PEDIATRICS, P.A. This consent is valid for the entire duration of my association with DAVENPORT PEDIATRICS, P.A. and may be relied upon by DAVENPORT PEDIATRICS, P.A. unless and until such consent is revoked in writing. I authorize DAVENPORT PEDIATRIC to receive pharmaceutical information via the nationwide prescription database. Yes_____ No_____

PRINTED NAME OF PARENT/ GUARDIAN: _____

SIGNATURE OF PARENT/ GUARDIAN: _____ **DATE:** _____
MM / DD / YYYY

DAVENPORT PEDIATRICS

CREDIT AND FINANCIAL POLICY

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE NUMBER: (_____) _____-_____

ADDRESS OF INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ RELATIONSHIP TO PATIENT:_____

POLICY ID #: _____ GROUP #: _____

POLICYHOLDER SOCIAL SECURITY #: _____ POLICYHOLDER DATE OF BIRTH: ____/____/_____
MM DD YYYY

SECONDARY INSURANCE: _____ PHONE NUMBER: (_____) _____-_____

ADDRESS OF INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ RELATIONSHIP TO PATIENT:_____

POLICY ID #: _____ GROUP #: _____

POLICYHOLDER SOCIAL SECURITY #: _____ POLICYHOLDER DATE OF BIRTH: ____/____/_____
MM DD YYYY

CREDIT AND FINANCIAL POLICY

Davenport Pediatrics, P.A. wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or to a member of your household/family.

Insurance

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

You shall also be responsible for any claim denied by the insurance company. The insurance company may deny a claim for any of the following reasons:

(1) Davenport Pediatrics is an out-of-network provider or Davenport Pediatrics does not participate with your insurance company.
(2) The claim is rejected because there was no insurance coverage at the time of service.
(3) Davenport Pediatrics was not the assigned primary care physician for the patient or for your insurance company.
(4) The procedure/ lab work done is not a covered service or benefit by your insurance company.
(5) Your insurance company is still waiting for additional information that they have requested from the parent/ guardian of the patient.
(6) Your insurance company has already made the payment and the remaining balance is your responsibility.
(7) Only hospital charges are covered by your insurance company.

There may be other reasons that the insurance company may reject a claim filed on your behalf. If there are any questions regarding their decision(s), you must contact your insurance company immediately.

Cash Account

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service.

At this time, even if you are able to subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will **not** be able to bill the charges to your insurance company for you.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a $25 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 10 minutes or more late. Multiple missed or no-showed appointments can result in the patient being discharged from the practice.

Returned Checks

You would also be responsible for the $35 returned check fee that the bank would charge in the event that the personal check issued by you is returned to us for any reason. You must also consult with your financial institution for any other fees they might charge you.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I hereby authorize DAVENPORT PEDIATRICS, P.A. to collect on my behalf any insurance/ medical benefits payable to me for the service(s) they have provided and assign to them the payment thereof. I authorize and assign the payment of any insurance/ medical benefits applicable to the service(s) cited on the claim form to DAVENPORT PEDIATRICS, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is considered as valid and effective as the original.

I understand that this assignment does not relieve me of any responsibility I may have for any payment of charges that are not covered by the insurance company. I understand that I may be held responsible for any or all unpaid charges on this account.

I have read and understand the financial policy of DAVENPORT PEDIATRICS, P.A. and I agree to be bound by its terms I also understand and agree that such terms may be amended by DAVENPORT PEDIATRICS, P.A. at any time.

PRINTED NAME OF PARENT/ GUARDIAN: _____

SIGNATURE OF PARENT/ GUARDIAN: _____ **DATE:** _____

DAVENPORT PEDIATRICS

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PROTECTED HEALTH INFORMATION

Information about your child's health is called "protected health information." It includes any information that DAVENPORT PEDIATRICS, PA receives or creates that identifies (or could identify) your child and deals with your child's physical and/ or mental health, and any medical care we provide your child and/or payment for such medical care.

DAVENPORT PEDIATRICS, P.A. understands the importance of privacy and is committed to maintaining the confidentiality of your child's medical information. We make a record of the medical care provided to your child and may receive other medical records from others. We use these records to provide and enable us and other healthcare providers to provide quality medical care, to obtain payment for medical services provided to your child and to enable us to meet our professional and legal obligations to properly operate our medical practice. We have a "Notice of Privacy Practice" (the "Notice"). The Notice describes in great detail how we might use or disclose protected health information. The notice also discusses your rights and our duties with respect to protected health information. You have the right to review the Notice before signing this consent. This notice is available on our website @ www.davenportpediatrics.com or you may request a copy from our front office staff.

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am consenting to DAVENPORT PEDIATRICS, P.A.'s use and disclosure of my child's health information in order to carry out treatment, payment or health care operation.

I understand that I have the right to revoke this authorization at any time by notifying DAVENPORT PEDIATRICS, P.A. in writing. However, if I do revoke this authorization, my revocation would not have any effect on action(s) previously taken in reliance on my prior consent.

I understand that I have the right to request that DAVENPORT PEDIATRICS, P.A. restrict how my child's protected health information is used or disclosed for purpose of treatment, payment or health care operations. However, I also understand that DAVENPORT PEDIATRICS, P.A. is not required to agree to any restriction I requested.

I understand that DAVENPORT PEDIATRICS, P.A. has the right to amend their privacy practices at any time in the future. I understand that after an amendment is made by DAVENPORT PEDIATRICS, P.A., the revised privacy practices will apply to all protected health information maintained, regardless of when it was created or received.

I acknowledge that I have been presented with a copy of DAVENPORT PEDIATRICS, P.A.'s Notice of Privacy Practices and have been provided an opportunity to review it. I am aware that I may request a copy of the Notice of Privacy Practices to keep in my possession.

RESPONSIBLE PARTY/ PARENT OR GUARDIAN: _____
PRINTED NAME

RESPONSIBLE PARTY/ PARENT OR GUARDIAN: _____ **DATE:** _____
SIGNATURE **MM/DD/YYYY**

Name(s) of patient(s) in practice:

NAME OF CHILD:_____ DATE OF BIRTH: _____/_____/_____
MM DD YYYY

NAME OF CHILD:_____ DATE OF BIRTH: _____/_____/_____
MM DD YYYY

NAME OF CHILD:_____ DATE OF BIRTH: _____/_____/_____
MM DD YYYY

NAME OF CHILD:_____ DATE OF BIRTH: _____/_____/_____
MM DD YYYY

DAVENPORT PEDIATRICS

INITIAL PEDIATRIC HISTORY FORM

Last Name	First Name	MI	Date of Birth (Month, Date, Year)

Mother/ Guardian	**How many brothers/ sisters?**
Father/ Guardian	**Who does the patient live with?**
Primary Care Physician/ Pediatrician	**Other doctors involved with patient's care?**

A. BIRTH HISTORY

Birthplace: _____ Birth weight: _____ Birth Length: _____

Was the pregnancy normal? □ No □ Yes □ Other _____ Was the delivery normal? □ No □ Yes □ Other _____

Was the baby full term? □ No □ Yes □ Other _____ Any nursing problems? □ No □ Yes □ Other _____

B. GROWTH AND DEVELOPMENT

At what age did the child:

first sat-up □ Precocious □ Average □ Other_____ first crawled □ Precocious □ Average □ Other_____

first rolled □ Precocious □ Average □ Other_____ first walked □ Precocious □ Average □ Other_____

first talked □ Precocious □ Average □ Other_____ toilet trained □ Precocious □ Average □ Other_____

School History: Current School Grade: _____ School Name: _____

Academic Performance: □ Not in School □ Remedial/ Special Ed □ Below Average □ Average □ Above Average

School Problems: _____ Attends special school or classes: _____

Discipline or behavior problems: _____

Ever seen by a psychologist, speech therapist, or special teachers: _____

C. PAST MEDICAL HISTORY

Any problems with: Sleeping: □ No □ Yes □ Other _____ Bedwetting: □ No □ Yes □ Other _____

Weight/Height: □ No □ Yes □ Other _____ Nail Biting: □ No □ Yes □ Other _____

Nightmares: □ No □ Yes □ Other _____

Diet: Nursed: □ No □ Yes □ Other _____ Bottled fed: □ No □ Yes □ Other _____

Colic problems: □ No □ Yes □ Other _____ Special diets □ No □ Yes □ Other _____

Contagious Diseases: (At what age) Chicken Pox: _____ Scarlet Fever: _____ Any Other: _____

Was your child ever diagnosed with any of the following? (At what age)

Seizures: □ No □ Yes □ Age _____ Asthma: □ No □ Yes □ Age _____

Bronchitis: □ No □ Yes □ Age _____ Pneumonia: □ No □ Yes □ Age _____

Ear Infections: □ No □ Yes □ Age _____ Any Other: _____

Please explain any YES answer in detailed description in the box provided.

Has the patient ever had any surgery or been hospitalized?	**□ No □ Yes**	**Surgeries/ Serious Injuries (Where, Why)**	**Dates**	**Hospitalizations other than surgery (Where, Why)**	**Dates**
Has the patient had any problems with anesthesia?					
Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	**□ No □ Yes**	**Medication**	**Dosage**	**Medication**	**Dosage**
Does the patient have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	**□ No □ Yes**				

FAMILY HISTORY: Please indicate if parents, brothers, and/ or sisters have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient
Cancer □ No □ Yes □ Other_____		Kidney Problems □ No □ Yes □ Other_____	
Diabetes □ No □ Yes □ Other_____		Allergies □ No □ Yes □ Other_____	
Heart Disease □ No □ Yes □ Other_____		TB □ No □ Yes □ Other_____	
Convulsions □ No □ Yes □ Other_____		Other_____	

GENERAL INFORMATION: Has your child had any unusual problems with the following?

Head: □ No □ Yes □ Other _____ Stomach: □ No □ Yes □ Other _____

Eyes: □ No □ Yes □ Other _____ Kidneys: □ No □ Yes □ Other _____

Ears/ Nose/ Throat: □ No □ Yes □ Other _____ Bladder: □ No □ Yes □ Other _____

Chest/ Heart/ Lungs: □ No □ Yes □ Other _____ Skin: □ No □ Yes □ Other _____

Bones/ Muscles/ Joints: □ No □ Yes □ Other _____ Blood: □ No □ Yes □ Other _____

D. IMMUNIZATIONS: Did you bring a record of immunizations of your child? □ No □ Yes □ Other _____

E. Any special comments about your child? _____

_____ _____ _____

Person Completing This Form/ Relationship to Patient **Reviewed by Provider** **Date**

DAVENPORT PEDIATRICS

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

MEDICAL TREATMENT AUTHORIZATION AND CONSENT

This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult(s) to arrange for routine or emergency medical care for the child when either the parents or legal guardians are unable to accompany the child and approve or consent to the child's medical care.

This is extremely important because medical care cannot be provided to the child without the approval or consent by either the child's parents or legal guardians, unless there is written consent authorizing another adult to approve or consent to the child's medical care.

DATE: _____
MM / DD / YYYY

I, _____, parent or legal guardian of _____,
(Name of Parent or Legal Guardian) (Name of Child)

hereby give authorization to the following person(s) to accompany my child and to approve or consent to any medical care or treatment to be provided by DAVENPORT PEDIATRICS, P.A., its physicians and support staff to my child.

	Name	Relationship to Child
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

_____
(Signature of Parent/ Guardian)

Persons on the above list must have proper identification (ID) to have the patient treated.

103 Park Place Blvd
Davenport, FL 33837
Phone: 863-421-1855
Fax: 863-421-2624

Maria Cristina Khan, MD, FAAP
Edwin Michael C. Sia, MD, FAAP

Authorization for Release of Protected Health Information

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient(s) Name:_____ Date of Birth:_____

To:	**Davenport Pediatrics PA**	**From:** Organization to release the information:
	103 Park Place Blvd	_____
	Davenport FL 33837	_____
	Fax: 863-421-2624	_____

Specific description of Information {including date(s)}:

(Check one)

_____ All Records (including Mental Health/Sexual Abuse/HIV)
_____ All Records (excluding Mental Health/Sexual Abuse/HIV)
_____ Records Within the Following Date Range: from _____ to _____
_____ Immunization record only
_____ Last Well Child Visit/Physical/Growth Chart/Immunization Chart
_____ Sexual Abuse Only
_____ HIV only
_____ Mental Health Records (Including ADHD) Only
_____ Other: Please specify_____

Section B: Must be completed for all authorizations

The patient or patient's representative must read the following statements:

1. I understand that this authorization will expire on _____ (or one year from date of signature).
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing; but, if I do, it would not have any effect on any actions they took before they received the revocation.
3. If a health care provider is receiving these records, the information will be used for continuity of care purposes only.
4. I understand that I may have a copy of this form at any time when requested.
5. I understand that my health care and payment for my health care will not be affected by signing this form.

X_____ _____ _____
Signature of patient or patient's representative Phone Number Date
(Form MUST be completed before signing)

Printed name of patient's representative:_____
Relationship to patient:_____

OFFICE POLICY

RE: PATIENTS WHO ARE CHILDREN OF DIVORCED OR SEPARATED PARENTS

Patient(s) Name:_____ Date of Birth:_____

Dear Parent/s or Guardian/s:

At Davenport Pediatrics, our primary concern is to provide the best pediatric care for your child. We are willing to work with either or both parents to ensure that your child's healthcare needs are met. However, kindly remember that our office is not a party to your divorce agreement. We cannot and will not be responsible for administering any of its terms.

Billing/ Payment

When your child visits our office, we hold the accompanying parent or guardian responsible for any co-pay, deposit or outstanding balance at the time of the visit.

As stated in our Credit and Financial policy, the parent or guardian who completes and signs our policy form will be considered the guarantor for medical charges that are not covered by your insurance. We cannot enforce any financial arrangement between the parents nor will we mediate any financial disputes. Any disputes about reimbursement for medical expenses need to be settled between the parents privately.

If there is a divorce decree requiring the other parent to pay a portion or all of the medical expenses incurred, it is the accompanying parent's responsibility to collect from the other parent. We will not make special provisions or act as an agent in collecting payment. A copy of the medical bill may be given to the accompanying parent upon request.

Consent to Medical Treatment

When a minor child visits our office accompanied by either parent, we will assume that parent has full legal custody and authority to make medical decisions for the child.

Physical custody is different from legal custody. Under Florida law, even if one parent has sole physical custody, either parent may still consent to the medical treatment of the child.

Parent/ Guradian Signature _____ Date _____

Print Name _____

A court order granting one parent sole legal custody would give that parent the exclusive right to consent to medical treatment. Unless we receive this order from the court in writing, we will assume that both parents have joint legal custody and both may consent to the medical treatment of the child.

Please be aware that we cannot take responsibility for calling the non-accompanying parent/s for consent prior to medical treatment every time your child visits our office. We will discuss the child's history, treatment and/ or present medical examination with the accompanying parent or guardian. It is the responsibility of the parents or guardian to communicate with each other about your child's care, scheduled office visits, and any other pertinent information relevant to the care of your child.

Medical Information

We need to depend on the child's parents to communicate clearly with each other about the child's health status and healthcare plans. Our general approach is to communicate our medical assessments and recommendations with the parent who accompanies the child to the office, or with the parent who contacts us by telephone or electronic communication.

We cannot take the responsibility of contacting each parent separately every time we see the child in the office. We are, however, happy to receive inquiries about the child's health from either parent at any time.

Please be aware that each parent has equal access to the child's medical record. Unless we receive a court order, we will not disallow either parent from looking at their child's medical records or obtaining results of their child's medical tests.

We reserve the right to charge an administrative fee for the copying of medical records.

Please Note

Non-compliance with this office policy may result in the termination of care of your child. We ask the parents to amicably settle any issues relating to the care of your child. Please be aware that we have the right to discharge your child from our practice if we determine that the issues between the parents become disruptive to our organization or impede the medical care we provide for your child.

Parent/ Guardian Signature _____ Date _____

Print Name _____