Fort Myers Pediatrics

5285 Summerlin RD Suite 101

Fort Myers Fl 33919

Follow My Health Universal Health Record

Fort Myers Pediatrics Invite you to have access to your child medical record through Follow My Health.

o I accept _____ Child First and Last Name:_____Dob:

Home Address:_____ city _____ Zip _____
Phone Number:_____
Email:_____

o Not interested
Why?_____

Fort Myers Pediatrics les Invita a que acceda a los reportes medicos de sus hijos por Follow My Health.

o Yo accepto _____ Nombre del paciente y Apellidos:_____Fecha de Nacimiento:-

Direccion:_____
Telefono:_____
Correo Electronico:_____

o No interesado
Razon?_____

Fort Myers Pediatrics

5285 Summerlin Rd Suite 101
Fort Myers Florida 33919
Phone (239)689-5561 Fax(239)689-5958

NEW PATIENT REGISTRATION / REGISTRACION PARA NUEVOS PACIENTES

Patient Name and Last Name: _____ Home Phone: _____
Nombre del Paciente y Apellidos *Telefono del Hogar*

Home Address: _____ Cell Phone: _____
Direccion del Hogar *Telefono del cegular*

City: _____ State: _____ Zip Code: _____ Date of Birth: _____ Age: _____
Ciudad *Estado* *Codigo Postal* *Fecha de Nacimiento*

Social Security #: _____
Numero de Seguro Social

Name of Mother/Guardian: _____ Phone Number: _____
Contacto de la Madre/Tutor Legal *Telefono del la Madre*

Mother's/Guardian Social Security #: _____ Mother's/Guardian DOB: _____
Numero de Seguro Social de la Madre/Tutor Legal *Fecha de Nacimiento del Madre/ Tutor Legal*

Name of Father: _____ Phone Number: _____
Contacto del Padre *Telefono del Padre*

Father's Social Security #: _____ Father's Date of Birth: _____
Numero de Seguro Social del Padre *Fecha de Nacimiento del Padre*

Pharmacy of Choice (name, address or closest intersection and phone): _____
Farmacia (nombre, direccion, telephone)

INSURANCE INFORMATION *INFORMACION* DE SEGURO MEDICO

Name of Primary Insurance: _____ Insured ID: _____
Nombre del Seguro *Numero de indentificacion de Asegurado*

Name of Secondary Insurance: _____ Insured ID: _____
Nombre del Seguro Secundario *Numero de indentificacion de Asegurado*

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, American Express and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta dueda, usted es responsable de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby assign payment directly to Fort Myers Pediatrics, LLC ("LLC") of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by LLC. I understand that I am financially responsible to LLC for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit; Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Fort Myers Pediatrics, LLC todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S SIGNATURE & NOTICE OF PRIVACY ACKNOWLEDGEMENT: I have read and understand the Privacy Act:

Signature *Firma del padre*: _____ DATE: _____

HIPAA Notice of Privacy Practices

Fort Myers Pediatrics
5285 Summerlin Rd Suite 101
Fort Myers Florida 33919

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFU LLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see vu: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable IDu Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14. 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

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Lead Exposure Risk Assessment Questionnaire for Children

In addition to the required testing of all children for lead with a blood lead test at one year of age and again at age two, assessment of risk for lead exposure should be done at each well-child visit or at least annually for each child six months to six years of age. The questions below serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

Risk Assessment Questionnaire

Question	Answer	
	Yes	No
1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling? **Note**: This could include a day care center, preschool, and the home of a babysitter or a relative.		
2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?		
3. Does your child have a brother/sister, housemate/playmate being followed or treated for lead poisoning?		
4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)? **Note**: This may include toys or jewelry products that have been recalled by the Consumer Products Safety Commission (CPSC) due to unsafe lead levels. Our Lead Hazard Product Recalls site provides a list of recent recalls that are related to lead hazards.		
5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? **Note**: Jobs include house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.		
6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? **Note**: May need to alert parent/caregiver if such an industry is local.		
7. Does your family use products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter? **Note:** Lead has been found in traditional medicines such as Ayurvedic medicine, liga, greta, azarcon, litargirio, and in cosmetics such as kohl, surma, and sindoor. Lead exposure risk is higher with old, imported, painted, cracked or chipped china, and in low-fired and terra cotta pottery, often made in Latin America and the Middle East.		

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TB/Cholesterol Risk Assessment

Name: _____

Dob: _____

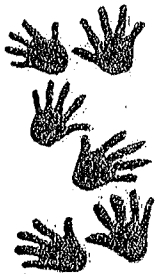
Date: _____

TB Risk Factor

1. Has your child been in contact with person who have tuberculosis?	YES	NO
2 Is any one of your family members who live in your household a recent immigrant from another country to the U.S or has anyone traveled to another country for more than a month?	YES	NO
3. Is anyone in the household infected with HIV or been in jail during the last 5 years?	YES	NO
4. Has your child ever had a positive PPD or tuberculosis test?	YES	NO

Cholesterol Risk Fact

1. Does either of the parents have a cholesterol > 240?	YES	NO
2. Has any member of your family has a heart attack or stroke before age 55?	YES	NO



FORT MYERS PEDIATRICS
5285 Summerlin Rd Suite 101
Fort Myers Fl 33919
PHONE: (239)689-5561 FAX: (239)689-5958

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT PATIENT INFORMATION

Patient Name: _____

FIRST LAST MIDDLE INITIAL

DATE OF BIRTH: _____ SEX: ____M ____F

ADDRESS _____

STREET CITY STATE ZIP

PHONE (____)_____

(PAST DOCTOR'S NAME AND PHONE NUMBER)

_____

For the purpose of review/examination. I further authorize you to provide copies as requested and indicate to the limitations below:

_____All Records

_____Last Visit Notes

_____Immunization

_____Labs / X- Ray

I give special permission to release information regarding: (Please initial)

____ Substance Abuse ____ Psychiatric/ Mental Health Information ____ HIV Information

Reason for request _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
(If not patient, state relation)

****

OFFICE USE ONLY: Date Received _____ Type of records sent _____

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Consent by Proxy

Tel: 239-689-5561 | Fax: 239-689-5958

The consent by proxy form allows someone other than a parent the right to make medical decisions as if they were the parent. This form may be used to have a caregiver or grandparent bring your child to any visit, including a well child exam with vaccines and allergy shots.

This form should be completed for Step-parents.

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE FORM

I give **Consent by Proxy** to:

(1)_____ as my
(Name, phone#)
childs_____ _____ as my proxy decision maker for consenting
(Relationship to child)

(2)_____ as my
(Name, phone#)
childs_____ _____ as my proxy decision maker for consenting
(Relationship to child)

(3)_____ as my
(Name, phone#)
childs_____ as my proxy decision maker for consenting
(Relationship to child)

to non-urgent medical care for my child listed below, I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

Name_____ DOB_____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state none.

_____

_____

_____

Time frame for which this authorization is given. If none, state none. Dates_____ TO_____

PARENT CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the healthcare of my child at the following telephone numbers. If you are unable for any reason to contact me, you may rely on this proxy decision maker for consent.

Parent Name_____ Day Phone_____

Cell Phone_____ Evening Phone_____

Signature_____ Date_____

Parent Name_____ Day Phone_____

Cell Phone_____ Evening Phone_____

Signature_____ Date_____