Pediatric & Internal Medicine Specialists, Inc.®

PedIM Healthcare

Patient Information

Name: _____
Last First M.I.

Address: _____
Street City State Zip

DOB: ____/____/_____ **Sex: M/F** _____ **School:** _____

Guarantor Information

Parent/Guardian Name: _____ **DOB:** ____/____/_____

Address: _____
Street City State Zip

Home Phone: _____ **Cell:** _____

Employer: _____ **Email:** _____

Parent/Guardian Name: _____ **DOB:** ____/_____/_____

Address: _____
Street City State Zip

Home Phone: _____ **Cell:** _____

Employer: _____ **Email:** _____

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Emergency Contact

Name: _____ Relation to Patient: _____

Home Phone: _____ Cell: _____

Name_____ Relation to patient: _____

Home Phone: _____ Cell: _____

Insurance Information

Insurance Company: _____

Policy#: _____ Group#: _____

Policy Holder: _____ DOB: _____/_____/_____

*Both natural parents will have custody of this patient unless there is a Florida court order to the contrary. Both natural parents retain full access to medical records and reports unless otherwise restricted by a specific court order.

Who has legal custody of the patient? Name: _____
Relationship: _____

With whom is the patient living: Name: _____
Relationship: _____

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PEDIATRIC HEALTH HISTORY

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

Reason for Visit: _____

Hospital of Birth: _____

Has your child had to receive any blood transfusions or blood products?

_____.

Has your child been hospitalized or had surgery in the past? _____

If yes, please give reason (Starting with most recent).

_____

_____

_____

Pharmacy:

_____

FAMILY MEDICAL HISTORY

	NAME	HEALTH PROBLEMS
Mother		
Father		
Sibling		
Sibling		
Sibling		

PAST MEDICAL CONDITIONS

(Please check if you or any BLOOD relative has these conditions)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Birth Defects			Lung/Asthma		
Hearing/Vision			GI		
Diabetes			Kidney		
Anemia			Arthritis		
Cancer Type:			Alcohol/Drug/ Tobacco/HIV		
Seizure			High Blood Pressure		
Migraines			Heart Disease		

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CHILD'S HISTORY

	YES	NO		YES	NO
Complications with Delivery			Broken Bone		
Diabetes			Lazy eye		
Diarrhea			Weight gain/Weight loss		
Speech Problems			Tonsillitis		
Walking Problems			TB		
Low Blood Count			Kidney Disease		
Bleeding Disorder			Stomach Problems		
Cold Sores			Allergies		
Easy Bruising			Joint Pain		
Head Injuries			Temper Tantrums		
Ear Infections			Hearing Problems		
Blood in Urine			Constipation		
Pain While Urinating			Trouble in School		
Growing Pains			Breathing Problems		
Asthma			Convulsions		
Heart Problems			Frequent Fevers		
Chickenpox			Jaundice/Yellow Skin		
Rosacea			Trouble Swallowing		
Runny Nose/Congestion			Vomits Frequently/Spits ups		
Sickle Cell			Vision Problems		
Dry Skin			Short Attention Span		

Complications during pregnancy? _____

Complications during labor? _____

Type of Delivery? Vaginal C-Section (Circle One)

Full Term _____ Pre-Term _____ How Many Weeks? _____

Any other problem in your child's development, such as motor skills, language concerns, or behavior concerns?

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

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Allergy Questionnaire

Patient Name: _____

D.O.B.: _____

What problem brings you or your child to this appointment? _____

_____

When did symptoms begin? _____

Are your symptoms getting worse? ☐ Yes ☐ No

Do you have any of these symptoms? (Please check)

☐ Cough	☐ Runny Nose	☐ Nasal Polyps	☐ Eczema
☐ Wheezing	☐ Nasal Congestion	☐ Poor Sense of Smell	☐ Hives/Swelling
☐ Shortness of Breath	☐ Itchy Nose	☐ Ear Infections	☐ Headaches
☐ Chest tightness	☐ Itchy/Watery Eyes	☐ Sinus Infections	☐ Snoring
☐ Sneezing	☐ Postnasal Drip	☐ Blocked Ears	☐ Fatigue
	☐ Phlegm/Sputum (color) _____		☐ Other

Check any of the following which seem to trigger (or cause) symptoms or bother you:

☐ Grass	☐ Cats	☐ Cosmetics	☐ Drafts	☐ Nervousness
☐ Hay	☐ Dogs	☐ Aerosol sprays	☐ House dust	☐ Cold Air
☐ Mold and Mildew	☐ Horses	☐ Perfumes	☐ Smoke	☐ Humidity
☐ Basements	☐ Other animals	☐ Insecticides	☐ Pollution	☐ Weather changes
☐ Leaves	☐ Alcoholic Beverages	☐ Odors	☐ Exercise	☐ Latex (rubber) Other _____

When are your symptoms worse? ☐ Year Round ☐ Seasonal

Are symptoms better away from home? ☐ Yes ☐ No If Yes, When? _____

Occupation (current or former) _____

Any harmful exposure at work or school? _____

ENVIRONMENTAL SURVEY

Do you have pets (number) – Indoor or Outdoor ☐ None ☐ Cats ____ ☐ Dogs ____ ☐ Birds ____ ☐ Other ____

Are there any tobacco smokers in your home? ☐ Yes ☐ No

Do you have allergy proof encasing for pillow or mattress? ☐ Yes ☐ No

What type of pillows do you have? _____

What type of comforter do you have? _____

What type of floor covering do you have in your bedroom? ☐ Wall to wall ☐ Area Rug ☐ Animal skin ☐ Bare floor

How old is your mattress? _____ What is in your mattress? (i.e. cotton/horse hair) _____

Do you have air conditioning? ☐ Yes ☐ No If yes, ☐ Window Unit ☐ Central

Do you have problems with roaches or mice? ☐ Yes ☐ No

Do you have water leaks, mold contamination? ☐ Yes ☐ No

Is your home/apartment excessively humid? ☐ Yes ☐ No

YOUR PAST MEDICAL HISTORY

Check all that apply:

☐ Eczema ☐ Upper Respiratory Infection ☐ Asthma ☐ Sinus Problems

☐ Emphysema

If yes to any of the above, please explain: _____

Do you smoke? ☐ Yes ☐ No how much? _____

Have you smoked in the past? ☐ Yes ☐ No When stopped? _____

If yes, how many years have you smoked? _____

Patient/Guardian Signature: _____ Date: _____

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Patient Financial Responsibility

All patients or guardians are responsible for 100% of the charges incurred for treatment at PedIM Healthcare.

- The patient or guardian who signs the financial policy statement is the responsible party.
- Established patients who have health insurance benefits that have been verified will be expected to pay that portion of the charges not covered under their policy as well as any applicable co-payments under the terms of their policy.
- Patients who have health insurance benefits that have been verified will be responsible for all charges, paid in full on the day of service, until their policy out of pocket has been met.
- PedIM Healthcare is not responsible for incorrect information given by your insurance company.
- Patients who have health insurance benefits that have not been verified will be responsible for any portion of the charge that are not covered, as well as any applicable co-payments under the terms of their policy.
- Having an active health insurance policy in no way negates a patient's responsibility for payment of their medical charges, if these charges are denied or not covered by the patient's insurance carrier.
- Patients may pay their bills by cash, check, or credit.
- There will be a $20.00 charge applied to your account for patients who do not keep their appointments, including no-shows.
- Patients who fail to pay their outstanding balance within 90 days of the service being provided may be turned over to a collection agency. The patient will still be responsible for the charges as well as all collection agency costs and fees, including reasonable attorney fees.

PedIM Healthcare utilizes Transaction Central, Patient Payment Assurance to securely maintain your payment information in compliance with federal and state laws.
Your payment information filed with Transaction central will be saved for future processing of patient responsible portions not paid by insurance; miscellaneous healthcare fees such as but not limited to late, cancelled or missed appointments.
We have developed these financial policies in an effort to keep your medical costs down. Printing and mailing statements is an extremely time consuming and expensive undertaking. We ask that you adhere to these policies as part of your financial responsibility. Our staff will assist you in any way that we can. If you have any questions regarding our fees or your insurance coverage and filing of your insurance claims please ask to speak with one of the members of our billing and insurance department. Billing Department: (352) 563-0931.
I authorize PedIM Healthcare to process financial transactions to pay my account balance. I agree to be financially responsible for any and all related charges, if they are not covered by my insurance policy.

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Consent for Treatment of a Minor

I, _____, the parent or legal guardian of _____
(Patient Name)

give permission for the following individuals, in my absence, to accompany and make decisions for my child. In addition, the listed authorized person(s) have permission to discuss medical information regarding my child.

Name of authorized person	Relation	Phone
Name of authorized person	Relation	Phone
Name of authorized person	Relation	Phone
Name of authorized person	Relation	Phone
Name of authorized person	Relation	Phone
Name of authorized person	Relation	Phone

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

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PRIVACY POLICY, FINANCIAL RESPONSIBILITY AND CONSENT FOR TREATMENT OF A MINOR

I, _____, hereby authorize Pediatric and Internal Medicine Specialists,
(**Printed** Name of Parent or Legal Guardian)

Inc, it's affiliated physicians and other medical personnel in charge of my child's,

_____, care to administer examinations, immunizations, treatments
(**Printed** Patient Name)

and view my prescription history from an external source as may be deemed medically necessary in the exercise of their professional judgment. Additionally, by signing this form I acknowledge that I have received a copy of the Privacy Policies and Financial Responsibility Policy for the office of Pediatric and Internal Medicine Specialists, Inc.

_____ _____
(**Printed** Patient Name) (Date of Birth)

_____ _____
(**Printed** Name of Parent or Legal Guardian) (Relationship to Patient)

_____ _____
(Signature of Parent or Legal Guardian) (Date)

_____ _____
Witness Signature (Date)

_____
Patients Chart Number

1990 N. Prospect Ave
Lecanto, FL 34461
www.pedimhealthcare.com

Pediatric & Internal Medicine Specialists, Inc.©
PedIM Healthcare

Tel: 352-527-6888
Fax: 352-527-8818
info@pedimhealthcare.com

Healthcare for your entire family...

Dacelin St. Martin, MD, FAAP Lilia Shammas, MD Louis Bois, MD Todor Toromanovski, MD
Tamra Assumpcao, PA-C Brenda Hayden-Brown, ARNP Maryellen Greene, PA-C Angela Kelley, PA-C Gliset Norman PA-C Sarah Joerres PA-C

We listen, We help, We understand, but most importantly, We CARE!

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:	**DOB:**

Previous Physician/Office Name:	
Specialty:	
Phone:	**Fax:**
City:	**State:**

I hereby authorize and release the custodian of my/my dependent's medical records to **PedIM Healthcare**, including psychological, psychiatric, developmental/rehabilitative alcohol, and/or drug abuse human immunodeficiency virus (HIV) testing and treatment, ARC (AIDS related condition), and/or acquired immunodeficiency syndrome (AIDS) information.

Release To: PedIM Healthcare

☐ Dacelin St. Martin, MD ☐ Louis Bois, MD ☐ Lilia Shammas, MD ☐ Todor Toromanovski, MD

P.O. Box 2066 Lecanto, FL 34460 Phone:352-527-6888 Fax: 352-527-8818

*****IF RECORDS EXCEED 15 PAGES WE REQUEST THAT THEY BE MAILED******

Purpose of Use or Disclosure:	☐ Continuity of Care ☐ Other:

Information to be Released:	☐ Complete Chart ☐ Radiology Reports ☐ Lab Reports ☐ Diagnostic Testing ☐ Immunizations ☐ Other: _____
PATIENT INITIALS_____	**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV, or AIDS information.**

-I understand that all medical, surgical, psychiatric, and psychological information is confidential and that the patient records are the property of Pediatric & Internal Medicine Specialists, PA and its related corporate entities. I will not hold Pediatric & Internal Medicine Specialist, PA, its employees, staff, or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.
-I understand that my authorization for release may be revoked at any time by written request to Pediatric & Internal Medicine Specialists, PA, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Pediatric & Internal Medicine Specialists, PA to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.
-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Pediatric & Internal Medicine Specialists, PA, its employees, its staff, and representatives from all liability relating to or arising out of this release of information contained Pediatric & Internal Medicine Specialists, PA records.
-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Pediatric & Internal Medicine Specialists, PA. However, if the only purpose for providing the service is to obtain information in order to release information to myself or a t third party, then I understand that I must sign the authorization in order to receive the service.
-I understand that there may be a charge of $1.00 per page for the first 25 pages and then $.25 per page thereafter, plus postage and handling, for copy services unless copies provided by Pediatric & Internal Medicine Specialists, PA are sent directly to a physician or health facility for the purpose of continuity of care.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below.
Expiration Date or Circumstance: _____

Patient Signature: _____ **Date:** _____

Relationship to Patient If Not Self: _____

Witness/Requested By:	**Date:**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

PedIM Healthcare is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. PedIM Healthcare is required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

The following describes how PedIM Healthcare may use your protected health information for treatment, payment or health care operations.

Treatment:

PedIM Healthcare may use health information about you to provide you with health care treatment or services. PedIM Healthcare may disclose health information about you to doctors, nurses, or other essential personnel who are involved in your care.

Payment:

PedIM Healthcare may use and disclose health information about you to receive payment for services provided to you. Under Florida law we must obtain your written consent in order to submit claims for services provided to you. Failure to sign may force us to decline you as a new patient or discontinue you as an active patient.

Health Care Operations:

PedIM Healthcare may use and disclose health information about you for operational purposes related to our office. We may also and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointments Reminders
Treatment Information
Disclosure to Department of Health and Human Services
Family and Friends
Notification
Disaster Relief
Health Oversight Activities
Abuse or Neglect
Judicial and Administrative Proceedings
Law Enforcement
Specialized government Functions
Coroners, Medical Examiner's and Funerals Directors
Organ Donation
Research
Public Health Activities
Public Safety
Worker's compensation
Business Associates

MINIMUM NECESSARY INCIDENTAL DISCLOSURES AND SUPER CONFIDNETIAL INFORMATION

Our staff will not use or disclose your medical information unless it is necessary to perform their jobs. We will follow both state and federal laws related to the use and disclosure of super-confidential information such as HIV/AIDS, alcohol/substance abuse and mental health records.

AUTHORIZATIONS and CONSENTS:

We will not use or disclose your medical information for any other purpose other than treatment, payment or health care operations without your written authorization. Once given, you may revoke your authorization in writing at any time. This consent is required under Florida law in order for our office to submit claims and other information needed to receive for services rendered to you or your family.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

- You may ask us to restrict certain uses and disclosures for your medical information. We are not required to agree to your request, but if we do we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by PedIM Healthcare during the last 6 yrs. Except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please require at the Registration desk (you will be directed to our Privacy Officer).
- To file a complaint with the U.S. Department of Health and Human Services you must submit your complaint in writing, within 180 of the alleged violation to:

Region I.V, Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W
Atlanta, GA 30303-8909
Voice phone 404-562-7886
Fax 404-562-7881

For the full version of PedIM healthcare privacy policy, view our website at www.pedimhealthcare.com