PEDIATRIC PATIENT INFORMATION

Name: ____
Last First M.I.

Address: ____
Street Address

____
City State Zip

DOB: ______/_______/________ Sex: M/F ______________ School: ________________________

Race: White / African American / Decline Ethnicity: ___________________________________

GUARANTOR INFORMATION

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

Address: ____
Street Address

____
City State Zip

Home Phone: _________________________________ Cell: ___________________________________

Employer: _______________________________________ Email: ________________________________

Parent/Guardian Name: ____ DOB: ____/______/______

Address: ____
Street Address

____
City State Zip

Home Phone: _________________________________ Cell: ___________________________________

Employer: _______________________________________ Email: ________________________________

EMERGENCY CONTACT INFORMATION

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: ___________________________

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		

OTHER FAMILIAL MEDICAL CONDITIONS

(Please check if any BLOOD relative has a history of the following 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**		

CHILD'S HISTORY

	YES	NO		YES	NO
Birth Defects			**Cancer**		
Seizures			**Migraines**		
Complications with Delivery			**Broken Bone**		
Diabetes			**Lazy eye**		
Diarrhea			**Weight gain/Weight loss**		
Speech Problems			**Tonsillitis**		
Walking Problems			**TB**		
Anemia			**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**		

Other medical history not listed: ____
Type of Delivery? ____
Gestational age? ____
Any other problem in your child's development, such as motor skills, language concerns, or behavior concerns?
____
____

Allergies: ____
Medications:
____
____

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

PRIVACY POLICY AND CONSENT FOR TREATMENT FOR A MINOR

I, ____, hereby authorize Pediatric and Internal Medicine Specialists
(**Printed** Name of Parent or Legal Guardian)
DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) and other medical personnel in charge of my child

____, 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 for the office of Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine).

____ ______________________
(**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

KB 10/30/18

ALLERGY QUESTIONNAIRE

Patient Name: ____

D.O.B.: ________________________

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 Financial Responsibility

All patients or guardians are responsible for 100% of the charges incurred for treatment at Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine). 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.
- Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) are 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.
- Patients who do not have health insurance will be responsible for all charges incurred payable on the day of service.
- 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.

Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) utilize 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 Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) 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.

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.

Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) are 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 and/or PedIM Healthcare powered by Sick N Well (telemedicine) are required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:
The following describes how Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) may use your protected health information for treatment, payment or health care operations.

Treatment:
Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) may use health information about you to provide you with health care treatment or services. Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) may disclose health information about you to doctors, nurses, or other essential personnel who are involved in your care.

Payment:
Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) 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:
Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) 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 CONFIDENTIAL 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.

PATIENT RIGHTS REGARDING THEIR 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 Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well (telemedicine) during the last 6 years. 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 Pediatric and Internal Medicine Specialists Inc. DBA PedIM Healthcare and/or PedIM Healthcare powered by Sick N Well's (telemedicine) privacy policy, view our website at www.pedimhealthcare.com