ORLANDO HEALTH
Physician Associates

Pediatric Patient Information Today's Date: ___ /___ /___

Child: _____ D.O.B. ___ / ___ / ___ ☐ male ☐ female
Child: _____ D.O.B. ___ / ___ / ___ ☐ male ☐ female
Child: _____ D.O.B. ___ / ___ / ___ ☐ male ☐ female
Child: _____ D.O.B. ___ / ___ / ___ ☐ male ☐ female

Parent #1: _____ DOB: ___ /___ /___
Address: _____ City:_____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Employer: _____ Occupation: _____
Parent #2: _____ DOB: ___ /___ /___
Address: _____ City:_____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Employer: _____ Occupation: _____
Preferred phone to call for appointment reminders: _____
Email address for portal: (Patients under 12 years old): _____
Parents are: ☐ married ☐ living together ☐ separated ☐ divorced Custodial Parent is ☐ #1 above ☐ #2 above
* please provide court paperwork if there are custody orders we should be aware of regarding who may bring child to be seen

Language best served in: _____ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ White ☐ African American ☐ Asian ☐ Native American ☐ Other

I permit the following individuals to bring my children for medical care and to carry out directives given to them by Orlando Health Physician Associates. I understand that payment is due at time of service. This consent applies to sick visits, and not to well visits or vaccine consents.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION (You must provide us with a current insurance card at each visit)
Insurance Company: _____ ID#_____Group #_____
Policy Holder: ☐ Parent 1 above ☐ Parent 2 above
☐ Other: Name: _____ D.O.B. _____

AUTHORIZATION FOR TREATMENT

I authorize Physician Associates, LLC to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse - to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Physician Associates, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Physician Associates, LLC. Furthermore any services not covered by my insurance will become my responsibility for for full payment of services rendered by Physician Associates, LLC.

_____ _____ _____/ _____/_____
Parent/Legal Guardian Signature Print Date

ORLANDO HEALTH
Physician Associates

PEDIATRIC HEALTH QUESTIONNAIRE

Date: ____ / ____ / ____

Patient Name: _____ D.O.B. ____ / ____ / ____

BIRTH HISTORY

Pregnancy	Complications during pregancy?	☐ yes	☐ no	
Delivery	Was the patient premature?	☐ yes	☐ no	
	Any complications after birth? *(jaundice, breathing, feeding, infection)*	☐ yes	☐ no	

MEDICAL HISTORY

	Age	Surgery, Serious Injury, Serious Illness, or Hospitalization Details
Surgeries, Injuries, Illnesses, Hospitalizations		

CURRENT MEDICATIONS:

Please list prescription or over the counter medications your child takes regularly or often with dosage

☐ none	Medication	Dosage

PREVIOUS MEDICATIONS:

Please list important prescription or over the counter medications your child used to take regularly

☐ none	Medication	Dosage

ALLERGIES

Please list any food, medication, or environmental allergies your child has experienced

☐ none	Allergen	Reaction

PEDIATRIC HEALTH QUESTIONNAIRE

Date: ____ / ____ / ____

Patient Name: _____ D.O.B. ____ / ____ / ____

FAMILY HISTORY:

Diagnosis	mother	father	sibling	MGM, MGF	PGM, PGF	other
Asthma	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Lazy Eye	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐
Rheumatologic Disease	☐	☐	☐	☐	☐	☐
Learning Disability, ADHD	☐	☐	☐	☐	☐	☐
Depression, Mental Illness	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐

Other relevant personal or family history:

Prior medical and vaccine records are very important to our care of your child. If you have not already provided us with prior medical records, please fill out releases for us today so that we may obtain those. Thank you.

Do you or a family member require assistance for hearing impaired? ☐ yes ☐ no

Form Completed By: _____ *Parent/Legal Guardian Signature* Date: ____ / ____ / ____

Form Completed By: _____ *Please PRINT Parent/Legal Guardian Name* Relationship to child: _____

Clinician Signature: _____ Date: ____ / ____ / ____

ORLANDO HEALTH
Physician Associates

PEDIATRIC FAMILY FINANCIAL AGREEMENT

In consideration of the patients listed below receiving services from Physician Associates, LLC, I agree:

I am responsible for all expenses for treating the patient(s).

It is my responsibility to make sure that my child(ren's) insurance is in order and that I have provided Physician Associates with correct and up to date insurance information.

Payment of charges is due at the time of the appointment.

If Physician Associates files my insurance for me, I agree to pay for all non-covered expenses, co-insurance, co-pays, and deductibles. I understand that these amounts are determined by my insurer and not by Physician Associates.

I also understand that patients with self-pay balances are expected to pay their account balance to zero prior to receiving further services by our pratice. Patients who have questions about their bills or who would like to set up a payment plan option may call to speak with a business office representative. Patients with balances over $100 must make payment arragements prior to future appointments being scheduled.

AUTHORIZATION TO RELEASE INFORMATION & TO COLLECT PAYMENT

I authorize Physician Associates, LLC to release any of the above-listed minor children's medical information including drug, alcohol and HIV positive test results, to my insurance company as needed to process claims.

I authorize my insurance company to make payments directly to Physician Associates, LLC for covered medical and/or surgical services provided to the children listed below.

Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____

Responsible Party's Signature: _____
Printed Name: _____ Date: ____ / ____ / ____

Our Vaccination Philosophy

As medical professionals, we believe that all children should receive all recommended vaccines according to the guidelines provided by the U.S. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP). These schedules are continually studied and revised by experts in the fields of medicine, immunology, and public health and are held as the ideal model for immunization in this country and in many other nations worldwide. All recommended vaccines have been studied carefully and are known to be safe and effective in preventing illness and saving lives.

As healthcare providers, we firmly believe that vaccination is the single most important intervention that we perform.

Controversy surrounding vaccines:

There has always been suspicion and controversy surrounding vaccination. The science is often difficult for healthcare providers to explain and also difficult for parents to understand. It can be very difficult to sort through conflicting information, and, as healthcare providers, we would like you to trust us as your interpreters.

Vaccines are, as we say in medicine, victims of their own success. Vaccination works so well that we rarely see any of the vaccine-preventable infections against which we immunize. This can make it difficult to understand the importance of completion of the recommended childhood immunization series.

It is also difficult to see our children endure multiple needle sticks in an office visit. There is, however, a large amount of research to assure us that giving multiple vaccines at once, though stressful, is not in any way overwhelming to any person's immune system. In fact, our immune systems are very powerful and handle hundreds of times more that what we deliver in vaccines during the course of a normal day.

Finally, there is no data to suggest that vaccines cause autism or other developmental disabilities. Thimerosal, a mercury-based preservative used in multi-dose vials of only a very few vaccines, has never been shown to be toxic and does not trigger or worsen neurologic diseases including autism. These facts are agreed upon throughout the scientific community and are based upon continued scientific research.

The risks of under-vaccination and alternative schedules:

As a result of under-vaccinating we are now seeing outbreaks of both pertussis and measles. Both infections can result in hospitalization and even death. Both infections are preventable by vaccinations given according to the ideal, CDC-defined immunization schedule.

Delaying or splitting up vaccines increases the time during which your child is vulnerable to infections. Repeated visits to the office for individual shots are traumatic to your child and offer more opportunities for your child to be exposed to illness in waiting rooms. In addition, if your child is ill with fever, for example, our advice to you and the medical tests your child will need will differ greatly if he/she is incompletely immunized.

This is a public health issue. Delaying or avoiding vaccines for your child puts other children at direct risk. This includes children who are not able to be vaccinated for medical reasons, such as cancer patients, and babies who are as yet too young to have vaccinated. We cannot allow the unnecessary introduction of vaccine-preventable illness into our waiting rooms and our facilities by condoning unfounded alternative immunization schedules.

Vaccine resources:

We recognize that the decision to vaccinate your child may be emotional. We will do everything we can to help you become comfortable with the decision to immunize following the accepted vaccine schedules per CDC guidelines. Should you have any doubts please discuss these with our staff or with your care provider in advance of your visit. We offer separate visits for discussion of vaccines if you wish. We would ask that you take the time to explore some of the following resources prior to your visit.

The Panic Virus, a book by Seth Mnookin, an investigative reporter and father.

CDC: For Parents: Vaccines for Your Children – A useful resource about vaccines designed for parents.

AAP: Immunization – Information on vaccines and preventable diseases.

CDC: Recommended Routine Vaccination Schedule: Ages 0-6 Ages 7-18

CDC: Vaccine Information Statements (VIS) – Information sheets produced by the CDC

CHOP: Vaccine Education Center - The Children's Hospital of Philadelphia's Vaccine Education Center

Our Vaccination Policy:

As healthcare professionals we strongly believe that all children should follow the vaccine schedule recommended by the American Academy of Pediatrics and the Centers for Disease Control and Prevention. Not adhering to this schedule can put your children and others at risk for serious illness or death. As medical professionals of Orlando Health and Physician Associates, we require compliance with the recommended CDC vaccination schedule in order to begin or to continue further relations with you and your family.

Effective November 1, 2016, our practice will not accept new families who have firmly committed to the decision not to vaccinate their children. If you are undecided, we will agree to see your children with the understanding that we will do our best to share correct information with you and will expect that you commit to adherence to the recommended vaccination schedule within two months of beginning as our patients with your newborn. If your child is older when they enter our practice and is not properly immunized, we will offer you an appointment to discuss vaccines. There will be a one-month grace period after that appointment; if you choose at that time not to proceed with vaccination per the CDC catch-up immunization schedule we will ask that you find another health care provider.

Established patients who are behind on their vaccines will be given a two-month grace period to decide to vaccinate. Those patients will then follow a written plan based upon the catch up schedule designed by the CDC, which will be maintained in the medical record. Should parents/guardians decide not to vaccinate according to this plan, we will ask you to find another healthcare provider.

We recommend annual influenza vaccine for all patients aged 6 months and up. However, failure to allow us to vaccinate your child against influenza will not result in discharge from our practices.

If you feel that you cannot adhere to our policy regarding the childhood vaccination schedule we ask you to find another health care provider who shares your views. We neither keep a list of such providers nor would we recommend any such physician.

N.B. This policy does not apply to patients with medical contraindications to certain vaccines.

Patient Name _____

Patient DOB _____

Parent/Guardian Initial_____ Date _____

Physician Initial _____ Date _____

October 2016

ORLANDO HEALTH
Physician Associates

PEDIATRIC LATE / MISSED APPOINTMENT POLICY

We work very hard to offer you an appointment that is convenient for both you and your children. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We ask that, whenever possible, you call with at least 24 hours notice if you cannot make a scheduled appointment. This allows us to offer that time to another patient in need of our time.

If an appointment is not canceled at least 24 hours in advance we record this as a "DNKA" ("Did Not Keep Appointment.") In such a situation you may be charged a cancellation fee of $25-50 depending upon the appointment type missed. These fees are not covered by insurance. Repeated missed appointments will lead us to ask you to seek care from a physician outside of our practice.

We understand that delays happen, and sometimes medical visits run long due to complex medical issues. However, we try very hard to run on time. We ask that you call us if you are running late for an appointment.

If you arrive 15 minutes past your appointment time we may have to reschedule the appointment.

Please remember that your consideration of our schedule allows us to deliver the best, unpressured care to your children and to the children of other families. It also allows us to keep our schedule full without running behind as much as we are able. This also allows us to enjoy providing excellent care to your children and to provide for our families as well. Thank you again for your consideration and respect.

By signing below, I acknowledge receipt of this Pediatric Late or Missed Appointment Policy.

Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____

Responsible Party's Signature: _____
Printed Name: _____ Date: ____ / ____ / ____

ORLANDO HEALTH PHYSICIAN ASSOCIATES NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

PEDIATRICS

Orlando Health Physician Associates' Notice of Privacy Practices provides information about how we may use and disclose health information about your minor child(ren). You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician 's office or by visiting our website at www.paof.com.

You have the right to request that we restrict how protected health informatin about your child(ren) is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but, if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about your child(ren) for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have received the Orlando Health Physician Associates Notice of Privacy Practices.

Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____
Child's Name: _____ D.O.B. ____ / ____ / ____

Responsible Party's Signature: _____
Printed Name: _____ Date: ____ / ____ / ____

PHYSICIAN ASSOCIATES USE ONLY

Parent declined signing this acknowledgement form. Date: ____ / ____ / ____
Reason given: _____
Staff Member Name: _____ Office Location: _____

PHYSICIAN ASSOCIATES
ORLANDO HEALTH

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ **hereby authorizes the use or disclosure of the individually**
Print Patient/Legal Representative or Parent/Legal Guardian Name

Identifiable health information of _____ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information:	Person/organization authorized to **receive** the information:
Name/organization _____	Name/organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

For the purpose of: ☐ Legal Request ☐ Moving out of Area ☐ New Local Physician ☐ Other (please specify)
_____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand **that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information.** I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: **From:** _____ **To**: _____

Place your <u>INITIALS</u> by each item to be released or reviewed:

____ Abstract of Record ____ All diagnostic test results ____ Pathology/Operative Report(s)
____ Radiology only ____ Consultation/Progress Note(s) ____ Lab only
____ Complete Record (charges may apply) ____ Other (specify) _____

In addition, place your <u>INITIALS</u> by each specific item: (if applicable)

____ Mental Health ____ HIV Testing ____ Genetic Counseling/Testing Information
____ Drug and/or Alcohol ____ AIDS Information ____ STD/Communicable Diseases

_____ _____
Patient/Legal Representative or Parent/Legal Guardian ***Signature Required*** Date of Authorization

_____ _____ _____
Patient Date of Birth Social Security Number (optional) Identification Shown

_____ _____
Translator or Interpreter's Name Telephone Number

_____
Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information **Date**