



LINE UP PATIENT I.D. LABEL HERE

PEDIATRIC PATIENT INFORMATION

Today's Date: ____/____/____

Child: _____ DOB: ____/____/____ male female

Child: _____ DOB: ____/____/____ male female

Child: _____ DOB: ____/____/____ male female

Child: _____ DOB: ____/____/____ 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

Preferred language for discussing health care: _____ 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: _____ DOB: ____/____/____

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 full payment of services rendered by Physician Associates, LLC.

_____/_____/_____
 Parent/Legal Representative Signature Print Name Date Time



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PEDIATRIC HEALTH QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

BIRTH HISTORY (NEW PATIENTS ONLY)

Pregnancy	Complications during pregnancy?	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Delivery	Was the patient premature?	<input type="checkbox"/> yes	<input type="checkbox"/> no	
	Any complications after birth? <i>(jaundice, breathing, feeding, infection)</i>	<input type="checkbox"/> yes	<input type="checkbox"/> no	

MEDICAL HISTORY (ESTABLISHED PATIENTS, PLEASE UPDATE FROM LAST FORM COMPLETION ONLY)

Surgeries, Injuries, Illnesses, Hospitalizations	Age	Surgery, Serious Injury, Serious Illness, or Hospitalization Details
<input type="checkbox"/> <i>no change</i>		

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

<input type="checkbox"/> none	Medication	Dosage
<input type="checkbox"/> <i>no change</i>		

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

<input type="checkbox"/> none	Medication	Dosage
<input type="checkbox"/> <i>no change</i>		

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

<input type="checkbox"/> none	Allergen	Reaction
<input type="checkbox"/> <i>no change</i>		



PEDIATRIC HEALTH QUESTIONNAIRE

LINE UP PATIENT I.D. LABEL HERE

Patient Name: _____ DOB: _____ Date: _____

FAMILY HISTORY: (Established Patients, please add updates only)

Table with 9 columns: Diagnosis, mother, father, sibling, MGM*, MGF*, PGM*, PGF*, other. Rows include Asthma, Allergies, Seizures, Migraines, Cancer, Thyroid Disease, High Cholesterol, High Blood Pressure, Heart Disease, Tuberculosis, Diabetes, Kidney Disease, Lazy Eye, Crohn's, Ulcerative Colitis, Lupus, RA, autoimmune, Learning Disability, ADHD, Depression, Mental Illness, Substance Abuse.

Details from above:

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 another caregiver require assistance for hearing impaired or language interpretation? Yes No.

Form Completed By: _____

Parent/Legal Representative Signature

Date

Time

Parent/Legal Representative Name (Print)

Relationship to Child

Clinician Signature

Date

Time

* Legend: MGM = Maternal Grandmother MGF = Maternal Grandfather PGM = Paternal Grandmother PGF = Paternal Grandfather

INTERPRETER ONLY

PATIENT ASSISTANCE PROVIDED

Interpreter Name: _____

Agency & I.D.#: _____

Team Member Name & I.D.#: _____

Video Remote Tel In person Language: _____

Reader for Visually Impaired

Name: _____



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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 practice. 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 arrangements 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: _____ DOB: ____/____/____

Child's Name: _____ DOB: ____/____/____

Child's Name: _____ DOB: ____/____/____

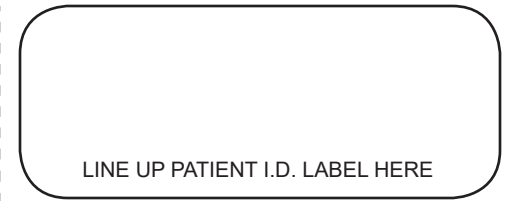
Child's Name: _____ DOB: ____/____/____

Parent/Legal Representative Signature

Date

Time

Printed Name



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 than what we deliver in vaccines during the course of a normal day.

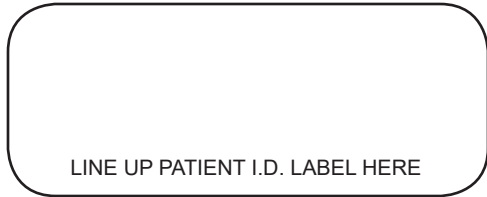
Finally, there is no data to suggest that vaccines cause autism or other developmental disabilities. Thimerosal, a mercury-based preservative used in multi-dose vials of only a very few vaccines, has never been shown to be toxic and does not trigger or worsen neurologic diseases including autism. These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



OUR VACCINATION PHILOSOPHY

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.

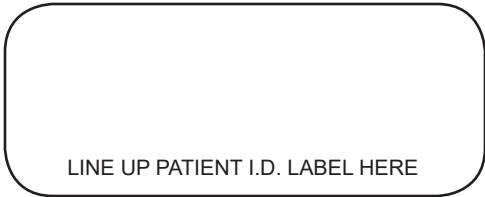
N.B. This policy does not apply to patients with medical contraindications to certain vaccines.

Patient Name: _____	Patient DOB: _____
Parent/Legal Representative Signature: _____	Date: _____ Time: _____
Physician Signature: _____ I.D.# _____	Date: _____ Time: _____



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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 assists us in keeping our schedule full without running behind. 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: _____ DOB: ____/____/____

Child’s Name: _____ DOB: ____/____/____

Child’s Name: _____ DOB: ____/____/____

Child’s Name: _____ DOB: ____/____/____

Parent/Legal Representative Signature

Date

Time

Print Name



ORLANDO HEALTH | Physician Associates

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM
PEDIATRICS**

LINE UP PATIENT I.D. LABEL HERE

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 information 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: _____ DOB: ____/____/____
Child's Name: _____ DOB: ____/____/____
Child's Name: _____ DOB: ____/____/____
Child's Name: _____ DOB: ____/____/____

Parent/Legal Representative Signature Date Time

Print Name

PHYSICIAN ASSOCIATES USE ONLY

Parent/Legal Representative declined signing this acknowledgment form. Date: ____/____/____

Reason given: _____

Staff Member Name: _____ Office Location: _____



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LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ hereby authorizes the use or disclosure of the individually Patient/Legal Representative Name

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

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

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

Place your INITIALS 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 INITIALS 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 Signature Required _____ Date _____ Time _____

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

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

INTERPRETER ONLY: Interpreter Name, Agency & I.D.#, Team Member Name & I.D.#, Video Remote, Tel, In person, Language.
PATIENT ASSISTANCE PROVIDED: [] Reader for Visually Impaired, Name: _____