WEST BROWARD PEDIATRICS PATIENT INFORMATION SHEET

DATE:_____ PRIMARY LANGUAGE SPOKEN:_____

LIST ALL CHILDREN IN THE FAMILY

FIRST	MIDDLE	LAST	DOB	GENDER
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____

HOME STREET ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE: _____

CHILDREN LIVE WITH: _____PARENT/GUARDIAN #1 _____PARENT/GUARDIAN #2 _____BOTH

PARENT/LEGAL GUARDIAN RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS:

PARENT/LEGAL GUARDIAN #1 (OR PATIENT IF 18 YEARS OR OLDER)

FIRST NAME: _____MIDDLE INITIAL:_____ LAST NAME: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH (MM/DD/YYYY) _____/_____/_____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

STREET ADDRESS (IF DIFFERENT FROM ABOVE): _____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER NAME: _____OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

WORK PHONE: _____EXT_____

PARENT/LEGAL GUARDIAN #2

FIRST NAME: _____MIDDLE INITIAL:_____ LAST NAME: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH : (MM/DD/YYYY) _____/_____/_____

HOME PHONE:_____ CELL PHONE: _____

EMAIL ADDRESS: _____

STREET ADDRESS (IF DIFFERENT FROM ABOVE): _____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER NAME: _____ OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

WORK PHONE: _____EXT_____

(CONTINUE TO PAGE TWO)

NEAREST RELATIVE OR EMERGENCY CONTACT:

FIRST NAME:_____ LAST NAME:_____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE:_____

REFERRED BY: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS: _____CITY: _____STATE:_____ ZIP:_____

PHONE NUMBER:_____

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY:_____

INSURANCE COMPANY PHONE #:_____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S EMPLOYER: _____

SUBSCRIBER'S DATE OF BIRTH: (MM/DD/YYYY)_____/_____/_____

SUBSCRIBER'S SOCIAL SECURITY #:_____

ID/POLICY #:_____

GROUP #:_____

EFFECTIVE DATE: (MM/DD/YYYY)_____/_____/_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATIONS

I hereby authorize and direct my insurance company to make payments directly to the providers of WEST BROWARD PEDIATRICS, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. I further permit a copy of this Authorization be used in place of the original. This Authorization is to apply to all claims submitted by the providers of WEST BROWARD PEDIATRICS. I hereby authorize the providers to release any information required in the course of the examination or treatment.

To avoid misunderstandings regarding medical insurance, all patients should understand that all professional services rendered are charged directly to the patient and that all patients are personally responsible for payment of fees. As a courtesy, we will prepare all necessary forms to help you obtain benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees. If your insurance company does not cover the fees in full, the balance is due in full and payable by you.

A $10.00 Administrative Fee, due to processing services will be applied to all unpaid balances not paid by the due date on your monthly statement.

I authorize WEST BROWARD PEDIATRICS and it's agents Dr. Michael Morrison, Dr. Alicia Salland, Dr. Paole Paré, Brenda Austin, APRN, Amber Badal, APRN, and Kelly Stars, APRN to render any emergency care for my children if I cannot be located at the time of emergency.

PARENT/LEGAL GUARDIAN SIGNATURE (OR SIGNATURE OF PATIENT 18 YEARS OR OLDER):

_____ DATE:_____/_____/_____

PRINTED NAME:_____ STAFF INITIALS _____

Plantation Office
220 S.W. 84th Avenue
Suite 206
Plantation, FL 33324
(954) 423-2300

WEST BROWARD PEDIATRICS

HIPAA NOTICE OF PRIVACY PRACTICES

Weston Office
1040 Weston Road
Suite 310
Weston, FL 33326
(954) 384-8885

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 CAREFULLY.

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.

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 healthcare services to you, to pay your healthcare 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 healthcare and any related services. This includes the coordination or management of your healthcare with a third party. 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 healthcare services. For example, obtaining approval for a hospital procedure or 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 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 you. 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 Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings: Law Enforcement, Coroners, Funeral Directors and Organ Donors; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates. 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 requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures

These disclosure 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 receive a 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 PHI 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 restrictions 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 receive this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for an 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 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 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 our Privacy Officer, Tracey Benson at 954-423-2300, Ext 306 or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. **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 Privacy Officer, Tracey Benson at (954) 423-2300, Ext 306.

You signature below is only acknowledgement that you have received this Notice of our Privacy Practices for you and your child/children:

_____ _____

Child's Name Date of Birth

_____ _____

Child's Name Date of Birth

_____ _____

Child's Name Date of Birth

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name of Parent/Legal Guardian

WEST BROWARD PEDIATRICS

PATIENT'S HISTORY FORM

Patient's Name: _____ Date of Birth _____

Does the patient have a history of:	NO	YES	N/A	Comments
Serious past injury or accidents				
Surgeries				
Hospitalizations				
Chickenpox				
Frequent ear infections				
Problems with ears or hearing				
Asthma, bronchitis, bronchiolitis, pneumonia				
Heart problems or heart murmur				
Anemia or bleeding problem				
Blood transfusion				
Frequent abdominal pain				
Constipation requiring a doctor visit				
Bladder or kidney infection				
Bed-wetting (after 5 years of age)				
If female, have menstrual periods started?				
If female, any problems with periods?				
Chronic or recurrent skin problems? (Acne, Eczema)				
Frequent headaches				
Convulsions or other neurological problems				
Diabetes				
Thyroid or other endocrine problems				
Use of alcohol or drugs				
Other significant problems				

PATIENT'S ALLERGY HISTORY

Does the patient have an allergy to:	NO	YES	N/A	Comments
Patient has no known drug allergies (NKDA)				
Penicillin (Amoxicillin, Augmentin)				
Cephalosporins, (Ceclor, Keflex, Cefzil)				
Sulfa (Septra, Bactrim)				
Macrolides (Zithromax, Biaxin, Erythromycin)				
Any other antibiotics				
Peanuts				
Milk				
Eggs				
Seafood				
Other foods				
Bees/Wasps				
Indoor allergies				
Outdoor allergies				
Animal				
Latex				
Other				

WEST BROWARD PEDIATRICS

PATIENT'S / FAMILY'S SOCIAL HISTORY

Comments	NO	YES	N/A	Comments
Are parents married				
Divorced (under comments, put whom the patient lives with, Mom or Dad)				
Does non-custodial parent have visitation				
Does the patient have any brothers or sisters				
Does the family have any pets				
Are there any smokers in the home				

FAMILY'S MEDICAL HISTORY

History of mom, dad and patient's grandparents	NO	YES	N/A	Comments
Deafness				
Nasal allergies				
Asthma				
Tuberculosis				
Heart disease (prior to age 50)				
High blood pressure (prior to age 50)				
High cholesterol				
Anemia				
Bleeding disorder				
Liver Disease				
Kidney Disease				
Diabetes (prior to age 50)				
Bed-wetting (after 10 years of age)				
Epilepsy or convulsions				
Alcohol abuse				
Mental illness				
Mental retardation				
Immune problems, HIV, AIDS				
Additional pertinent conditions				

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____

Plantation Office
220 S.W. 84th Avenue
Suite 206
Plantation, FL 33324
(954) 423-2300

WEST BROWARD PEDIATRICS

Weston Office
1040 Weston Road
Suite 310
Weston, FL 33326
(954) 384-8885

RECORDS RELEASE AUTHORIZATION

ATTENTION: MEDICAL RECORDS DEPARTMENT

Name of Previous Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

I authorize and request you to release the following records for my Child/Children listed below to West Broward Pediatrics via e-mail **OR** fax below:

E-mail Address: Records@WestBrowardPediatrics.com

OR

Fax Number: (954) 424-4200

* Problem List
* Last Two Well Exams
* Last Two Sick Visits
* Growth Chart
* Full Immunization Record

* For Children six months of age and younger, please provide all records

_____ **I DO authorize** release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ **I DO NOT authorize** release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

Name of Parent or Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____

Witness: _____ Date: _____