

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 This Authorization will remain in effect until rescinded by myself in writing.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 _____

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.

Your 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 / 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 - HOSPITAL OR MEDICAL FACILITY

ATTENTION: MEDICAL RECORDS DEPARTMENT

Hospital or Medical Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

Please forward my child's records to West Broward Pediatrics by e-mail **OR** fax below:

E-mail Address: Records@WestBrowardPediatrics.com

OR

Fax Number: (954) 424-4200

I authorize and request you to release the following 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 _____

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: _____