AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENTS INFORMATION:

NAMES: **DOB:**

_____ _____

_____ _____

_____ _____

RELEASE MEDICAL RECORDS FROM:

OFFICE NAME: _____

PH#_____

FAX#_____

RELEASE MEDICAL RECORDS TO:

PORT ORANGE PEDIATRICS

1728 DUNLAWTON AVE #1

PORT ORANGE, FL 32127

PH# 386-322-5390 FAX# 386-322-5391

MEDICAL RECORDS TO BE RELEASED:

__ Office Visits __Radiology reports __Pathology/Laboratory reports

__ Imaging __Other

PURPOSE OF RELEASE:

__Transfer of Care to a new provider __Personal reasons

__Other (please specify) _____

__I DO __ I DO NOT authorize the release of information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment of alcohol/drug use.

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS):

_____ DATE: _____

Signature of Legal Representative

_____ _____

Printed name of Legal Representative Relationship to Patient

Port Orange Pediatrics, PA

1728 Dunlawton Ave. • Suite #1
Port Orange, FL 32127
386-322-5390

Names of Children **(Please Print)** **Date**_____

Last Name	First Name	Middle	Sex M/F	Date of Birth	Social Security Number

(Please list additional children on the back)

Patient Address _____ **City**_____ **ST**_____ **Zip**_____

Home Phone Number (_____)_____

Emergency Contact Other Than Parents _____

Relationship of Emergency Contact _____ **Phone Number (_____)**_____

Name of Additional Caretaker _____ **Relationship** _____ **Phone Number (_____)**_____
(Example: stepparent, grandparent, babysitter, etc.)

Responsible Party Information

Father/Legal Guardian			Mother/Legal Guardian		
Name			Name		
Birthdate	SSN		Birthdate	SSN	
Address			Address		
City	ST	Zip	City	ST	Zip
Home Phone ( )			Home Phone ( )		
Cell Phone ( )			Cell Phone ( )		
Employed By			Employed By		
Occupation			Occupation		
Work Phone ( )			Work Phone ( )		
Email Address			Email Address		

Insurance Information

(Please furnish us with a copy of your insurance card.)

NOTE: Patients who carry health insurance should remember that payment for our services is the responsibility of the insured, and patients are expected to pay their co-pay at the time of service. Any balance not covered by insurance is due and payable upon receipt of billing statement.

Primary Insurance		Secondary Insurance	
Name of Insured		Name of Insured	
Relationship to Patient		Relationship to Patient	
ID #	Group #	ID #	Group #

ACKNOWLEDGEMENT OF RECEIPT: I hereby acknowledge that I have received the Notice of Privacy Practices of Port Orange Pediatrics, PA. I understand this notice contains information regarding how Port Orange Pediatrics, PA uses my medical information.

ASSIGNMENT AND RELEASE: I hereby authorize Port Orange Pediatrics, PA, to treat and to furnish information to insurance carriers concerning treatment, and I hereby assign to the provider all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also authorize Port Orange Pediatrics, PA to make reasonable disclosures of my children's Personal Health Information to parents, schools, doctors, and others involved in their care, unless otherwise specified.

Parent's Signature _____ Date_____

PATIENT HISTORY

Port Orange Pediatrics, PA

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386-322-5390

Today's Date_____/_____/_____

Patient's Name _____ Date of Birth_____/_____/_____

Patient's Past History:

notes:

1. At what age did your child Start Talking? _____.
2. Has your child had more than 4 ear infections? ..... Y N
3. Does your child usually have more than 5 colds, sore throats or respiratory illness each year?..... Y N
4. Does your child usually get an ear infection after a cold?..... Y N
5. Does your child seem to have a continuous stuffy nose or constant cold?..... Y N
6. Has your child had "ASTHMA" or "WHEEZING"?..... Y N
7. Has your child had any feeding or gastrointestinal problems?..... Y N
8. Has your child had any problems with urination or urinary tract (kidney) infections?..... Y N
9. Has your child had any heart problems? ..... Y N
   What?_____
10. Has your child ever had a convulsion or seizure?..... Y N
11. Has your child had any visual or eye problems?..... Y N
12. Has your child had any ALLERGIC REACTION TO MEDICATIONS? What?_____ Y N
13. Have any of your children died?..... Y N
14. Has your child ever been hospitalized or had any surgery?..... Y N
    What for?_____
15. Does your child have any other medical or psychological problems that we should know about? Y N
    What?_____
16. Do you have any concerns about your child's development?..... Y N

FAMILY HISTORY

Please list any family members having the following problems; include parents, grandparents, aunts, uncles, and cousins.
Answer as if answering for your child.

Mark an "X" in the box to all that apply.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling 1	Sibling 2
Obesity								
Cardiovascular Disease								
High Blood Pressure								
High Cholesterol								
Diabetes								
Thyroid Problems								
Asthma								
Allergies/Hay Fever								
Inherited Disorders								
Psychiatric Disorders								

Office Policies of Port Orange Pediatrics, PA

1. Appointments & Scheduling

- All visits require an appointment unless otherwise directed.
- Same-day sick appointments are available on a first come, first serve basis.
- Well-child visits should be scheduled in advance to ensure timely preventive care.
- Late arrivals (more than 15 minutes) will need to be rescheduled.

- We require at least 24 hours' notice for cancellations.

2. Vaccination Policy

- Our practice follows the immunization schedule recommended by the American Academy of Pediatrics.
- We strongly encourage timely vaccination to protect all children in our practice.
- In the case of delayed vaccines or following a different immunization schedule than what is recommended by the American Academy of Pediatrics, we **require** the parent to know which vaccines they want **at the time** of the child's appointment. If you have a religious exemption, please provide the office a copy of this document so we may have it on file.

3. Medication Refills

- Please allow 48–72 business hours for routine refill requests.
- ADHD medication refills need to be submitted one week prior to needing medication. It is a requirement to have a medication check appointment every three months to continue to receive medications.

4. Forms & School/Daycare Paperwork

- Please allow 48 to 72 hours for completion of forms.
- **A fee of $10 may apply for forms that need to be completed same day**.
- **If your child needs a note for a school excuse, the child must be seen in-office.**

5. Communication & Patient Portal

- Non-urgent questions are encouraged through our secure patient portal.
- Medications will not be prescribed through portal messages for acute conditions. The child must be seen in-office for formal evaluation.
- The portal should **not** be used for urgent medical concerns.

6. Dismissal from Practice

- Reasons for dismissal may include repeated no-shows, non-payment or inappropriate behavior.
- Written notice will be provided in accordance with state regulations. Emergency care will be provided for 30 days following dismissal.

_____ _____

PARENT SIGNATURE **DATE**