COMPASSION PEDIATRICS & URGENT CARE

NEW PATIENT PACKAGE

PATIENT INFORMATION:

Patient Last Name, First Name:	Birth Date:	Male ☐ Female ☐	Social Security#
Street Address:		Apt#	Contact Phone:
City:	State:	Zip Code:	E-mail:

PARENT/ LEGAL GUARDIAN INFORMATION:

Parent/ Legal Guardian's Name:	Birth Date:	Social Security#
Cell Phone:	Work Phone:	Place of Employment/ Occupation:
Parent/ Legal Guardian's Name:	Birth Date:	Social Security#
Cell Phone:	Work Phone:	Place of Employment/ Occupation:

EMERGENCY CONTACT:

Name:	Cell Phone:	Home Phone:	relationship:
Name:	Cell Phone:	Home Phone:	relationship:

PRIMARY INSURANCE INFORMATION:

Insurance Name:	Insurance Phone:
Policy Holder Name:	Realtionship with Patient:
ID/ Policy #	Group #
Insurance Address:	City and State:

SECONDARY INSURANCE INFORMATION:

Insurance Name:	Insurance Phone:
Policy Holder Name:	Realtionship with Patient:
ID/ Policy #	Group #
Insurance Address:	City and State:

*I certify that the above information is correct to the best of my knowledge. I release to Compassion Pedicatrics & Urgent Care, it's employees and clinicians from all liabillity for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Parent/ Legal Guardian & Person Financially Responsible:

SIGNATURE: _____ **DATE:** _____

COMPASSION PEDIATRICS & URGENT CARE

NEW PATIENT PACKAGE

PATIENT HISTORY:

Patient's Name: _____ **D.O.B:** _____ **Date:** _____

Name of all person's living in the patient home at the present time:

NAME:	AGE:	REALTIONSHIP:	OCUPATION:

LANGUAGES SPOKEN:

☐ English ☐ Spanish ☐ Portuguese ☐ French ☐ Creole

☐ Chinese ☐ Other (s) most fluent first: _____

ETHNICITY:

☐ Hispanic ☐ Not Hispanic ☐ Prefer not to answer ☐ Other: _____

ETHNICITY:

☐ White ☐ Black ☐ Asian ☐ Hawailan Native ☐ Pacifin Islander

Prefer not to answer Other: _____

SOCIAL HISTORY:

☐ Home ☐ Daycare ☐ School (Grade) : _____

☐ Pets: Dog(s): _____ Cat(s) : _____ Other(s) : _____

☐ Smoker: ☐ Tobacco ☐ Other: _____

PHARMACY:

* This is where all of your prescriptions will be electronically send in the near future.

* We need at least phone number of the pharmacy of your preference.

☐ CVS ☐ Walgreens ☐ Publix ☐ Target ☐ Wal-mart

☐ Other: _____

Address: _____

Phone: _____

COMPASSION PEDIATRICS & URGENT CARE

NEW PATIENT PACKAGE

PATIENT MEDICAL HISTORY:

Patient's Name: _____ **D.O.B:** _____ **Date:** _____

BIRTH HISTORY:

Where was the patient born? (Hospital and City) _____

☐ Birth Wt. : _____ Birth Ht.: _____ Gestational Age (Weeks) _____

☐ Cesarean Section ☐ NSVD (vaginal delivery)

Problems/ Complications (list):

_____

_____

_____

ALLERGIES:

☐ MEDICATION: (List type of reaction)

_____

☐ FOOD : (List type of reaction)

_____

☐ OTHER (s) : (List type of reaction)

_____

FAMILY MEDICAL HISTORY (check & circle all that apply) :

☐ Heart Disease : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

☐ Asthma : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

☐ Cancer : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

Type of Cancer: _____

☐ Diabetes : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

☐ Ovarian Cyst : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

☐ Thyroid Disease : Mom Dad Maternal Grandma Paternal Grandma Aunt Uncle Brother Sister.

Type of Thyroid Disease : _____

☐ Other(s): (list): _____

FAMILY MEDICAL HISTORY (check & circle all that apply) :

Past Surgical History:

☐ Tonsils Removed ☐ Adenoids Removed ☐ Inguinal Hernia Repair

☐ Ear Tube Placement ☐ Heart

Surgery: _____

Broken Bone (surgical repair): _____

Other (s): _____

Continue... Patient Medical Hsitory:

Hospitalizations: ☐ None ☐ Yes.

Reason (If any): _____ Date: _____

Medications:

☐ Daily Medications or Vitamins (include dosage) :

_____

_____

☐ Medications Taken Today (include dosage) :

_____

_____

Has Patient ever had any of the following: (check as many as apply)

- ☐ ADD / ADHD
- ☐ Allergic Rhinitis (allergies)
- ☐ Anemia, Hemophilla
- ☐ Asthma
- ☐ Atopic Dermatitis (Eczema)
- ☐ Autism
- ☐ Bronchitis / Wheezing
- ☐ Cancer
- ☐ Cerebral Paisy
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Frequent Ear Infections
- ☐ Hay Fever / Allergy
- ☐ Heart Murmur
- ☐ High Boold Pressure
- ☐ High Colesterol
- ☐ Obesity
- ☐ Pneumonia
- ☐ Seizures (Epillepsy)
- ☐ Sinisitis
- ☐ Varicella (chickenpox)
- ☐ Other (s): List:

Date: _____

I would like to discuss the following concern (s):

_____

_____

_____

_____

SIGNATURE: _____ **DATE:** _____

(Patient/ Parent/ Legal Guardian)

COMPASSION PEDIATRICS & URGENT CARE

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child (as patient of this practice) or you (as patient of this practice) may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy:

Compassion Pediatrics & Urgent Care is dedicated to maintaining the Privacy of its patient's protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend our Notice. By federal and state law we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI:

Our practice may use and disclose PHI for the purposes of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes.

- Treatment
- Payment
- Health Care of Information
- Release or Sharing of Information
- The Rights of Minors and Personal Representatives
- Release of Information to Business Associates
- Release of Information Required by Law
- Research Purposes
- Marketing Purposes

Your Health Information Rights:

You have the following rights regarding the PHI that we maintain about your child or you

- Requesting Restrictions on PHI
- Inspection and Copies of PHI
- Amendment of PHI
- Accounting of Disclosure
- Right to a paper copy of this notice
- Right to File a Complaint
- Right to Provide an Authorization of Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Lesley K. Bow at (407) 203-8957.

I have read this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitle to receive a copy of your Notice of Privacy Practices.

_____ _____

Patient Name (print or type) Date

_____ _____

Signature of Patient (legal Guardian) Relationship with Patient.

COMPASSION PEDIATRICS, LLC
4445 S.Semoran Blvd Suite A
Orlando, Florida 32822
TEL. 407-203-8957
FAX 407-985-1904

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ ,hereby authorize Compassion Pediatrics, LLC to:
Patient/Legal representative

[ ] Allow review (open and closed records)
[ ] Release copies of Protected Health Information _____
[ ] Obtain records Patient

From: Name of Individual, Healthcare facility or agency

_____
_____
Address City State Zip Code

Send records to: _____
_____
Address City State Zip Code

For the purpose of: [ ] Continued Treatment [ ] Personal Use
[ ] Patient Communication [ ] Other (please specify) _____
(Behavioral Health)

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

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, IV 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. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule. I further understand that Compassion Pediatrics, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

____ Complete Record
or
____ Abstract of Record

____ All Diagnostic Test results
____ Therapy Records
____ Consultation/Progress Note(s)
____ Radiology only

____ Pathology/Operative Report(s)
____ Lab only
____ Other (please specify) _____

In addition, place your initials by each specific item: (if applicable)

____ Mental Health
____ Drug and/or Alcohol
____ HIV Testing
____ Genetic Couseling/Testing Information
____ AIDS Information

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

_____ _____
Patient's Date of Birth Patient's Social Security Number

_____
Address City State Zip Code

_____ _____
Telephone Number Translator or Interpreter's Name

[ ] I wish to revoke this authorization
Patient Signature: _____ Date: _____

Official Use Only: _____ Date: _____
[ ] Name of Person Releasing Information [ ] Name of Person Assisting with Review
Number of pages copied ____

COMPASSION PEDIATRICS & URGENT CARE

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 years to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name _____ _____
Last Name, First Name, Middle Name Date of Birth

For occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____ _____
Name Relationship to Patient Phone number

_____ _____ _____
Name Relationship to Patient Phone number

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for: _____ days only, or _____ (initial here) indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance. By signing form parent or legal guardian agrees and grants authorization to the individual(s) above to sign consent for immunization administration as well as any minor procedures. Compassion Pediatrics, LLC assumes that both parties are in complete agreement and therefor will be not be held responsible for any miscommunication between parties.

It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____ _____
Parent or Legal Guardian Signature Relationship to Patient Date

_____ _____
Printed Name Phone number

COMPASSION PEDIATRICS & URGENT CARE

NO SHOW OR CANCELLATION POLICY

Any cancellations that occur less than 24 hours prior to the appointment time will accrue a **No Show** charge of $25.00 and must be paid upon arrival before the patient can be seen.

If the patient calls 24 hours prior to their appointment time they will not be charged for the No Show.

After 3 **No Shows** within the same year the patient will be released from the office. _____

PATIENT NAME: _____ **D.O.B.** _____

_____ _____ _____

PARENT OR GUARDIAN NAME **SIGNATURE** **DATE**