Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

Permissions

Current Insurance Information and Valid Identification is REQUIRED to be presented at

EVERY appointment at the time of check in.

We understand that at times this is an inconvenience however it is for the safety of our patients and it enables our office to provide the best service we can.

I, ______________________________ ,give the person(s) listed below permission to be involved in the medical care of

Name: ____ Date of Birth: _______________ .
Last First (mm/dd/yyyy)

This authorization grants **Volusia Pediatrics, LLC** permission to release necessary medical information to the listed person(s), call in regards to appointments, labs, referrals and allows them to accompanying my child to appointments.

Name____Relationship to Patient ___________________________

Home Phone # (___)__________________ Cell Phone # (___)__________________Work Phone # (___)________________

Name____Relationship to Patient ___________________________

Home Phone # (___)__________________ Cell Phone # (___)__________________Work Phone # (___)________________

Name____Relationship to Patient ___________________________

Home Phone # (___)__________________ Cell Phone # (___)__________________Work Phone # (___)________________

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Name____Relationship to Patient ___________________________

Home Phone # (___)__________________ Cell Phone # (___)__________________Work Phone # (___)________________

Name____Relationship to Patient ___________________________

Home Phone # (___)__________________ Cell Phone # (___)__________________Work Phone # (___)________________

____________________________________ ___/___ /___

Parent / Guardian Signature **Date**

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The policies documented below are to be applicable to the following child:

Name: _____ Date of Birth: _____
Last First (mm/dd/yyyy)

All policies are applicable to all person(s) involved in child's care.

NO SHOW POLICY:

You are required to notify the office of cancellation or re-schedule at least **24 hours in advance** of your appointment. If the office is not notified in advance or you are later than 15 minutes for your appointment time, it is considered a "No Show". After three "No shows" the office reserves the right to discharge your child(ren) from the practice.

SAME DAY POLICY:

Appointments for same day are made at the first available time. Due to the limited amount of appointments available, if multiple same day appointments are cancelled or no-showed by the patient then the office reserves the right to schedule the patient for next day appointments only.

CONFIRMATION POLICY:

You are required to confirm your scheduled appointment at least **24 hours in advance** of your appointment. If the office is unable to confirm your appointment, the office reserves the right to book over your scheduled appointment.

PEDIATRIC CARE

You may select any of our physicians as your primary pediatrician. Please inform the front office staff to notate this information in your child(ren)'s account. However, there may be times that your child(ren) will need to be seen on an urgent basis when your physician is not available. If this should occur, one of our other physicians will be happy to provide your child(ren) with care. Since our physicians share the responsibility of your pediatric care, your office visits will be rotated unless specifically requested. If the patient needs to be seen for an urgent matter then they will be scheduled with the first available physician.

Please Select One: ( ) Garcia, MD ( ) Chiapco, MD ( ) Chopra, MD ( ) Banfield, MD ( ) Worley, MD ( ) Smith, ARNP
( ) Powell, ARNP ( ) No Preference

_____ _____/____/_____
Parent / Guardian Signature Date