

Please fill out the following information. All pages must be signed where indicated.

We request this information to be updated annually for all patients. Thank you!

Name:		Date of Birth:	Sex: M / F SS#:
Last			
			nder Ethnicity: Not Hispanic or Latin
☐ Black or Africar	ı American □ White □Hispanic	Other Race	
	_	_	☐ Unreported / Refused to Report
Patient Lives with	Mother and Father Mother Onl	ly Father Only Other	(Please Specify)
			S# Date of Birth//
Place of Employment	Occupatio	n	Work#
Father/Legal Guardia	ın Name	S:	S# ⁻ Date of Birth//
Place of Employment	Occupatio	n	Work #
Home Address			
Mailing Address	(Street)	(City)	(State) (ZIP)
(If Different)	(Street)	(City)	(State) (ZIP)
Primary Phone #		Secondary Phone	· #
Siblings that are or w	vill be patients of Volusia P	'ediatrics:	
Name:	Date of Birth:	Relation:	Same Home Address: Y / N
Last	First (m	nm/dd/yyyy)	,
Name:	Date of Birth:	Relation:	Same Home Address: Y / N
Name:	Date of Birth:	Relation:	Same Home Address: Y / N
Last	First (m	nm/dd/yyyy)	Same Home Address: Y / N
Email Address			
(To be u	used for Patient Portal, E-Confirmations a	nd health related communications only)	
Name of Insurance		_ID #	Group#
Policy Holders Name			
		Treatment Agreement:	
I authorize Volusia Pedia	ntrics. LLC. its physicians and suppor	<u>Treatment Agreement:</u> t staff to medically treat and/or adm	ninister necessary medication and/or immunizations when
	ble in the diagnosis and/or treatmer	•	mister recessary measurements.
·	-	Financial Agreement:	
I request that payment o	f authorized Health Insurance benef		a Pediatrics, LLC for any services furnished to me by that
		·	ephone) to the Health Care Financing Administration of
•			s payable for relatable services. I agree to pay all fees,
			on of Health Insurance, within 60 days. In the event legal
			me, I agree to pay reasonable attorney's fees or other pted. NO SHOW VISITS MAY BE ASSESSEED A \$25.00 FEE
Decemb / Cuardian	20		
Parent / Guardian S	signature	Date	







Please fill out the following information to the best of your ability so that we can provide the best care possible

Birth History	New Patient History Form				
Delivery Vaginal C - Section Complications No Yes	Name	DOB			
Complications No Yes Daycare	Birth History			Social History	
Complications No Yes Daycare	Delivery Vaginal C - Section			Child Lives with	
Full Term Pre-Term Weeks Smoker No Yes Birth Weight Ibs Pets Immunizations Up to Date No Yes During Pregnancy did Mom: Smoke No Yes During Pregnancy did Medications No Yes Dury Acid Refux (GERD), Colic No Yes Dury Acid Refux (GERD		S No	Yes	_	П., П.
Birth Weight Ibs Pets Immunizations Up to Date No Yes Medication Allergies No Yes Wes Ves Ve				Daycare	∐No ∐Yes
Feeding Breast Bottle During Pregnancy did Mom: Smoke No Yes Drink alcohol No Yes Used controlled substances or medications No Yes Used controlled substances or medications No Yes Past Medical History Does your child have or have ever had: Developmental / Mental Delay Problems with Vision or Hearing No Yes Acid Reflux (GERD), Colic No Yes Acid Reflux (GERD), Colic No Yes Ear Infections Single Reccurring Ear Tubes Strep Throat Single Recurring Removed Adnoids Tonsils Sinus Problems Chest Cold No Yes Asthma, Bronchitis, Bronchiolitis, Pneumonia No Yes Chronic or recurrent skin problems / Eczema No Yes Heart Problems No Yes Reart Problems No Yes Heart Problems No Yes Asthma, Bronchitis, Bronchiolitis, Pneumonia No Yes Heart Problems Chronic or recurrent skin problems / Eczema No Yes Heart Problems No Yes Heart Problems No Yes Anemia or Bleeding problems No Yes Anemia or Bleeding problems No Yes Constitation requiring doctor visits No Yes Red Wetting (after 5 years old) No Yes Constitation requiring doctor visits No Yes Red Wetting (after 5 years old) No Yes Conversed Seasonal / Year-cound allergies No Yes Conversed Seasonal / Year-cound allergies No Yes Conversed Seasonal / Year-cound allergies No Yes Chronic skin problems No Yes Conversed Seasonal No Yes Conversed Se	Full Term Pre-Term Weeks	<u>—</u>		Smoker	No Yes
During Pregnancy did Mom: Smoke No Yes Drink alcohol No Yes Orink alcohol No Yes Surgery No Yes Orink alcohol Albae Orink alcohol No Yes Orink Alcohol Albae Orink alcohol No Yes Orink alcohol No Yes Orink Alcohol Albae Orink Orink Albae Orink Albae Orink Orink Albae Orink Orink Albae Orink Ori	Birth Weightlbs			Pets	No Yes
Drink alcohol No Yes	Feeding Breast Bottle			Immunizations Up to Date	□No □Yes
Drink alcohol No Yes	During Pregnancy did Mom: Smok	e No	Yes	Medication Allergies	 □No □Yes
Past Medical History Does your child have or have ever had: Developmental / Mental Delay Problems with Vision or Hearing Acid Reflux (GERD), Colic Ear Infections Single Reoccurring Ear Tubes Strep Throat Single Removed Adnoids Tonsils Sinus Problems Removed Adnoids Tonsils Sinus Problems No Yes Asthma, Bronchiolitis, Pneumonia Asthma, Bronchiotis, Pneumonia No Yes Seasonal / Year-round allergies No Yes Chronic or recurrent skin problems Anemia or Bleeding problems No No Yes Bed Wetting (after 5 years old) No Yes Bed Wetting (after 6 years old) No Yes Behavioral / Mental problems No Yes Does your child have any other conditions Not mentioned above		= =			
Past Medical History Does your child have or have ever had: Developmental / Mental Delay Problems with Vision or Hearing Acid Reflux (GERD), Colic Ear Infections Single Reoccurring Ear Tubes Strep Throat Single Removed Adnoids Tonsils Sinus Problems Removed Adnoids Tonsils Sinus Problems No Yes Asthma, Bronchiolitis, Pneumonia Asthma, Bronchiotis, Pneumonia No Yes Seasonal / Year-round allergies No Yes Chronic or recurrent skin problems Anemia or Bleeding problems No No Yes Bed Wetting (after 5 years old) No Yes Bed Wetting (after 6 years old) No Yes Behavioral / Mental problems No Yes Does your child have any other conditions Not mentioned above	used controlled substances or medications		⁄es		
Does your child have or have ever had: Developmental / Mental Delay Problems with Vision or Hearing Acid Reflux (GERD), Colic Ear Infections Single Reccurring Ear Tubes Strep Throat Single Recurring Removed Adnoids Tonsils Sinus Problems Sinus Problems Sinus Problems No Yes Asthma, Bronchitis, Bronchiolitis, Pneumonia Past Nebulizer / Inhaler Use Seasonal or year-round allergies No Yes Seasonal or year-round allergies No Yes Heart Problems Sinus Problems No Yes No Yes No Yes No Yes No Yes No Yes Seasonal Or year-round allergies No Yes Heart Problems No Yes Sinus Problems No Yes No Yes No Yes No Yes Seasonal or year-round allergies No Yes Heart Problems No Yes No Yes No Yes No Yes No Yes No Yes Seasonal Or year-round allergies No Yes Heart Problems No Yes No Yes Chest Cold No Yes Cancer No Yes Seasonal Or year-round allergies No Yes Heart Problems No Yes No Yes Cancer No Yes Seasonal Or year-round allergies No Yes Heart Problems No Yes Chest Cold No Yes Cancer No Yes Seasonal Or year-round allergies No Yes No Wes No Wes No Wes Chest Cold No Yes Cancer No Yes Seasonal Or year-round allergies No Yes No Wes No Wes No Wes No Wes Chest Cold No Yes Cancer No Yes Seasonal Or year-round allergies No Wes Deafness (Born With) No Yes Epilepsy or convulsions No Yes Chicken Pox No Yes No Yes Does your child have any other conditions No Wes No Wes Does your child have any other conditions No Wes Does your child have any other conditions Not mentioned above	Past Medical History			Family History	,
Problems with Vision or Hearing	Does your child have or have ever had:			,	
Acid Reflux (GERD), Colic	Developmental / Mental Delay	No No	Yes	Seasonal or year-round allergies	No Yes
Ear Infections Single Reoccurring Ear Tubes Strep Throat	Problems with Vision or Hearing	No N	Yes	Bleeding Disorders	No Yes
Single	Acid Reflux (GERD), Colic		Yes	Heart Problems	No Yes
Ear Tubes Strep Throat Single Recurring Removed Adnoids Tonsils Sinus Problems Asthma, Freq bronchitis No Yes Past Nebulizer / Inhaler Use No Yes Seasonal / Year-round allergies No Yes Seasonal / Year-round allergies No Yes Seasonal or Pecurrent skin problems No Yes Seasonal or Pecurent skin	Ear Infections		Yes	(Before 50 years of age)	
Strep Throat Single Recurring Removed Adnoids Tonsils Sinus Problems Ashma, Freq bronchitis No Yes pneumonia /emphysema Sinus Problems No Yes Chest Cold No Yes Ashma, Bronchilitis, Pneumonia No Yes Ashma, Bronchilitis, Pneumonia No Yes Past Nebulizer / Inhaler Use No Yes Seasonal / Year-round allergies No Yes Chronic or recurrent skin problems No Yes Chronic or recurrent skin problems No Yes Anemia or Bleeding problems No Yes Constipation requiring doctor visits No Yes Bed Wetting (after 5 years old) No Yes Convulsions or other neurologic problems No Yes Chicken Pox No Yes Bladder or Kidney infections No Yes Surgery No Yes Surgery Sinus Problems Ashma, Freq bronchitis No Yes Sinus Problems Ashma, Freq bronchitis No Yes Ashma, Freq bronchitis No Yes Ashma, Freq bronchitis No Yes Diabetes (before 50 years old) No Yes Cancer No Yes Kidney Disease No Yes Kidney Disease No Yes Bedwetting (after 10 years old) No Yes Cancer No Yes Deafness (Born With) No Yes Liver disease No Yes Epilepsy or convulsions No Yes Sepilepsy or convulsions No Yes Se				o a constant of the constant o	No Yes
Single Recurring Removed Adnoids Tonsils No Yes Post P					
Removed Adnoids Tonsils Sinus Problems Chest Cold Asthma, Bronchitis, Bronchiolitis, Pneumonia No Yes Asthma, Bronchitis, Bronchiolitis, Pneumonia No Yes Past Nebulizer / Inhaler Use No Yes Seasonal / Year-round allergies Chronic or recurrent skin problems / Eczema No Yes Chronic or recurrent skin problems / Eczema No Yes Anemia or Bleeding problems Constipation requiring doctor visits Bed Wetting (after 5 years old) No Yes Convulsions or other neurologic problems No Yes Chicken Pox Thyroid or other endocrine problems No Yes Bladder or Kidney Disease No Yes Bedwetting (after 10 years old) No Yes Epilepsy or convulsions No Yes Migraine Headaches No Yes Chesity No Yes Does your child have any other conditions not mentioned above Frequent Headaches No Yes Surgery No Yes Surgery No Yes Surgery No Yes No Yes Does your child have any other conditions not mentioned above		∐No ∐\	Yes		
Sinus Problems				•	NoYes
Chest Cold Asthma, Bronchitis, Bronchiolitis, Pneumonia No Yes Past Nebulizer / Inhaler Use Seasonal / Year-round allergies Chronic or recurrent skin problems / Eczema Heart Problems Anemia or Bleeding problems Constipation requiring doctor visits Bed Wetting (after 5 years old) No Yes Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems No Yes Bladder or Kidney infections ADHD / Behavioral / Mental Problems No Yes Surgery Diabetes (before 50 years old) No Yes TB / HIV No Yes Cancer No Yes Kidney Disease No Yes Kidney Disease No Yes Chronic skin problems No Yes Deafness (Born With) No Yes Epilepsy or convulsions No Yes Migraine Headaches No Yes Behavioral / Mental problems No Yes Does your child have any other conditions not mentioned above (For Girls) Issues with her periods No Yes Surgery No Yes				, , ,	
Asthma, Bronchiolitis, Pneumonia No Yes Past Nebulizer / Inhaler Use No Yes Seasonal / Year-round allergies No Yes Chronic or recurrent skin problems / Eczema No Yes Heart Problems No Yes Anemia or Bleeding problems No Yes Constipation requiring doctor visits No Yes Bed Wetting (after 5 years old) No Yes Convulsions or other neurologic problems No Yes Chicken Pox Thyroid or other endocrine problems No Yes Bladder or Kidney Disease No Yes Bed Wetting (after 5 years old) No Yes Chicken Pox Thyroid or other endocrine problems No Yes Bladder or Kidney infections ADHD / Behavioral / Mental Problems No Yes Surgery TB / HIV No Yes Cancer No No Yes Kidney Disease Bedwetting (after 10 years old) No Yes Kidney Disease No Yes Kidney Disease No Yes Chronic skin problems No Yes Deafness (Born With) No Yes Epilepsy or convulsions No Yes Bedwetting (after 10 years old) No Yes Deafness (Born With) No Yes Epilepsy or convulsions No Yes Bepilepsy or convulsions No Yes Migraine Headaches No Yes Does your child have any other conditions No Yes Does your child have any other conditions No Tes Does your child have any other conditions Not mentioned above				,	=
Past Nebulizer / Inhaler Use					
Seasonal / Year-round allergies		= =		•	
Chronic or recurrent skin problems / Eczema No Yes Heart Problems Anemia or Bleeding problems No Yes Constipation requiring doctor visits No Yes Bed Wetting (after 5 years old) Frequent Headaches No Yes Convulsions or other neurologic problems No Yes Chicken Pox Thyroid or other endocrine problems No Yes Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her periods Supperson No Yes Surgery No Yes Bedwetting (after 10 years old) No Yes Chronic skin problems No Yes Epilepsy or convulsions No Yes Migraine Headaches No Yes Bedwetting (after 10 years old) No Yes Chronic skin problems No Yes Epilepsy or convulsions No Yes Behavioral / Mental problems No Yes Alcohol Abuse Does your child have any other conditions not mentioned above No mentioned above	· ·	∐No ∐'	Yes		No Yes
Heart Problems Anemia or Bleeding problems Constipation requiring doctor visits Bed Wetting (after 5 years old) Frequent Headaches Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Anemia or Bleeding problems No Yes No Yes Deafness (Born With) No Yes Deafness (Born With) No Yes Epilepsy or convulsions No Yes Behavioral / Mental problems No Yes Obesity Alcohol Abuse No Yes Does your child have any other conditions not mentioned above No Yes	_	= =		·	No Yes
Anemia or Bleeding problems	Chronic or recurrent skin problems / Eczema No	∘∐ ∐'	Yes	Bedwetting (after10 years old)	No Yes
Constipation requiring doctor visits Bed Wetting (after 5 years old) No Yes Frequent Headaches Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems Bladder or Kidney infections ADHD / Behavioral / Mental Problems No Yes No Yes Does your convulsions No Yes Behavioral / Mental problems No Yes Alcohol Abuse No Yes Drug Abuse No Yes Does your child have any other conditions not mentioned above (For Girls) Issues with her periods Surgery No Yes	Heart Problems	No No	Yes	Chronic skin problems	No Yes
Bed Wetting (after 5 years old) Frequent Headaches Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Epilepsy or convulsions Migraine Headaches Migraine Headaches No Yes Behavioral / Mental problems No Yes Obesity Alcohol Abuse Drug Abuse Does your child have any other conditions not mentioned above Mo Yes No Yes	Anemia or Bleeding problems	No No	Yes	Deafness (Born With)	No Yes
Frequent Headaches Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Migraine Headaches No Yes Behavioral / Mental problems No Yes Obesity Alcohol Abuse Drug Abuse Does your child have any other conditions not mentioned above No Yes	Constipation requiring doctor visits	□ No □	Yes	Liver disease	No Yes
Convulsions or other neurologic problems Chicken Pox Thyroid or other endocrine problems Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Behavioral / Mental problems No Yes Obesity Alcohol Abuse Drug Abuse Drug Abuse Does your child have any other conditions not mentioned above No Yes No Yes No Yes Does your child have any other conditions not mentioned above	Bed Wetting (after 5 years old)	□ No □	Yes	Epilepsy or convulsions	No Yes
Chicken Pox	Frequent Headaches	□ No □	Yes	Migraine Headaches	No Yes
Thyroid or other endocrine problems Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Alcohol Abuse Drug Abuse Drug Abuse Does your child have any other conditions not mentioned above No Yes	Convulsions or other neurologic problems	□ No □	Yes	Behavioral / Mental problems	No Yes
Bladder or Kidney infections ADHD / Behavioral / Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Drug Abuse Drug Abuse Does your child have any other conditions not mentioned above No Yes No Yes No Yes	Chicken Pox	□ No □	Yes	Obesity	No Yes
ADHD / Behavioral /Mental Problems (For Girls) Started her period (For Girls) Issues with her periods Surgery Does your child have any other conditions not mentioned above No Yes No Yes No Yes	Thyroid or other endocrine problems	□ No □	Yes	Alcohol Abuse	No Yes
(For Girls) Started her period No Yes not mentioned above (For Girls) Issues with her periods No Yes Surgery No Yes	Bladder or Kidney infections	□ No □	Yes	Drug Abuse	No Yes
(For Girls) Issues with her periods No Yes Surgery No Yes	ADHD / Behavioral /Mental Problems	□No □\	Yes	Does your child have any other cor	nditions
(For Girls) Issues with her periods No Yes Surgery No Yes	(For Girls) Started her period	No No	Yes		
Surgery No Yes	<u> </u>	=			
	1	=			
Trospital Admission	Hospital Admission	No No	Yes		



Current Insurance Information and Valid Identification are required at every appointment at the time of check in.

Permissions

				Date of Birth:
This authorization	grants Volusia Pe	ediatrics, LLC permission	to re	ease necessary medical information to the listed person(s), call parts and many 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 # ()
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 # ()
	ian Signature			//



The policies documented below are applicable to the following patient: Date of Birth: -Name: -(mm/dd/yyyy) All policies are applicable to all person(s) involved in child's care. **VACCINE POLICY:** Please read and sign the attached Vaccine Policy. Medical Exemptions are the only acceptable exception to this policy. **ePrescribing Policy:** Please read and sign the attached ePrescribing policy. INSURANCE CARD/IDENTIFICATION CARD POLICY: The patient's current insurance information and your valid identification card are required at every appointment. **NO SHOW POLICY:** You are required to notify the office of cancellation or re-schedule prior to your appointment date and time. 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. NO SHOW VISITS MAY RESULT IN A \$35.00 FEE **SAME DAY POLICY:** Appointments for same day are made at the first available time. Due to the limited number 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 providers as your primary care provider. 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 preferred provider is not available. If this should occur, one of our other providers will be happy to provide your child(ren) with care. **FORMS FEE:** There will be a \$10.00 fee for any form that is requested outside of the regular well child visit. Forms will be provided at no-charge during in-office well child visits. **RECORDS FEE:** Records will be sent directly to any other medical providers at your request, at no charge. Printed records provided to you have a charge of \$1.00 per page for the first 25 pages, additional pages are charged \$0.25 per page. Records provided on a CD are charged a \$25.00 fee. Please Select One: 🗌 Dr. Cristina Garcia 🔲 Ann Schlaefer, APRN, DNP 🔲 Taylor Castellano, APRN 🗀 Stephanie Bryant APRN ☐No Preference

Date

Parent / Guardian Signature







This notice describes how health information about your child (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance

Portability and Accountability Act of 1996 (HIPAA).

Notice of Privacy Practices

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy if your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

- 1. To public health authorities and health oversight agencies that are authorized by law to collect information.
- 2. Lawsuits and similar proceedings in response to a court or administrative order.
- 3. If required to do so by a law enforcement official
- 4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
- 5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 6. To federal officials for intelligence and national security activities authorized by law.
- 7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- 8. For Workers Compensation or similar programs.

Your rights regarding your health information

- 1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather that work. We will accommodate reasonable requests.
- 2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical
 records and billing records, but not including psychotherapy notes. You must submit your request in writing to Volusia Pediatrics, LLC 317 South Dixie
 Freeway, New Smyrna Beach, FL 32168 (386) 424-1414.
- 4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment your request must be made in writing to Volusia Pediatrics, LLC 317 South Dixie Freeway, New Smyrna Beach, FL 32168 (386) 424-1414. You must provide us with a reason that supports your request for amendment.
- 5. Right to a copy of this notice. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice please contact our front office staff.
- 6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Cristina Garcia at (386) 424-1414. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- 7. Right to provide an authorization for uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact Volusia Pediatrics LLC 317 South Dixie Freeway, New Smyrna Beach, FL 32168 (386) 424-1414.

I hereby acknowledge	that I have been presented with a copy of Volusia Pediatrics, LLC	Notice of Privacy Practices.
	Signature	Date
	Name of Patient	Data of Birth



INDIVIDUAL CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This notice describes how we are allowed to use or disclose your child's information for purposes of insurance billing, treatment, payment, or practice operations.

General Consent to Use/Disclose Medical Information

Our Notice of Privacy Practices, receipt of which you acknowledge by signing the Consent, provides information about how we may use and disclose medical information about you. You have the right to review our notice before signing this consent. As provided for in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting us at the address noted below.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and practice operations. You may also restrict the information that is made available to the public. We are not required to agree with a restriction, but if we do we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and practice operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made disclosures or used information in reliance on your prior consent.

Consent Related to HIV/AIDS Information

The information we use or disclose as described in our Notice of Privacy Practices may contain information about acquired immunodeficiency syndrome (AIDS), AIDS-related complex, or tests for or infection with the Human Immunodeficiency Virus (HIV). You consent only to use or disclosure of this health information for treatment, payment or practice operations as described in our Notice.

Consent Relating to Mental Health and Substance Abuse Information

I consent to the use or disclosure of my child(ren)'s medical information as described above:

The information we use or disclose as described in our Notice of Privacy Practices may contain information regarding psychiatric conditions, alcohol or substance abuse. You consent only to the use or disclosure of this health information for treatment, payment, or practice operations as described in our Notice.

Consent to Use Health Information for Health — Related Communications (Permission for use of Patient Portal) We may like the opportunity to communicate to you information about services we offer, treatment options and health-related benefits. Please indicate a preference by initialing one of the following statements. Yes, you may use my health information to communicate with me about services, treatment options and health related benefits. [Initial] No, I do not wish to receive these communications.

Signature	Date
Name of Patient	Date of Birth

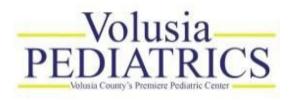






Authorization for Release of Confidential Information

Parent/Guardian contact	t number:				
l,	, Parent or Guardian of				
Patient Name:					
Date of Birth:					
Hereby authorize the releas	e of medical records from:				
Physician / Office / Hospital	Physician / Office / Hospital:				
Address:					
Phone:					
Fax:					
	TO: Volusia Pediatrics,				
	317 South Dixie Freeway				
	New Smyrna Beach, FL 32168				
Ph	one: 386 - 424 - 1414 Fax: 386 - 424 - 9130				
This authorization 6	expires on or sixty (60) days from the signature date.				
	Information to be released may include: (mark all that apply)				
Complete Record	Last Visit Lab/ X-Ray / Diagnostic Results				
Psychiatric	Drug and/or alcohol abuse				
Shot Record	Physical / Wellness Record				
Office Notes	Consultation Report Patient History				
HIV / ARC / AIDS Testing	Other(Please Specify)				
drug, HIV, ARC, and/or AIDS information, if present, will be discontinuous $\dot{\rm T}$	written notice to Volusia Pediatrics, LLC except to the extent that action has already been taken on this authorization. Alcohol, sclosed only if authorized. This information is confidentially protected by federal law, which prohibits disclosure without specific ermitted by such regulation. I further understand that I may select which information from the above list of confidential				
Parent / Guardian Signature	 Date				



Patient Name:	Patient D/O/B:
VACCII	NATION POLICY
Dear Parents,	
to save lives, and we firmly believe in the safety o	e in the effectiveness of vaccines to prevent serious illness and of our vaccines. Vaccinating children and young adults may be rention that we perform as health providers and that you can
schedule recommended by the American Academy	ent health, which is why we have adopted the vaccination y of Pediatrics (AAP), The National Institute of Health, and patients must follow the recommended vaccine schedule , t the time of the scheduled vaccine(s).
have a duty to protect the health of <u>all our patients</u> newborns). <u>If you should refuse to vaccinate you</u>	n over your children's health. At the same time, however, we so including those who cannot yet be vaccinated (such as ur child, we will ask you to find another healthcare p a list of such providers, nor would we recommend any such
illness, disability and even death. As medical prof	putting your child at unnecessary risk for life-threatening essionals, we feel very strongly that vaccinating your child on lutely the right thing to do to protect all children and young
Thank you for taking the time to read this policy. have about vaccines with any of the providers in o	Please feel free to discuss any questions or concerns you may our practice.
Parent/Guardian Signature	Date
Witness	



CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Volusia Pediatrics as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. *As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.*

Consent

By signing this consent form, you are agreeing that your provider at Volusia Pediatrics may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Volusia Pediatrics. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name	Patient DOB
 Signature of Patient or Guardian	Today's Date
 Relationship to Patient	



IMPORTANT INFORMATION REGARDING INSURANCE AND BILLING

Our providers are here to provide you with the best medical care. Their primary concern is your Health and well-being, not your insurance company. Therefore, it is the patient's responsibility To be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with Numerous insurance plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service [for example: any testing, removal of cerumen, nebulizer Treatments, etc.] is not covered under your policy.

I have read the above and understand that I am responsible for knowing the coverage of my Insurance policy as well as choosing a lab my insurance company participates with. I Understand I am financially responsible for any services provided by Volusia Pediatrics that My insurance plan does not cover.

 Print Patient Name	Patient DOB
Signature of Patient or Guardian	Today's Date
Relationship to Patient	