Volusia
PEDIATRICS
Volusia County's Premiere Pediatric Center

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 First (mm/dd/yyyy)

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race _____

Ethnicity: ☐ Not Hispanic or Latin
☐ Hispanic or Latin
☐ Unreported / Refused to Report

Patient Lives with ☐ **Mother and Father** ☐ **Mother Only** ☐ **Father Only** ☐ **Other** _____
(Please Specify)

Mother/Legal Guardian Name _____ SS# ___-___-____ Date of Birth__________

Place of Employment _____ Occupation _____ Work # _____

Father/Legal Guardian Name _____ SS# ___-___-____ Date of Birth__________

Place of Employment _____ Occupation _____ Work # _____

Home Address _____
(Street) (City) (State) (ZIP)

Mailing Address _____
(If Different) (Street) (City) (State) (ZIP)

Primary Phone # _____ Secondary Phone # _____

Siblings that are or will be patients of Volusia Pediatrics:

Name: _____ Date of Birth: _____ Relation: _____ Same Home Address: Y / N
Last First (mm/dd/yyyy)

Name: _____ Date of Birth: _____ Relation: _____ Same Home Address: Y / N
Last First (mm/dd/yyyy)

Name: _____ Date of Birth: _____ Relation: _____ Same Home Address: Y / N
Last First (mm/dd/yyyy)

Email Address _____
(To be used for Patient Portal, E-Confirmations and health related communications only)

Name of Insurance _____ ID # _____ Group# _____

Policy Holders Name _____ Relation _____

Treatment Agreement:

I authorize **Volusia Pediatrics, LLC,** its physicians and support staff to medically treat and/or administer necessary medication and/or immunizations when my doctor deems advisable in the diagnosis and/or treatment of my child.

Financial Agreement:

I request that payment of authorized Health Insurance benefits be made on my behalf to **Volusia Pediatrics, LLC** for any services furnished to me by that group. I authorize any holder of medical information about me to release (via facsimile, mail, telephone) to the Health Care Financing Administration of Health Insurance Company and all its agents any information needed to determine these benefits payable for relatable services. I agree to pay all fees, charges and balances for such treatment not covered by the Health Care Financing Administration of Health Insurance, within 60 days. In the event legal action should become necessary to collect unpaid balances due for medical services rendered to me, I agree to pay reasonable attorney's fees or other collection costs, as determined. **Cash, debit and credit cards are the only form of payment accepted. NO SHOW VISITS MAY BE ASSESSEED A $25.00 FEE**

_____ _____
Parent / Guardian Signature Date

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

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

New Patient History Form

Name DOB

Birth History

Delivery ☐ Vaginal ☐ C - Section
Complications ☐ No ☐ Yes

Full Term ☐ Pre-Term ☐ Weeks _____

Birth Weight _____ lbs

Feeding ☐ Breast ☐ Bottle

During Pregnancy did Mom: Smoke ☐ No ☐ Yes
Drink alcohol ☐ No ☐ Yes
used controlled substances or medications ☐ No ☐ Yes

Social History

Child Lives with _____

Daycare	☐ No	☐ Yes
Smoker	☐ No	☐ Yes
Pets	☐ No	☐ Yes
Immunizations Up to Date	☐ No	☐ Yes
Medication Allergies	☐ No	☐ Yes

Past Medical History

Does your child have or have ever had:

Developmental / Mental Delay	☐ No	☐ Yes
Problems with Vision or Hearing	☐ No	☐ Yes
Acid Reflux (GERD), Colic	☐ No	☐ Yes
Ear Infections ☐ Single ☐ Reoccuring ☐ Ear Tubes	☐ No	☐ Yes
Strep Throat ☐ Single ☐ Reoccuring	☐ No	☐ Yes
Removed ☐ Adnoids ☐ Tonsils		
Sinus Problems	☐ No	☐ Yes
Chest Cold	☐ No	☐ Yes
Asthma, Bronchitis, Bronchiolitis, Pnumonia	☐ 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
Frequent Headaches	☐ No	☐ Yes
Convulsions or other neurologic problems	☐ No	☐ Yes
Chicken Pox	☐ No	☐ Yes
Thyroid or other endocrine problems	☐ No	☐ Yes
Bladder or Kidney infections	☐ No	☐ Yes
ADHD / Behaviorial /Mental Problems	☐ No	☐ Yes
(For Girls) Started her period	☐ No	☐ Yes
(For Girls) Issues with her periods	☐ No	☐ Yes
Surgery	☐ No	☐ Yes
Hospital Admission	☐ No	☐ Yes

Family History

Have any family members had the following

Seasonal or year round allergies	☐ No	☐ Yes
Bleeding Disorders	☐ No	☐ Yes
Heart Problems (before 50 years of age)	☐ No	☐ Yes
High Blood Pressure (before 50years of age)	☐ No	☐ Yes
Sinus Problems		
Asthma, Freq bronchitis pnumonia /emphysema	☐ No	☐ Yes
Nebulizer / inhaler Use	☐ No	☐ Yes
Diabetes (before 50 years old)	☐ No	☐ Yes
TB / HIV	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes
Bedwetting (after10 years old)	☐ No	☐ Yes
Chronic skin problems	☐ No	☐ Yes
Deafness (Born With)	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Epilepsy or convulsions	☐ No	☐ Yes
Migraine Headaches	☐ No	☐ Yes
Behavioral / Mental problems	☐ No	☐ Yes
Obesity	☐ No	☐ Yes
Alcohol Abuse	☐ No	☐ Yes
Drug Abuse	☐ No	☐ Yes

Does your child have any other conditions not mentioned above:

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

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

Permissions

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 # (___)______________

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 # (___)______________

________________________________ ___/___ /___

Parent / Guardian Signature **Date**

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

The policies documented below are applicable to the following patient:

Name: _____ Date of Birth: _____
Last First (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.

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 $25.00 FEE**

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 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 ( ) Dr. Oliver Chiapco ( ) Dr. Laura Luke ( ) Ann Schlaefer, APRN, DNP
( ) Taylor Castellano, APRN ( ) No Preference

_____ _____/____/_____
Parent / Guardian Signature Date

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

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.
3. 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_____ Date of Birth _____

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

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

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.
[Initial]

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

Signature_____ Date _____

Name of Patient_____ Date of Birth _____

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

Authorization for Release of Confidential Information

Parent/Guardian contact number: _____

I, _____ , Parent or Guardian of

Patient Name: _____

Date of Birth: _____

Hereby authorize the release of medical records from:

Physician / Office / Hospital: _____

Address: _____

_____

Phone: _____

Fax: _____

TO: Volusia Pediatrics,

317 South Dixie Freeway
New Smyrna Beach, FL 32168
Phone: 386 - 424 - 1414

633 Dunlawton Ave
Port Orange, FL 32127
Fax: 386 - 424 - 9130

This authorization 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)

I understand that this consent is revocable upon written notice to **Volusia Pediatrics, LLC** except to the extent that action has already been taken on this authorization. Alcohol, drug, HIV, ARC, and/or AIDS information, if present, will be disclosed only if authorized. This information is confidentially protected by federal law, which prohibits disclosure without specific written authorization of the undersigned, or else otherwise permitted by such regulation. I further understand that I may select which information from the above list of confidential information will be released.

_____ _____

Parent / Guardian Signature Date

Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

Patient Name: _____ Patient D/O/B: _____

VACCINATION POLICY

Dear Parents,

The providers at Volusia Pediatrics firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives, and we firmly believe in the safety of our vaccines. Vaccinating children and young adults may be the single most important health-promoting intervention that we perform as health providers and that you can adhere to as parents/caregivers.

It is our responsibility to promote and protect patient health, which is why we have adopted the vaccination schedule recommended by the American Academy of Pediatrics (AAP), The National Institute of Health, and the Centers for Disease Control (CDC). **All new patients must follow the recommended vaccine schedule**, though exceptions can be made if the child is ill at the time of the scheduled vaccine(s).

We respect your right in making the final decision over your children's health. At the same time, however, we have a duty to protect the health of all our patients, including those who cannot yet be vaccinated (such as newborns). **If you should refuse to vaccinate your child, we will ask you to find another healthcare provider who shares your views**. We do not keep a list of such providers, nor would we recommend any such physician.

Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness, disability and even death. As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults.

Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any of the providers in our practice.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Witness **Date**