Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

Welcome

We are so pleased that you chose Volusia County's Premiere Pediatric Center for your child's healthcare needs.
Please fill out the following information to the best of your ability so that we can provide the best care possible

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

Language: ☐ English ☐ Other _____ ☐ Needs Translator
(Please Specify)

Patient Lives with ☐ **Mother and Father** ☐ **Mother Only** ☐ **Father Only** ☐ **Other** _____

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

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

Home (Primary) Phone #_____ Cell (Secondary) Phone # _____

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

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 # _____

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)

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. **THERE IS A $30 CHARGE FOR RETURNED CHECKS**

_____ _____
Parent / Guardian Signature Date

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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:

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.

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**

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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.

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 ( ) Worley, MD ( ) Smith, ARNP ( ) Powell, ARNP ( ) 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 _____

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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 _____

Inquiries regarding our privacy practices should be directed to: **Volusia Pediatrics, LLC - 317 South Dixie Freeway New Smyrna Beach, FL 32169 - (386) 424-1414**

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, LLC

317 South Dixie Freeway
New Smyrna Beach, FL 32168

633 Dunlawton Ave
Port Orange, FL 32127

Phone: 386 - 424 - 1414 **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