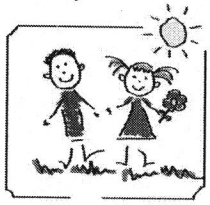
The office of:
Julie Konowitz-Sirkin, M.D.
Barbara Chamberlain, M.D.
Petra McEwan, M.D.
Kisha Marzouca, M.D.
Nixalyz (Sally) Benitez, ARNP
Amanda Szymanski, ARNP

J.F.K. Pediatrics
160 John F. Kennedy Dr. Ste. 101
Atlantis, Florida 33462
Phone (561) 964-1215
Fax (561) 964-1245
(Atlantis Location)

Just For Kids Pediatrics
9868 S. SR7 Ste. 305
Boynton Beach, Florida 33472
Phone (561) 369-0111
Fax (561) 369-4003
(Boynton Beach Location)



Dear Parents,

Welcome and thank you for enlisting your trust in our team here at J.F.K Pediatrics/ Just for Kids Pediatrics to be chosen as your child's Pediatrician. We look forward to developing a long, happy, and healthy relationship with your family.

We are happy to offer 24 hour-a-day assistance to you and your family. If you are in need of assistance at any time please contact the office number, during business and after business hours. (Please note: when calling afterhours kindly leave a voicemail and allow 30 minutes for a response. The on call nurse will contact you regarding your concerns.)

Many of the forms are available online for your convenience. These forms can be mailed, faxed, or dropped off to either of our locations. If there are any questions please contact the office directly. The Atlantis office can be reached at (561) 964-1215, and the Boynton Beach office can be reached at (561) 369-0111.

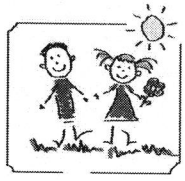
Many of the answers to your questions can be found below, however, if you are in need of assistance feel free to contact the office directly.

Thank you,

The Physicians and Staff of Just For Kids Pediatrics

J.F.K. Pediatrics/ Just for Kids Pediatrics

160 JFK Dr. Ste. 101
Atlantis FL, 33462
Ph (561) 964-1215
Fax (561) 964-1245



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PATIENT INFORMATION FORM

Today's date:	Preferred Provider: ❑ Dr. Konowitz ❑ Dr. Chamberlain ❑ Dr. McEwan ❑ Dr. Marzouca ❑ Sally❑Amanda
Preferred Language: ❑ English ❑ Spanish ❑ Creole ❑ Other _____	Vulnerability: ❑ Yes ❑ No ❑ Decline to answer
Race: ❑ White ❑ Black or African American ❑Hispanic or Latino ❑ Other ❑ Decline to answer	Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Decline to answer

PATIENT INFORMATION

Patient's last name:		First:	Middle:
DOB: / /	Sex: ❑ M ❑ F	Social Security no.:	
Patient's Primary Phone: ( )			
Street address:			
City:		State:	Zip Code:

PARENT/ GUARDIAN INFORMATION:

Parent/ Guardian:			
DOB: / /	Sex: ❑ M ❑ F	Social Security no.:	
❑ For access to the Patient Portal	Email:		
Street address:			❑ If same as Patient (above)
City:		State:	Zip Code:
Primary Phone: ( ) ❑To receive communication via Text*		Secondary Phone: ( ) ❑To receive communication via Text*	

(PLEASE GIVE YOUR ID & INSURANCE CARD TO THE RECEPTIONIST.) ❑Self Pay

Primary Coverage (Please note if you have Commercial Insurance and Medicaid, Commercial will take Primary)			
Policy Name: ❑Aetna ❑AvMed ❑Cigna ❑FL Blue ❑Humana ❑TriCare ❑United Healthcare ❑Other: _____			
Policy Type: MCD / HMO / PPO / Open Access / EPO/ Choice Plus / Other: _____	Circle One (If applies): HSA / HRA / FSA /Other: _____		Effective Date:
Insurance Guarantor	Last name:	First:	Middle:
Member ID:	Social Security no.:	DOB: / /	
Please indicate level of coverage: ❑ Secondary ❑ Other (Please note if you have Commercial Insurance and Medicaid, Medicaid will take Secondary)			
Policy Name: ❑Aetna ❑AvMed ❑Cigna ❑FL Blue ❑Humana ❑TriCare ❑United Healthcare ❑Other: _____			
Policy Type: MCD / HMO / PPO / Open Access / EPO/ Choice Plus / Other: _____	Circle One (If applies): HSA / HRA / FSA /Other: _____		Effective Date:
Insurance Guarantor	Last name:	First:	Middle:
Member ID:	Social Security no.:	DOB: / /	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize J.F.K. Pediatrics, Inc. or insurance company to release any information required to process my claims.
I authorize for the above mentioned patients Medication Reconciliation (Medication History) to be obtained.
I acknowledge I have received the PCMH Patient Orientation. *Data rates may apply

Signature of Parent/ Guardian:	*Date:*
Staff signature:	*Date:*

NEW PEDIATRIC PATIENT HISTORY AND REVIEW

(To be filled out by the parent)

Mother's name: _____ D.O.B.: _____ Occupation: _____

Father's name: _____ D.O.B.: _____ Occupation: _____

Who referred you to our practice? _____

PREGNANCY AND BIRTH HISTORY:

1. Mother's age at delivery _____
2. Any complications/infections during pregnancy? No Yes
   If "yes," describe _____
3. Any medications during pregnancy? No Yes
   If "yes," list _____
4. Where was the baby delivered? _____
5. Was the baby on time? No Yes
6. What was the birth weight? _____
7. What was the birth length? _____
8. Did the baby have difficulty starting to breathe? No Yes
9. Any problems in the first 3 months of life? No Yes
   If "yes," list _____
10. Passed hearing screen? No Yes
11. Hepatitis B vaccination given at the hospital? No Yes

PAST MEDICAL/SURGICAL HISTORY:

1. Where has your child gone for health care?
   _____
2. Reason for change? _____
3. Date of last checkup? _____
4. Any hospitalizations or surgeries since birth? No Yes
   If "yes," list _____
5. Any serious injuries? No Yes
   If "yes," list _____
6. Any history of frequent infections? No Yes
   If "yes," list _____
7. Any medications taken regularly? No Yes
   If "yes," list _____
8. Has your child had any allergic reactions to any foods, medications, or insect bites? No Yes
   If "yes," describe _____
9. List any other health problems _____
10. Does your child have a record of immunizations? No Yes

FAMILY HISTORY: Please list immediate family members with a history of any of the following:

Anemia_____ Hepatitis_____

Asthma_____ GI problems_____

Allergies_____ High cholesterol_____

Diabetes_____ Skin problems_____

Obesity_____ Alcoholism_____

Blood problems_____ Arthritis_____

Lung problems_____ TB_____

High blood pressure_____ Seizures_____

Heart disease_____ Migraines_____

Mental retardation_____ Stroke_____

Kidney problems_____ Cancer_____

Thyroid problems_____ Other_____

SOCIAL HISTORY:

1. Parental marital status: please circle
   Married/Separated/Divorced/Widowed/Single parent
2. Sibling name(s) and D.O.B.(s): _____
3. Who lives at home? _____
4. Does anyone at home smoke or is the child exposed to smoke? No Yes
5. Type of home: house/apt/mobile home/other
6. Water supply: city water/well water
7. Any pets? No Yes
   If "yes," indoor/outdoor? Type of pet(s)
   _____
8. Describe childcare outside of the home: _____
9. Name of child's school and grade: _____
10. Child's hobbies: _____

FEEDING AND NUTRITION:

1. For the first six months, breast or bottle fed?
   If bottle, which formula? _____
2. Any feeding problems? No Yes
3. Does child take vitamins? No Yes
   If "yes," list _____
4. Is your child's appetite usually good? No Yes

DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did he/she say any words at age 18 months? No Yes
4. How does your child compare to others of his/her own age? Below average/average/above average
5. Does he/she get along with other children? No Yes
6. Does he/she get in trouble at school? No Yes
7. Circle if your child has any of the following:

speech problems	nail biting
discipline problems	bad temper
thumb sucking > 4 years	bed wetting
toilet training problems	hyperactivity

SAFETY/ENVIRONMENT:

1. Is your hot water heater set at 120 degrees? No Yes
2. Are there home smoke alarms on each floor? No Yes
3. Is there a fire extinguisher in the house? No Yes
4. Are there any fire arms in the house? No Yes
   If "yes," are they unloaded/locked storage? No Yes
5. Does your child always wear a safety restraint in the car? No Yes
6. Does your child always wear a helmet when riding a bike or skating? No Yes

Patient Name: _____

Date of Birth: _____

Today's Date: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

J.F.K. Pediatrics
160 J.F.K. Drive, Suite 101
Atlantis, FL 33462

Just For Kids Pediatrics
9868 S. SR 7, Suite 305
Boynton Beach, FL 33472

Consent for Purposes of Treatment, Payment and Healthcare Operations (6/08)

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to J.F.K. Pediatrics.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. The Notice of Privacy Practices for Practitioner is also posted in the waiting room at 110 J.F.K. Drive, Suite 118 and at 9868 S. SR7, Suite 305. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

I understand that payment is expected at the time of service. There will be a $20.00 bounced check fee for any check cashed with insufficient funds. Checks over $30.00 will not be accepted and the balance must be paid using cash or credit/ debit card. If I receive 3 bills and do not provide a response to these, a $20.00 administration fee will be applied to my balance. If my insurance fails to provide reimbursement for any services provided, I understand I will be responsible for these charges.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative — Printed Name of Patient

_____ _____

Date of Signing — Description of Personal Representative's Authority

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Fax: (561) 964-1245

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Boynton Beach, Florida 33472
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Fax: (561) 369-4003

Authorization for Treatment

Consent for medical treatment: I hereby voluntarily authorize J.F.K Pediatrics/ Just for Kids Pediatrics, as is necessary in the judgment of the physician, to give medical treatment to my child.

In my absence, I authorize the below named individuals to accompany my child to J.F.K Pediatrics/ Just for Kids Pediatrics and I give consent for any medical treatment necessary for the benefit of my child.

(Please provide name and phone number)

1. _____ Ph: _____
2. _____ Ph: _____
3. _____ Ph: _____
4. _____ Ph: _____
5. _____ Ph: _____
6. _____ Ph: _____

_____
Child(rens) Name(s)
(Please Print)

_____
Parent or Guardian
(Please Print)

_____
Date of Birth(s)

_____
Signature of Parent or Guardian

_____
Witness

_____
Date

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Request for Email Communications

Communications over the internet and or using email systems that are not encrypted are inherently unsecured. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so please complete this form.

Please be advised that:
This request applies to the office of J.F.K Pediatrics/ Just for Kids Pediatrics and/ or its physicians. J.F.K Pediatrics/ Just for Kids Pediatrics will **NOT** communicate health information that is specially protected under state and federal law (for example HIV/AIDS information, mental health information etc.) via email even if we agree to communicate with you via email.

Please initial next to each phrase:

_____ I certify that the email I would like to be communicated via is:
_____

_____ I certify that my child(ren) name(s) and DOB(s) are:
_____

_____ I certify that the email provided on this request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

_____ I understand and acknowledge that communications over the internet and/ or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of any communications when communicated via email.

_____I understand that email communications in which I engage may be forwarded to other providers, including providers not directly associated with J.F.K Pediatrics/ Just for Kids for purposes of providing treatment to my child.

_____ I agree to hold J.F.K Pediatrics/ Just for Kids and individuals associated with J.F.K Pediatrics/ Just for Kids harmless from any and all claims and liabilities arising from or related to this request for communications via email with this said email address listed above.

_____
Signature of Patient or Legal Representative

_____
Printed name of Patient or Legal Representative

_____
Description of Personal Representative's Authority

_____
Date of Signing

_____
Signature of Witness

_____
Printed name of Witness

_____
Job Description

_____
Date of Signing