WATERS PEDIATRIC CENTER

Patient Registration

PATIENT INFORMATION

Patient Full Name (Nombre del paciente): _____

Date of Birth (Fecha de nacimiento): _____ Male/Female (Masculino/Femenino): _____

SSN (#de SS): _____

Race (Raza): Caucasian(Blanco) Hispanic (Hispano) Black or African American (Negro o Africo Americano) Other (Otro)

PARENTAL INFORMATION

**** Note: If you are not the patient's biological parent; you must provide proper documentation that you are their legal guardian/ Si usted no es el padre/madre biologico del paciente; debe proveer la documentacion apropiada de que usted tiene la custodia legal del paciente****

Who does the child live with? (Con quien vive el paciente)? _____ Email: _____

Mother's full name (Nombre de la madre completo) _____ D.O.B. _____

Address (Direccion) _____ Apt. # (#de apt.): _____

City (Ciudad): _____ State (Estado): _____ Zip code (codigo postal) _____

Telephone # (# de telefono): 1.) _____ 2.) _____

Father's full name (Nombre del padre completo) _____ D.O.B. _____

INSURANCE INFORMATION

Primary Insurance Name (Nombre Primario del Seguro): _____

Policy # (Numero de Polisa): _____ Group # (Numero de Grupo): _____

Secondary Insurance Name (Nombre Secundario del Seguro): _____

Policy # (Numero de Polisa): _____ Group # (Numero de Grupo): _____

****Note:** If you have Both Private Ins & Medicaid, by law we are obligated to use the private insurance as primary and Medicaid as secondary. Co-pays, Deductibles, Co-ins are due at time of service and are not covered by Medicaid. (Nota: Si usted tiene los dos seguro privado & Medicaid , por ley estamos obligados a utilizar el seguro privado como primario y Medicaid como secundario. Los co-pagos, deducibles, co-ins son debido al tiempo de servicio y no estan cubiertos por Medicaid.)

I attest that I am this child's legal guardian and all of the information above is correct and true to the best of my knowledge. I understand Waters Pediatrics can not get involved in custody/divorce issues. Both parents have equal rights to access their child's records, appointments, etc. unless stated otherwise by courts.
(Doy fe de que soy guardian legal de este nino y toda la informacion anterior es verdadera y correcta a lo mejor de mi conocimiento. Entiendo que Waters Pediatric Center no puede involucrarse en asuntos de custodia / divorcio. Ambos padres tienen el mismo derecho a acceder a los registros de su hijo, citas, etc. A menos que se indique lo contrario en los tribunales.)

Parent/Legal Guardian (Nombre del Padre o Madre/Guardian Legal): _____

Relationship to Patient (Relacion al Paciente): _____

Signature (Firma): _____ Date (Fecha): _____

****Pharmacy Information**

Name & Phone # of Pharmacy (Nombre y Numero de la Farmacia): _____

Address (direccion): _____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of Recipient of Records)						
Name	**Waters Pediatric Center**				**Phone**	**813-887-1010**
Address	**7730 West Waters Avenue**				**Fax**	**813- 887 - 1021**
City/State Zip	**City:**	**Tampa**	**State:**	**FL**	**Zip**	**33615**

RECORDS FROM: (Who is Releasing the Records)			
Name	Phone		
Address			
City/State Zip	City	State	Zip

For the Following Purposes:

Continued Medical Care		Personal Information	Legal Follow-up
Disability Insurance		Other	

By Checking **the** Boxes Below, I Specifically Authorize the Use and/or Disclosure of **the** Following Health Information And/or Medical Records. 11" Such Information and/or Records Exist:

	Please send the entire Medical Record	(all information) to the above named recipient.			
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

____HIV/AIDS relate information and/or records HBV. TB or Other Communicable Diseases

___Mental Health Information and/or Records

____Domestic Violence

____Genetic Testing Information and/or records

____Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how Much and what kind of information is to be disclosed.) Describe:

Other:

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy Regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I. further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally. I understand that I may revoke this authorization, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date):_____ _____.

Date:

Print Patient's Name:_____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable):_____

Relationship to patient: _____

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if*** *other than your home.* **(Confidential Communications)**

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **'CONFIDENTIAL': Yes: No:**

5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information ***if*** *other than your home phone number.* (____) _____ Email Address:_____ @ _____

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? Yes: No:

7. **I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.**

PATIENT NAME:_____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

Waters Pediatric Center	Sita L. Duggirala

Waters Pediatric Center/ Dr. Sita Duggirala MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse To Sign This Acknowledgement*

I, _____ , have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

(Please Print Name)_____

(Signature)_____

(Date)_____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

PARENTAL CONSENT FOR TREATMENT

(CONCENTIMIENTO DE LOS PADRES PARA TRATAMIENTO)

In accordance with Florida Law, Waters Pediatric Center will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent. In Florida, a patient is considered a "minor" if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor. (De conformidad con la Ley de Florida, Waters Pediatric Center no proporciona atención médica a los menores a menos que un padre les acompaña, un padre da su consentimiento por escrito o de forma se proporciona la clínica para comunicarse con los padres. En Florida, un paciente se considera un "menor" si él / ella es menor de 18 años, nunca se ha casado, o no se ha declarado un menor emancipado legalmente.)

I authorize the following individuals to seek medical treatment for the following child in my absence.(Yo autorizo a las siguientes personas a buscar tratamiento médico para el siguiente niño en mi ausencia.)

Patient/Child Patient (Paciente/paciente niño/a)
Child Date of Birth (Fecha de nacimiento del niño/a)
Name/Relationship (Nombre/Relacion)
Phone # (Numero de telefono)
Name/Relationship (Nombre/Relacion)
Phone # (Numero de telefono)
Name/Relationship (Nombre/Relacion)
Phone # (Numero de telefono)

Acknowledgement of Review of
Notice of Privacy Practices
(Reconocimiento de Revisión de
Aviso de prácticas de privacidad)

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.
(He revisado la Noticia de la oficina de prácticas de privacidad, que explica cómo se utilizará mi información médica y divulgada. Entiendo que tengo derecho a recibir una copia de este documento.)

Printed name of Patient (Nombre del paciente en molde) _____

Patient DOB (Fecha de nacimiento del paciente)
_____

Printed name of Parent or Guardian (Nombre del padre/guardian moldado) _____

Signature of Parent or Guardian (Firma del padre o guardian) _____

Date (Fecha) _____

PATIENT AUTHORIZATION
(AUTORIZACION DEL PACIENTE)

Patient/Child Name (Nombre del paciente/nino _____

Date of Birth (Fecha de nacimiento) _____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".
(Por favor iniciales todas las casillas aplicables. Si una categoría no se aplica a usted, por favor escriba "N / A)

☐ **I certify that the information I gave in applying for payment of Medicaid benefit is correct. I assign Medicaid benefits payable for services to Waters Pediatric Center. (Certifico que la información que he dado en la solicitud de pago de beneficios de Medicaid es correcta. Cedo los beneficios de Medicaid a pagar por sus servicios a Aguas Centro Pediátrico.)**

FINANCIAL RESPONSIBILITY (RESPONSABILIDAD FINANCIERA)

☐ **I will honor Waters Pediatric Center's payment policy by payment in full at the time services are rendered, unless prior arrangements have been made. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at Waters Pediatric Center,. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that I may be billed for out sourced services (i.e. lab, x-ray, etc.); and I may receive additional billing from another facility. I agree to pay all expenses related to collection, whether by collection agency or by an attorney. (Yo honraré política de pago Waters Pediatric Center mediante el pago en su totalidad en el momento se prestan los servicios, a menos que se han hecho arreglos previos. Entiendo que la cobertura de seguro no es una garantía de pago, y yo estoy de acuerdo que soy responsable por el pago de los servicios prestados en Waters Pediatric Center, Yo soy responsable de cualquier seguro de salud co-pagos, deducibles y los posibles remanentes no cubiertos o por pagar por mi compañía de seguros. Entiendo que se me puede cobrar por servicios fuera de origen (es decir, laboratorio, rayos x, etc), y que pueda recibir la facturación adicional de otra instalación. Estoy de acuerdo en pagar todos los gastos relacionados con la recolección, ya sea por la agencia de recaudación o un abogado.)**

INSURANCE RESPONSIBILITY (RESPONSABILIDAD DE SEGURO)

☐ **I irrevocably assign and transfer to Waters Pediatric Center, all insurance benefits covering Waters Pediatric Center, P.A. services for the payment of serviced rendered. I understand it is my responsibility for providing a current copy of my insurance card and to comply with all pre-certification requirements. (Irrevocablemente cedo y transfiero a Waters Pediatric Center, todos los beneficios del seguro que cubre en Waters Pediatric Center, PA servicios para el pago de servicios prestados. Entiendo que es mi responsabilidad de proporcionar una copia actualizada de mi tarjeta de seguro y para cumplir con todos los requisitos de pre-certificación.)**

AUTHORIZATION FOR CARE (AUTORIZACION PARA TRATAMIENTO)

☐ **I grant permission for Waters Pediatric Center, to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures. (Yo doy permiso a Waters Pediatric Center, a prestar esa atención que mi médico considere necesario en mi diagnóstico y tratamiento. Entiendo que estos cuidados puede incluir el tratamiento médico y procedimientos quirúrgicos menores.)**

AUTHORIZATION FOR RELEASE OF INFORMATION (AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN)

☐ **I hereby authorize Waters Pediatric Center, to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release Waters Pediatric Center, from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, Hepatitis B and other diseases. This authorization is irrevocable and is not limited in time. (Por la presente autorizo a Waters Pediatric Center, para liberar la información necesaria por las siguientes razones: a otros médicos para continuar con la atención profesional, a cualquier compañía de seguros, o sus representantes, o de otro modo, según lo permitido por la ley. Libero a Waters Pediatric Center, de cualquier responsabilidad por la publicación de esta información, y entiendo esta versión incluye específicamente cualquier y toda la sangre y otros exámenes similares, incluido el VIH, la hepatitis B y otras enfermedades. Esta autorización es irrevocable y no está limitado en el tiempo.)**

Signature of Parent or Guardian (Firma del padre o guardian) _____

Date (Fecha) _____