EXCEL PEDIATRICS AND FAMILY CARE
265 CITRUS TOWER BLVD, STE 102, CLERMONT, FL.34711
PH# 352-394-3929 FAX# 352-394-6446 TOLL FREE# 1-866-394-3929

PATIENT INFORMATION SHEET

ALLERGIES TO MEDICATIONS? (IF YES, SPECIFY)_____
Patient Name: _____
D.O.B. _____/_____/_____ Age: _____ Sex: _____ SS#_____-_____-_____
Race [Optional]:_____Preferred language:_____
Home Tel :(___) _____-_____ Alternate phone #: (_____)_____-_____
Home address: _____
City:_____ State: _____ Zip: _____
Father's or spouse Name: _____D. O. B. _____/_____/_____
SS#_____-_____-_____ Work ph# (_____) _____-_____
Mother's or spouses Name: _____ D. O. B. _____/_____/_____
SS# _____-_____-_____ Work ph# (_____) _____-_____
In case of emergency call: _____ Ph# (_____) _____-_____
Relationship to patient: _____ Work Ph# (_____) _____-_____
Please list anyone other than parents authorized to bring patient to appointments:
Name:_____Relation to patient:_____D.O.B_____
Name:_____Relation to patient:_____D.O.B_____
Name:_____Relation to patient:_____D.O.B_____
Email Address:_____
* If you need additional space, please use the bottom of this page.

FINANCIAL RESPONSIBILITY/ GUARANTOR INFORMATION:

Who is financially responsible for the bill: _____
Insurance Name: _____ Insured SS# _____-_____-_____
Insured D.O.B. _____/_____/_____Relationship to patient: _____

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and consent to any treatment, administration of necessary medications and /or immunizations my doctor deems advisable in the diagnosis and/or treatment of myself or child.
Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I understand that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and completed all the above answers to the best of my knowledge.
Signature: _____ Date: _____

RECEIPT OF DOCUMENTS

I have received copies of the Office financial policy and the HIPPA privacy statement.
Signature: _____ Date: _____

EXCEL PEDIATRICS AND FAMILY CARE HEALTH HISTORY

Name: _____ Date of Birth: _____ Today's Date _____

Pharmacy: _____
Address: _____
Phone Number: _____ Fax #: _____

Previous Family Doctor: _____
Address: _____
Phone Number: _____ Fax #: _____

Please list the Names and Phone Numbers for any Specialists (i.e. Cardiology, Pain Management) you are seeing and the condition you are seeing them for.

NAME	SPECIALTY	PHONE NUMBER	CONDITION

Name:_____
DOB:_____

PREVIOUS OR ONGOING MEDICAL PROBLEMS

PROBLEM	ONSET	RESOLVED/ONGOING

SURGERIES

TYPE OF SURGERY	WHY WAS IT PERFORMED?	DATE	SURGEON (IF KNOWN)

ALLERGIES

Are you allergic to any medications? YES NO If yes, what medication and what reaction do you have?

MEDICATION	REACTION

Name:_____
DOB:_____

CURRENT MEDICATIONS/VITAMINS

MEDICATION	WHAT IS IT FOR?	DOSE (mg)	DIRECTIONS

FAMILY HISTORY

Use the list of diseases below and any other significant findings to fill in the appropriate boxes below:

Examples: Alcoholism, aneurysm, arthritis, glaucoma, cancer (indicate type), diabetes, high cholesterol, high blood pressure, gallstones, heart disease, depression, anxiety, bipolar disorder, schizophrenia, polycystic kidney disease, seizures, bleeding or clotting disorder, anemia, thyroid disorder, tuberculosis.

FAMILY MEMBER	HEALTH PROBLEMS	AGE OF ONSET	CAUSE OF DEATH, IF DECEASED
Mother			
Father			
Brother			
Sister			
CHILD #1			
CHILD #2			
CHILD #3			

Name:_____
DOB:_____

SOCIAL HISTORY

Please circle and fill out appropriately

Do you smoke? YES NO PREVIOUSLY If yes, how many packs per day? _____
For how long? _____
Quit date: _____
Have you ever been exposed to second hand smoke? YES NO
Do you drink Alcohol? YES NO If yes, how many drinks per week?
_____
Do you now or have you ever used illicit drugs? YES NO If yes, what kind?
_____
Do you participate in any sexual activity that be considered risky?
_____
Marital Status: _____ Sexual preference: HETEROSEXUAL HOMOSEXUAL BISEXUAL
Living arrangement: SINGLE SPOUSE FAMILY ROOMATE SIGNIFICANT OTHER
Do you have an advanced care directive?
_____

Name:_____
DOB:_____

HEALTH MAINTENANCE

TEST OR IMMUNIZATION	DATE OF LAST	RESULT (IF KNOWN)
Physical Examination		
Cholesterol Test		
PSA (Prostate screening)		
Colonoscopy		
PAP Smear		
Mammogram		
Bone Density		
Tetanus or Tdap booster		
Hepatitis A series		
Hepatitis B series		
Pneumovax (Pneumonia)		
Other _____		

GYNECOLOGICAL HISTORY (WOMEN ONLY)

Age when first period occurred: ____
# of pregnancies: ____
# of live births: _____
# of miscarriages: _____
# of abortions: _____
# of living children: _____
Past infertility problems: YES NO
In planning for future health care for you, we would like to know what extra health services you feel you might want or need. In addition to caring for you when you are sick, what else would you like your provider to do for you?

_____
_____

LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide a reminder call at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $35 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel (or re-schedule) less than 24 hours in advance.

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

EXCEL PEDIATRICS AND FAMILY CARE

265 CITRUS TOWER BLVD , STE # 102
CLERMONT, FL. 34711
352-394-3929

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose you protected health information in the following situations without your authorization. These situations include: as required by the law, Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosers: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.5000.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in Writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You may have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i. e. electronically.

You may have the right to have your physician amend your protected health information If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature on the patient info sheet is only and acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date: _____

Excel Pediatrics and Family Care
265 Citrus Tower Blvd Suite 102, Clermont, Fl. 34711
Phone # 352-394-3929 Fax # 352-394-6446

OFFICIAL FINANCIAL POLICY

The past few years have busy regarding health care reform. The insurance companies have initiated new changes that will affect your account. There are some billing guidelines and hints that allow us to survive health care reform. Please thoroughly read and sign this sheet.

1.) We will collect your deductible, co-pay, uncovered services, or percent responsibility (in full) before you see the doctor. Please be prepared to pay this before your child's visit with the doctor.

2.) Please be thorough and comprehensive with your insurance information, and bring your insurance card with you. You will be responsible for any unpaid balance due to lack of information.

3.) It is at our discretion that we will charge your account with a rebilling fee if we must re-file balances over 45 days old. This fee will be payable by you.

4.) As a courtesy we will file your insurance. It is your responsibility to make sure we receive a prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.

5.) Your insurance will send you an explanation of benefits that explains what they have paid our office. This is the record that you must keep on file. If you do not agree with their payment, please contact the insurance company.

6.) If your insurance denies payment on your account, you will be asked to pay by money order, cash, or credit card to our office. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge.

7.) Self pay patients: This category includes people with no insurance or those who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered, before your visit with the doctor. We accept cash, checks, money orders, and credit cards. If you are not able to pay for the services in full, you must contact our office to make payment arrangements before coming to see the doctor.

Signature: _____ Date: _____

Authorization to Discuss Medical Information

I hereby authorize Excel Pediatrics and Family Care to use or disclose the specific information disclosed below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___ Appointment Date/Times ___ Diagnosis ___ Medications

___ Lab Tests and or Results/ Imaging Results/ Other Results

___ Summary of Medical Record ___ Care Plan

___ Other (Please Specify) _____

Indicate Confidential Information:

___ Mental Health ___ HIV information ___ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____ Phone Number: _____

I understand that:

*I may revoke this authorization in writing by contacting the office

*This authorization is giving Excel Pediatrics and Family Care the right to discuss my medical information with the one or more people listed above.

Signature: _____ Date: _____

Relationship to Patient: _____

(If patient is a minor or has a personal representative)

PATIENT COMMUNICATION CONSENT FORM

TEXT MESSAGE/ EMAIL ACCOUNT/ PHONE ALERTS STARTING LATE SUMMER 2019

I authorize Excel Pediatrics and Family Care (EPFC) to send text messages, voice calls, and/or email appointment reminders to me on my provided phone number/email.

EPFC cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

a. **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL/TEXT, CALL 911.** Do not email/text for any problems. If you have any question or concern, please call 352-394-3929.

b. All messages or needs should be relayed to us by using regular voice telephone communication due to privacy laws.

c. Do NOT reply to any emails/ text messages. All messages are automated.

d. You should speak with your provider to discuss medical issues rather than sending email or text messages regarding such situations.

e. Email and text messages may be filed electronically into your medical record.

f. EPFC is not liable for breaches of confidentiality caused by you or any third party.

g. It is your responsibility to follow up with your provider if warranted.

By accepting these terms, I agree that all adults and minors associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message/call charges from my phone provider may apply.

Account Guarantor's Name:_____ Date of Birth: _____

Patient's Name(s)_____ Date of Birth:_____

Patient's Name(s)_____ Date of Birth:_____

Patient's Name(s)_____ Date of Birth:_____

Patient's Name(s)_____ Date of Birth:_____

Account Guarantor's Cell Phone: (____)_____ Home Phone: (____)_____

Account Guarantor's Email(s):_____ _____

Current Address: _____

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the messaging services. I understand that this authorization can only be revoked in writing.

It is the patients responsibility to ensure that we have the right phone number/ email on file.

Signature_____ Date:__/__/__

Notes:_____

_____

_____

Mohammad Afzal, MD
Suzanne Wallis, ARNP
Adam Figliola, ARNP

Excel Pediatrics and Family Care
265 Citrus Tower Blvd. Ste #102
Phone 352-394-3929 Fax 352-394-6446

Authorization to Release Information
Please Fax Records to 352-394-6446

Patients Name: _____ Date of Birth:_____

Address:_____

Phone:_____ SS#:_____

I authorize (please print name of previous Doctor or Facility_____to disclose above named individual's health information. (only checked boxes below) to Excel Pediatrics. Please give phone and fax numbers if available.

Phone:_____ Fax:_____

Problem List ( )
Medication List ( )
List Of Allergies ( )
Immunization Record ( )
Most recent History & Physical ( )
Most recent Discharge Summary ( )
Laboratory Results ( ) Date: _____
X-Ray and Imaging Reports ( ) Date:
Consultation Reports ( )From:_____
Designated Record Set ( )

I understand that the information in my health record may include information relating to sexually transmitted diseases. AIDS, and HIV. Included may also be information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have the right to revoke authorization at any time. Understanding that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The authorization will expire in six months unless otherwise dated here. ___/___/_____.

I understand that authorizing disclosure of health information is voluntary. Refusing to sign this authorization is your choice. I need not sign this form in order to ensure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ Date:_____
Signature of Parent, Guardian or Self

_____ Date:_____
Witness