

LEESBURG PEDIATRICS  
8113 CENTRALIA CT LEESBURG, FL 34788  
PH# 352-435-7938 FAX# 352-805-4145

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: \_\_\_\_\_



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?

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## **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**  
**LEESBURG PEDIATRICS**  
8113 CENTRALIA CT  
LEESBURG, FL 34788  
352-435-7938

**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 your 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 your 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 Disclosures: 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 filing 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: \_\_\_\_\_

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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: \_\_\_\_\_

Mohammad Afzal MD  
Marybel Morgan 8113  
Tiffany Guice APRN

**Leesburg Pediatrics**  
**Centralia Ct Leesburg, FL 34788**

Phone (352) 508-5176  
Fax (352) 508-5179

**Authorization to Release Information**

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

\_\_\_\_\_  
Signature of Parent, Guardian or Self

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_

# Authorization to Discuss Medical Information

I hereby authorize Tavares Pediatrics 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 Tavares Pediatrics 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 Tavares Pediatrics (TP) to send text messages, voice calls, and/or email appointment reminders to me on my provided phone number/email.

TP 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:

**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 352-508-5176.

- a. All messages or needs should be relayed to us by using regular voice telephone communication due to privacy laws.
- b. Do NOT reply to any emails/ text messages. All messages are automated.
- c. You should speak with your provider to discuss medical issues rather than sending email or text messages regarding such situations.
- d. Email and text messages may be filed electronically into your medical record.
- e. TP is not liable for breaches of confidentiality caused by you or any third party.
- f. 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 \_\_\_\_\_