Bloomingdale Pediatric Associates

Sonia M. Ruiz, M.D., P.A.
Village Professional Center • 4316 Bell Shoals Road • Valrico, FL 33594
(813) 684-1881 • ***www.BloomingdalePediatrics.com*** • **(813) 685-0471 Fax**

CHILD'S NAME _____ HOME PHONE #: _____

CHILD'S SOCIAL SECURITY#:#: _____-_____-_____ DATE OF BIRTH _____/_____ /_____ GENDER: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Primary Language Spoken By Parent _____ Primary Language Spoken in Home _____

NAME OF MOTHER:_____ MOTHER'S DATE OF BIRTH: _____/_____ /_____

NAME OF FATHER:_____ FATHER'S DATE OF BIRTH: _____/_____ /_____

MATERIAL STATUS OF PARENTS (PLEASE CIRCLE): MARRIED UNMARRIED DIVORCED SEPARATED

IF DIVORCED, WHO HAS CUSTODY OF THE CHILD?

FATHER

EMPLOYER: _____

WORK ADDRESS: _____

WORK PHONE#: _____

CELL PHONE#: _____

EMAIL ADDRESS: _____

INSURANCE COMPANY:_____

ADDRESS: _____

PHONE #: _____

POLICY #: _____

SOCIAL SECURITY #: _____-_____-_____

MOTHER

EMPLOYER:_____

WORK ADDRESS: _____

WORK PHONE#: _____

CELL PHONE#:_____

EMAIL ADDRESS: _____

INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____

POLICY #: _____

SOCIAL SECURITY #: _____-_____-_____

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EMERGENCY CONTACT:_____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

LIST OTHER FAMILY MEMBERS:

NAME: _____ AGE: _____ DATE OF BIRTH _____/_____ /_____

NAME: _____ AGE: _____ DATE OF BIRTH _____/_____ /_____

NAME: _____ AGE: _____ DATE OF BIRTH _____/_____ /_____

NAME: _____ AGE: _____ DATE OF BIRTH _____/_____ /_____

REFERRED BY: _____

Welcome to BLOOMINGDALE PEDIATRIC ASSOCIATES. We are pleased that you have chosen us as your health care provider**.** PAYMENT IS DUE A THE BEGINNING OF EACH VISIT. Your signature authorizes Bloomingdale Pediatric Associates to perform and administer medical treatment for your child. I understand that all services are rendered on paid bases only. If collection becomes necessary, the undersigned shall pay all cost including attorney fees. Failure to comply may result in denial of care to your child except in life-threatening situations.

PARENT SIGNATURE: _____ DATE: _____/_____ /_____

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Authorization For Use Or Disclosure Of Medical Information OUT OF Our Office

Patient Full Name: _____ Date of Birth: _____

This signature authorizes Bloomingdale Pediatric Associates to release general medical information, pursuant to Florida Statute Section 456.057, as well as specific, applicable information as noted below, from my child's medical record.

____ Psychiatric/Psychological information as protected by Florida State 456.057

____ Drug/Alcohol information as protected by Florida Statute 397.501

____ Sexually Transmitted Diseases as protected by Florida Statute 384.29

____ HIV/AIDS information as protected by Florida Statute 381.04(3)(f).
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Name of persons, agencies or organizations to which information is to be released:

_____

Address/Fax: _____

This protected health information is being used or disclosed for the following purpose:

_____

_____

Specific information to be released:

All records ___ Or specify: _____

Specific dates to be released:

All dates ____ Or specify: _____

Information to be released by the above may not be redisclosed without further authorization by the patient. This authorization will be valid for ninety (90) days after the date of the patient's signature as it appears below. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to

ATTN: Business Manager at 4316 Bell Shoals Road,
Valrico, FL 33594.

I understand that a revocation has no effect on action previously taken.

Bloomingdale Pediatric Associates will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent that state law provides greater access rights)
- Refuse this authorization and that with my signature, the facility named above is released from all legal liability that may arise from the released information requested.

Signature of Empowered Representative: _____ Date: _____

Include Title/Legal Status of Empowered Representative: _____

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Authorization For Use Or Disclosure Of Medical Information INTO Our Office

Patient Full Name: _____ Date of Birth: _____

I, _____, hereby authorize _____

Address/phone _____

Fax: _____

to disclose the following protected health information from
my child's medical record to: **Bloomingdale Pediatric Associates**

Specific information to be released:

All records ___ Or specify: _____

Specific dates to be released:

All dates ___ Or specify: _____

This protected health information is being used or disclosed for the following purpose:

____ Transfer records from previous physician (PCP or specialist) to this new PCP

____ Have existing specialist communicate with my PCP

____ Allow a hospital or birthing center to send newborn records on my newborn to this PCP

____ Allow an Emergency Room to send records to my PCP regarding emergent care services

Other: _____

Information to be released by the above may not be redisclosed without further authorization by the patient. This authorization will be valid for one year (365) days after the date of the patient's signature as it appears below or unless patient transfers care to another primary care physician. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to ATTN: Business Manager at 4316 Bell Shoals Road, Valrico, FL 33594. I understand that a revocation has no effect on action previously taken.

Bloomingdale Pediatric Associates will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I understand I have the right to refuse to sign this authorization.

Signature of Empowered Representative: _____ Date: _____

Include Title/Legal Status of Empowered Representative: _____

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 Primary Language _____

CHILD'S NAME _____ AGE (year/months)_____/_____

SEX: MALE _____ FEMALE _____ BIRTHDAY_____/_____ /_____ ALLERGIES _____

History to be filled out by the parent or guardian

Pregnancy & Birth

1.	Did you have an illness during your pregnancy?	Yes	No
2.	Did the baby come on time?	Yes	No
3.	What was the birth weight? _____		
4.	Did your baby have any trouble starting to breathe?	Yes	No
5.	Did the baby have any trouble while in the hospital?	Yes	No

Feeding and Digestion

1.	Was there severe colic or any unusual feeding problems in the first 3 months?	Yes	No
2.	Is your child's appetite usually good?	Yes	No
3.	Is it good now?	Yes	No
4.	Does he/she often have diarrhea?	Yes	No
5.	Do any food disagree with him/her?	Yes	No
6.	Has constipation ever been much of a problem?	Yes	No
7.	Does he/she take vitamins?	Yes	No
8.	If on formula, which one? _____		

Family History

1. Circle any of the following diseases that the child's parents, grandparents, aunts, uncles, brothers, sisters have had or have:

TUBERCULOSIS	**DIABETES**	**ASTHMA**	**ALLERGY**
SEIZURES	**HEART DISEASE**	**MENTAL ILLNESS**	**INHERITED DISEASES**
LUNG DISEASES	**CANCER**		

2. Are the child's parents both in good health?
3. List name, ages, gender and general health of brothers and sisters:

Name	Age	M/F	General Health

4. Have any of your children died? Yes No

Explain _____

Child's Name:

Infections, Illnesses, Miscellaneous Problems And Development

Has your child had 4 ear infections in 6 months?	Yes	No
Has your child had 6 or more infections within a year?	Yes	No
Does he/she usually have more than three cold or throat infections a year with fever?	Yes	No
Does he/she usually have any trouble with urination?	Yes	No
Has he/she ever had a convulsion?	Yes	No
Does he/she hear well?	Yes	No
Does he/she have eye problems?	Yes	No
At what age did he/she sit alone?	_____	
At what age did he/she walk alone?	_____	
Did your child have any trouble sleeping as an infant?	Yes	No
Does he/she have any trouble sleeping now?	Yes	No
Are there any problems with his/her teeth?	Yes	No
Does he/she ever complain their head hurts?	Yes	No

Allergies

Has he/she ever had eczema or hives?	Yes	No
Has he/she ever had wheezing or asthma?	Yes	No
Does he/she tend to have a stuffy nose or "constant cold"?	Yes	No
Has he/she had any allergies or reactions to any medications or injections?	Yes	No

MEDICATION ALLERGIES _____

EMOTIONAL PROBLEMS

Is he/she doing well in school?	Yes	No
Does he/she interact well with other children?	Yes	No

Circle any or the following which your child has:

NAIL BITING	**IRRITABILITY**	**CAN'T TOILET TRAIN**	**BREATH HOLDING**
THUMB SUCKING	**BED WETTING**	**SPEECH PROBLEMS**	**BAD TEMPER**
NIGHTMARES	**JEALOUSY**	**DISOBEDIENT**	

Test & Immunization

1. Has he/she had the diphtheria (DPT), tetanus & whopping cough vaccine?	Yes	No
a. His/her last DPT Booster date:	_____	
2. Has he/she had the measles vaccine?	Yes	No
a. If yes, date:	_____	
3. Has he/she had a skin test for tuberculosis?	Yes	No
a. If Yes, date:	_____	
4. Has your child had a recent hemoglobin test?	Yes	No
5. If Yes, state and results given:	_____	
6. Has your child's urine ever been checked?	Yes	No
7. Has your child's urine ever had blood in it?	Yes	No
8. When was the last time your child's urine was checked?	_____	
9. Has your child ever had blood in his/her stool?	Yes	No

Comments? _____

_____

_____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Bloomingdale Pediatric Associates, P.A. for the purpose of diagnosing or providing treatment to my dependents, obtaining payment for my health care bills or to conduct healthcare operations of Bloomingdale Pediatric Associates, P.A. I understand that diagnosis or treatment of my dependents, by Dr. Ruiz or other associates or this practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information of my dependents is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bloomingdale Pediatric Associates, P.A. will strive to comply with my request as long as it does not go against the best interest of quality health care or against guidelines provided by HIPAA. Once Dr. Ruiz or other associate agrees to a restriction that I request, the restriction is binding on Bloomingdale Pediatric Associates, P.A. and the agreeing provider (we require a written request and have a form for this purpose).

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Ruiz or another associate or Bloomingdale Pediatric Associates, P.A. has taken action in reliance on this consent.

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

I understand I have a right to review Bloomingdale Pediatric Associates, P.A.'s Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of our protected health information that will occur in my dependent's treatment, payment of bills or in the performance of healthcare operations of Bloomingdale Pediatric Associates, P.A. A summary of the Notice of Privacy Practices for Bloomingdale Pediatric Associates, P.A. is also posted in the waiting areas. This Notice of Privacy Practices also describes my rights and Bloomingdale Pediatric Associates, P.A. duties with respect to our protected health information.

Bloomingdale Pediatric Associates, P.A. 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 and requesting a revised copy be sent in the mail or asking for one at the time of our next appointment. With my signature I acknowledge having received a copy of the Bloomingdale Pediatric Associates, P.A. Notice of Privacy Practices.

Signature of parent/guardian _____ DATE: _____/_____ /_____

NOTICE OF PRIVACY PRACTICES

Bloomingdale Pediatric Associates, P.A.

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

Allowed Uses and Disclosures Of Your Medical Information:

- Treatment – such as ordering diagnostic tests, other health care providers, Pharmacy, etc.
- Payment – such as submitting billing information insurance company, disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).
- Health Care Operations – such as child abuse or neglect.

In addition to the above, your medical information may be used or disclosed for emergency treatment, when we are required by law to treat you, we attempt to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances; or we created or received the information in treating an inmate.

You have the right to, upon written request:

- Request restriction on certain uses and disclosures of the information, providing it does not affect or hinder treatment, payment, healthcare operations or public health activities as discussed above.
- Establish confidential communications with us (ex restrict where and how you want us to contact you).
- Request to view or have copies made of your medical information.
- Request to amend incorrect or incomplete medical information.
- Receive an accounting of any disclosures made.
- Receive a paper copy of the disclosure if the disclosure is not protected by HIPAA standards.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and attempt to obain written acknowledgement.
- Abiding by the terms of this notice.
- Making available to you a written document of any change to this notice.

Complaints:

If you wish to file a complaint with us, we have a form you can request to fill. Please provide the office manager with this written notice of how you believe we violate your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and we will not retaliate for any allegations you make. If we do not answer your request to your satisfaction, you are entitled to notify the Department of Health and Human Services; and address will be provided to you upon request.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another insurance company (applying for life insurance), or a relative. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient contact:

We need to contact you to provide test results, appointment reminders, treatment information, or for patient satisfaction surveys. If you want to request alternative or confidential communication, please ask to speak with the privacy officer.

To obtain information, contact: HIPAA Privacy Officer at (813) 684-1881 or 2062.

Effective Date: April 8, 2003

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Parent/Guardian Consent for Purposes of Payment and Healthcare Operations

This document certifies you have received a copy of Bloomingdale Pediatric Associates, P.A.'s Notice of Privacy Practices (NPP).

Bloomingdale Pediatrics Associates, P.A. 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 and requesting a revised copy be sent in the mail or asking for one at the time of my/our next appointment. With my signature I acknowledge having received a copy of the Bloomingdale Pediatric Associates P.A. Notice of Privacy Practices

_____ _____
Signature of Parent/Guardian or Personal Representative Date

_____
Name of Parent/Guardian or Personal Representative

_____
Relationship to Patient

Parent or Personal Representative refused to sign acknowledgement

_____ Staff Initials

_____ Date