LAKE WORTH PEDIATRICS

Patient Information

Name of the Child: _____ Age: _____ Sex: M___ F___

Date of Birth: _____ Nick Name: _____ S S No. of child : _____

Mother's Name : _____ Father's Name: _____

Primary care taker: _____ Relation to child: _____ Driving License No. _____

Home Phone: _____ Work Phone: _____

Home Address: _____ City _____ State: ____ ZIP: _____

Primary Language Spoken _____

Besides parents/guardian who else is authorized to bring the child for medical treatment?/ Relation to the child :

_____ / _____

INSURANCE INFORMATION

Primary Insurance Information ***Name of Insurance :***

Person Financially Responsible _____

Primary Insurance Holder: Mother____ Father _____ Guardian _____ Other _____

Date of Birth of Primary Insurance Holder : _____ Driver's License Number : _____

Address : _____

Home Phone: _____ Work Phone: _____

Plan Name: _____ Policy Number: _____

Group Number: _____ Employer: _____

Employer's Address _____

Secondary Insurance Information

Secondary Insurance Holder: Mother____ Father _____ Guardian _____ Other _____

Plan Name: _____ Policy Number: _____

Group Number: _____ Employer: _____

Employer's Address _____

EMERGENCY CONTACT

In the event of Emergency whom shall we contact ?

1.Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Release and Assignment

I certify that my minor/child is covered by Insurance with _____ and assign directly to Dr. Shankaraiah / Dr. Masse / Dr. Foster, Donna Ihle, ARNP at Lake Worth Pediatrics all ins. benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctors to release all information necessary to secure the payments and benefits. I authorize the use of this signature on all my Insurance submissions, whether manual or electronic. I, the undersigned, and parent/gaurdian of _____, hereby authorize the providers at Lake Worth Pediatrics to provide any and all medical treatment for the above patient as they in their discretion see fit. The authorization shall be deemed effective as of _____ and shall remain in effect until terminated by the undersigned.

_____ _____

Signature of Parent/ Guardian Date:

LAKE WORTH PEDIATRICS

Clinical Information Sheet

Name of the Patient: _____ Birth Date_____

Race: _____ Sex:_____

Father's Name:_____ Age____ Occupation: _____

Mother's Name: _____ Age____ Occupation: _____

Number of siblings _____ Ages of Siblings 1.____ 2._____ 3. _____ 4_____

Family History of Following Disorders Seizures Asthma Diabetes

Hypertension Heart Disease Cancer Early Deaths

Additional Comments: Chronic Illnesses in any siblings : _____

Patient History ***Known Allergies:***

Birth History Hospital:_____ OB Doctor : _____

Condition at Birth : _____

Birth Weight : _____ Additional Comments : _____

Past Medical History Known Chronic Illnesses : _____

Hospitalizations if any: _____Reasons: _____

Surgeries done in the past: _____

Developmental Milestones Age of attaining following miles stones First Smile _____

Rollover ____ Sat up _____ First Words_____ First Steps _____

Feeding History: Breast Feeding ____ ***Formula*** ___ ***If Formula, kind of Formula*** _____

Supplimental feedings : _____ Started regular food at _____

Vaccination Up to date ___(please furnish the records at front desk) not known: _____

Earliest Date at which you can submit records _____

LAKE WORTH PEDIATRICS
3112 SOUTH CONGRESS AVENUE STE A
PALM SPRINGS, FL 33461
Ph: 561-964-0110
Fax: 561-964-0401

MEDICAL RECORDS RELEASE FORM

PATIENT'S NAME _____ **D.O.B** _____

I _____, **authorize** _____

_____ **to release my son's/daughter's**

medical records (including HIV information) to Dr. N. Shankaraiah at Lake Worth Pediatrics.

Date: _____

Parent: _____

Guardian: _____

HIPAA Notice of Privacy Practices

Lake Worth Pediatrics
3112 S. Congress Avenue
Palm Springs, FL 33461
Ph: 561-964-0110

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, that may identify you and that relates 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 staff 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 health care 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, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the 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 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 164.500.

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.

You 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 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 Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____