Margate Pediatrics

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

Dated April 14, 2003

I, (name of patient) _____, acknowledge and agree that I have received a copy of Margate Pediatrics Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Patient Legal Representative (If applicable) Date

_____ _____

Print Name of Legal Representative Relationship to patient

_____

_____

FOR CLINIC USE ONLY:

This office has made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

GENERAL CONSENT FORM CONSENT FOR TREATMENT

I, _____, hereby authorize Margate Pediatrics, the attending physician designated by him, and other center employees to examine and treat me. I also authorize such treatment and procedures as deemed necessary by the physician, including but not limited to, the taking of such X-rays, medications, blood sample, urine samples, and other therapies as deemed necessary. I also authorize the medical assistant to administer routine vaccinations as outlined by American Academy of Pediatrics at every visit, from now onward, including the flu vaccine as ordered by the physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made or implied to me as to the results that may be obtained by examinations and treatment.

I hereby certify that I understand the above authorization.

Witness: Patient Signature:

_____ _____

Date and Time: Patients or Person authorized to Consent:

_____ _____

Relationship to patient: Mom Dad Other: _____

Margate Pediatrics

Patient's Name: _____

I, the undersigned, assume responsibility for charges incurred on any date of Service, if any of the following situations should apply:

_____ Insurance denied.

_____ Baby not added to insurance policy within 30 days of birth.

_____ Patient not assigned to Margate Pediatrics

_____ Cobra not effective.

_____ Lapse of insurance.

_____ Deductible not met.

_____ Corrected insurance info supplied within timely limits for claims submission.

Signed: _____

Parent/Guardian

Date: _____

OFFICE POLICY

Walk Ins:

- We see patients by **appointments**.
- Please call us before you come to see us. Calling us in advance before you come in will help us provide you better service and run the office smoothly.
- Please call and make appointments for all **URGENT** needs **EARLIER** in the day to be accommodated the same day.

Late or Early Arrivals:

- Late or Early arrivals can create disruption with our smooth operation. Please arrive on time.

Insurance/Billing

- It is **PATIENTS RESPONSIBILITY** to know these terms and conditions of their insurance company including copay, deductibles, covered and non-covered benefits.
- **Bringing new insurance information at the time of the appointment will cause unnecessary wait time for you in the waiting room.**
- If we are not your **PCP**, we **CANNOT** see you using your insurance.

Referrals/School Forms/Medical Records Policy

- It is the **PATIENTS RESPONSIBILITY** to notify ALL requests for **Referrals, School Forms, and Medical Records minimum** 7 business days in **ADVANCE**. It may take 1-2 weeks for processing.
- **DO NOT MAKE APPOINTMENT** with the specialist until your referral is ready.
- **ALL** forms and referrals are prepared and signed by the physician after seeing the patient and reviewing all pertinent information.

No Show

- We need a **24 hour** notice if you are changing your **time** or **date** of appointment.
- Not showing up for your appointment will incur a **$25.00 no show fee**.

I have read the office policies:

Patient Name: _____ **Patient Date of Birth: _____**

Parent Signature: _____ **Date: _____**

ASSESSMENT QUESTIONNAIRE

Lead Poisoning Risk

INSTRUCTIONS: Parents/caretakers of children less than six years of age who are not part of the targeted populations should complete this questionnaire at each annual check-up.

A "yes" or "don't know" response to any question indicates the child is at risk for lead poisoning and should receive a blood lead test and appropriate follow up.

Question	YES, or NO Or DON'T KNOW
1. Does your child live in or regularly visit (once a week or more) any house or building Built before 1978?	
2. Does your child live in or regularly visit any house or building that has recently undergone renovation?	
3. Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? Examples: Occupations: building renovation, battery factory or recycling, auto or radiator repair; highway bridge sandblasting or painting, welding metal structures, or wire cable cutting Hobbies: refinishing furniture; home renovation; casting bullets, auto battery or radiator repair, making stained glass, ceramics, toy soldiers, dive weights, or fishing weights.	
4. Does your child have contact with cosmetics, candies, spices, jewelry, ceramic dishware and/or home (or folk) remedies not made in the United States; and/or leaded crystal, imported ceramic or pewter dishes?	
5. Does your child play in loose soil, near a busy road or near any industrial sites such as a battery recycling plant, junkyard or lead smelter?	
6. Have you ever seen your child eat dirt or put his/her mouth on painted surfaces, paint chips, toys, jewelry or vinyl mini blinds?	
7. Has your child recently visited or lived in another country for an extended period of time?	

TB Risk Factors

1. **Has your child been in contact with persons who have tuberculosis?**	Yes	No
2. **Has your child or any member in your household traveled outside the country, or have you had any recent visitors from another country?**	Yes	No
3. **Is anyone in the household infected with HIV or has been in jail in the last five years?**	Yes	No
4. **Has your child ever had a positive PPD or tuberculosis test?**	Yes	No

CHOLESTEROL Risk Factors

1. **Do either of the parents have a cholesterol level > 240?**	Yes	No
2. **Have any members of your family had a heart attack or a stroke before age 55?**	Yes	No

Patients Name: _____ Date: _____

_____

Signature of Parent/Guardian

Patient Information

Margate Pediatrics
5100 W Copans Rd #800 Margate, FL 33063

NOTE: **If patient is under 18 years old, fill out this form with the guardian or parent's information**

DATE:_____E-MAIL ADDRESS:_____

Pharmacy Name: _____ Pharmacy Phone Number: _____

PHARMACY LOCATION: _____

PATIENT NAME: _____

(LAST) (FIRST) (MIDDLE INITIAL)

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____

Home Telephone: _____Work Telephone: _____

Cell Phone: _____

PER STATE OF FLORIDA REQUIREMENT, PLEASE SELECT YOUR ETHNICITY FROM THE 3 CHOICES BELOW:

(NON-HISPANIC) (HISPANIC) (UNKNOW)

PER STATE OF FLORIDA REQUIREMENT, PLEASE SELECT YOUR RACE FROM THE 10 CHOICES BELOW:

(ALASKA NATIVE) (AMERICAN INDIAN) (ASIAN) (BLACK) (NATIVE HAWAIIAN)

(NO RESPONSE) (OTHER PACIFIC ISLANDER) (OTHER) (UNKNOW) (WHITE)

WHOM DO WE NOTIFY IN THE EVENT OF AN EMERGENCY: _____

Relationship: _____ Telephone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ID#: _____

Secondary Insurance Company: _____ID#: _____

Subscriber Name: _____Group Number: _____

Subscriber's Date of Birth: _____

FINANCIAL INFORMATION

IF PATIENT IS UNDER 18, PLEASE ENTER THE FOLLOWING INFORMATION:

NAME OF PARENT OR GUARDIAN RESPONSIBLE FOR THIS ACCOUNT: _____

Mother's Name: _____ Date of Birth: _____

Mother's Work Telephone: _____ Occupation: _____

Father's Name: _____ Date of Birth: _____

Father's Work Telephone: _____ Occupation: _____

Margate Pediatrics

Aliya Asad M.D.

Date: _____

Patient: _____

I authorize Margate Pediatrics to discuss my PHI, protected health information with the following people (e.g. *SPOUSE, ADULT, CHILDREN, FRIEND, ATTORNEY, etc*...):

Please list name and phone number:

1. Name: _____

   Phone Number: _____

2. Name: _____

   Phone Number: _____

_____

(Patient Signature)

_____

(Witness)

_____

(Witness)

5100 W Copans Rd #800, Margate, FL 33063

Phone Number: (954) 975 4611 | Fax: (954) 975 4079

MARGATE PEDIARICS

ALIYA ASAD, M.D FAAP

5100 WEST COPANS RD.

SUITE 800 MARGATE, FL 33063

Phone: (954) 975-4611 & Fax: (954) 975-4079

To: _____

PHYSICIAN'S NAME OR FACILITY

_____

STREET

_____ _____ _____

CITY **STATE** **ZIP**

Please mail copies of the medical records in your custody for the undersigned patient(s) to:

MARGATE PEDIARICS

5100 WEST. COPANS RD. SUITE 800

MARGATE, FL 33063

Child's Name: _____ **Date of Birth:** _____

_____

_____ _____

If New-Mother's full Name **Date of Birth**

_____

_____ _____

PARENT/GUARDIAN'S SIGNATURE **DATE**