Loop Pediatrics

NEW PATIENT INFORMATION				
Patient Last Name, First Name		**Birth Date**	**Male** ☐ **Female** ☐	**Social Security #**
Street Address		**Apt#**		**Home Phone**
City	**State**	**Zip Code**	**E-mail Address**	

PARENT/GUARDIAN INFORMATION		
Mother's Name	**Birth Date**	**Social Security #**
Cell Phone	**Work Phone**	**Place of Employment/Occupation**
Father's Name	**Birth Date**	**Social Security #**
Cell Phone	**Work Phone**	**Place of Employment/Occupation**

EMERGENCY CONTACT INFORMATION			
Name	**Home Phone**	**Cell Phone**	**Relationship**

INSURANCE INFORMATION	
Insurance Name	**Insurance Phone**
Policy Holder Name (If Medicaid write Self)	**Policy Holder Relationship to Patient (please Circle)** Parent / Self /Other: _____
ID#/Policy #	**Group#**
Insurance Address	**City and State**

Who if anyone other than parent or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in Loop Pediatrics without your presence and making medical decisions for his or her treatment.	☐ N/A	☐ Yes the following individuals
Name	**Relationship**	
Name	**Relationship**	
Name	**Relationship**	

I certify that the above information is correct to the best of my knowledge. I release to Loop Pediatrics, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individuals(s) pertaining to my child's care and medical records.

Patient/Legal Guardian & Person Financially Responsible's Signature: _____
Date: _____

***Please fill out ALL fields**

Patient History

Patient's Name _____ Birth Date: _____ Date: _____

Name all persons living in the patient's home at the present time

Name	Age	Relationship	Medical Concerns

Languages Spoken:
☐English ☐Spanish ☐Portuguese ☐French ☐Creole ☐Urdu ☐Chinese
☐Other[s] (most fluent first): _____

Ethnicity: ☐ Hispanic ☐ Prefer not to answer ☐ Other: _____

Race:
☐Asian ☐American/Indian/Alaskan Native ☐Black ☐White ☐Hawaiian Native ☐Pacific Islander ☐Prefer not to answer

Allergies: (list type of reaction)
☐ Medication:
_____
☐Food
_____
☐ Other[s]: _____

Birth History

Where was the patient born? (Hospital and city) _____
Birth Wt: _____ Birth Ht: _____ Gestational Age (how many weeks?): _____
☐ Cesarean Section ☐ NSVD (vaginal delivery)
☐ Problems/complications (list):
_____
_____
_____

Family Medical History (Check and circle all that apply)

☐ Heart Disease: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
☐ Asthma: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
☐ Cancer: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
Type of Cancer: _____
☐ Diabetes: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
☐ Ovarian Cyst: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
☐ Thyroid Disease: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis
Type of Thyroid Disease: _____
☐ Other[s] (list): _____

***Please fill out ALL fields**

Patient's Past Medical History

Has the patient ever had any of the following: (check as many as apply)

- ❑ ADD/ADHD
- ❑ Allergic Rhinitis (allergies)
- ❑ Anemia, Hemophilia
- ❑ Asthma
- ❑ Atopic Dermatitis (Eczema)
- ❑ Autism
- ❑ Bronchitis/Wheezing
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Developmental Delay
- ❑ Diabetes
- ❑ Frequent Ear Infections
- ❑ Hay Fever / Allergy
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Obesity
- ❑ Pneumonia
- ❑ Seizures (Epilepsy)
- ❑ Sinusitis
- ❑ Varicella(Chickenpox) Date: _____
- ❑ Other[s]: (list) _____ _____

I would like to discuss the following concerns:
_____
_____
_____

Past Surgical History

☐Tonsils Removed ☐Adenoids Removed ☐Inguinal Hernia Repair ☐Ear Tube Placement ☐Heart Surgery _____ Broken Bone (surgical repair) _____
Other[s]: _____

Hospitalizations: ☐ None ☐ Yes
Reason (if any): _____ Date[s]: _____

Medications

☐Daily Medications or Vitamins (include dosage):
_____
_____
☐Medications taken today: _____

Social History:

☐Daycare ☐School (Grade: _____)
☐Pets: Dog[s]: _____ Cat[s]: _____ Other[s]: _____
☐Smoker[s] in home (includes inside and oustside): _____

Patient's Habits (if >13 yrs old)

☐ Non-Smoker
☐ Smoker: Tobacco ☐Other: _____

Pharmacy (Very Important! This is where your prescriptions will be electronically sent in the near future. We need at least the phone number for the pharmacy of your preference.)**

☐CVS ☐Walgreens ☐Publix ☐Target ☐Wal-Mart ☐Other: _____
Phone Number (w/ area code):_____
Address: _____

Office: 407-483-5900
Fax: 407-483-5902
looppediatrics@gmail.com

1144 Cypress Glen Circle
Kissimmee, Fl 34741
www.looppediatrics.com

Dr. Sanjay Mehra

*******PLEASE MAIL OR E-MAIL THE RECORDS IF MORE THAN 20 PAGES*******

Medical Release

I, _____ (**Parent/Legal Guardian**), hereby authorize Loop Pediatrics to:

____ Release Copies of the medical records of my child

_____ (**Patient name, DOB, and SSN**) to:

____ Obtain copies of the medical records of my child

_____ (**Patient name, DOB, and SSN**) from:

_____
Name of Facility and/or Physician Phone Number/ Fax Number

_____
Address

_____
City State Zip

THE FOLLOWING:

- ☐ Hospital records including Hx & Phys and Discharge Summaries from the dates: _____ to _____
- ☐ Emergency Room Notes from the period: _____ to _____
- ☐ Diagnostic Tests and Labs
- ☐ Immunization Records (Please fax Immunization Records, All other requested records may be sent by mail)
- ☐ Office Notes from this period: _____ to _____
- ☐ Complete Medical Record

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Change of Physician
- ☐ Continuing Care
- ☐ Insurance
- ☐ Workers Comp
- ☐ Personal
- ☐ Legal Investigation
- ☐ Disability Determination/SSI
- ☐ Other, Please specify: _____

INFORMATION TO BE EXCLUDED, NOT RELEASED:

- ☐ Mental Health Records
- ☐ HIV Testing
- ☐ Drug Alcohol Treatment
- ☐ Sexual Assault/ Victimization Records
- ☐ Other, please specify: _____

I hereby authorize disclosure of the health information for the above name patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN RELATION TO PATIENT DATE

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child (as a patient of this practice) or you (as a patient of this practice) may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy
Loop Pediatrics is dedicated to maintaining the privacy of it s patients' protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend, our Notice. By federal and state law we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI
Our practice may use and disclose PHI for the purposes of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes.

- Treatment
- Payment
- Health Care Operations
- Release or Sharing of Information
- The Rights of Minors and Personal Representatives
- Release of Information to Business Associates
- Release of Information Required by Law
- Research Purposes
- Marketing Purposes

Your Health Information Rights
You have the following rights regarding the PHI that we maintain about your child or you.

- Requesting Restrictions on PHI
- Inspection and Copies of PHI
- Amendment of PHI
- Accounting of Disclosures
- Right to a Paper Copy of This Notice
- Right to File a Complaint
- Right to Provide an Authorization of Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please contact Dr Sanjay Mehra at 407-483-5900.

I have read this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____
Name of Patient (Print or Type)

_____
Date

_____
Signature of Patient or Patient Representative
(Representative's signature is required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

FINANCIAL AND INSURANCE POLICIES

PLEASE INITIAL BELOW INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

_____ I hereby authorize direct payment of medical benefits to Loop Pediatrics for services rendered by the physicians or the organization; I understand that I am responsible for any balances not covered by insurance

_____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____ Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment. All other payment arrangements must be made with our billing department 24 hours prior to the appointment time

_____ A returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by the drawee bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately

_____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible these requests should be made 2 days prior to the appointment date wit the specialist. It is up to the discretion of a Loop Pediatrics provider whether or not to issue a referral requested after the appointment or procedure date.

_____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to your insurance carrier.

_____ I hereby authorize Loop Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

_____ I certify that the information given by me in the applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or the intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

_____
DATE

_____ _____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN PRINT NAME OF PARENT / LEGAL GUARDIAN PRINT NAMEOF PATIENT