PERSONAL PEDIATRICS

Marla Robbins, MD **Lauri Kayaleh, MD** **Maxine Silverman, MD**

Patient Name:_____ **Date:**_____

HOW DID YOU HEAR ABOUT US?

Previous patient of Dr. Robbins: ____

Previous patient of Dr Kayaleh: ____

Previous patient of Dr. Silverman: ____

Friends: ____

Other Physician: ____

Southwest Bulletin: ____

WFTV: ____

Google: ____

Yahoo: ____

Yellow pages.com: ____

Bing: ____

Dex knows: ____

Other: ____

If you have received this packet as an email,

Please complete the forms & email us back at admin@personalpeds.com

Personal Pediatrics

Marla Robbins, MD Lauri Kayaleh, MD

Maxine Silverman, MD

7051 Dr. Phillips Blvd, Suite 1
Orlando, FL 32819
Phone: 407-345-9929 Fax: 407-447-8969

I hereby authorize and request the release of medical records pertaining to my child/children. I understand that these records may contain information including, psychological, psychiatric, substance abuse/alcohol abuse, HIV/AIDS results, testing and/or information.

Please Transfer Records To:

Physician Group: _____

Complete Address: _____

Phone/Fax number: _____

Name of Child/Children: _____

Date of Birth: _____

Obtain Records From:

Physician/Group: _____

Complete Address: _____

Phone/Fax Number: _____

Name of Child/Children: _____

Date of Birth: _____

THIS AUTHORIZES THE FOLLOWING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO BE RELEASED, SUCH AS DATE OF SERVICE, LEVEL OF DETAILED TO BE RELEASED, ORIGIN OF INFORMATION ETC.

HISTORY/PHYSICAL EXAM/OFFICE NOTES: _____

IMMUNIZATION RECORDS: _____

LABORATORY RESULTS: _____

Print Name: _____ **DATE:** _____

Signature: _____

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A parent or legal guardian should accompany a child younger than 18 years of age to any appointment or treatment. If your child will be coming for a visit without a parent or legal guardian, you are asked to complete this form. This consent is valid only for the specified time perod, with a maximum of one year from the date signed.

<table>
<tr><td rowspan="4">Minor Patient</td><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td>Phone:</td></tr>
<tr><td>Time Period</td><td colspan="3">Written consent is valid for the time period of _____ to _____. (Not to exceed one year) This consent can be revoked by me at any time in writing.</td></tr>
<tr><td>Authorize another individual to accompany minor</td><td colspan="3">I authorize _____ _____
Name of Person Relationship to Patient
to give consent to medical treatment on behalf of my child listed above. The above-named individual may receive test results and additional information pertinent to the care and treatment of this minor child. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

_____ _____
Parent/Guardian Signature Date Signed

_____
Emergency Contact Number</td></tr>
<tr><td>Authorize minor patient to be unaccompanied</td><td colspan="3">I authorize my child listed above to go indepedently to appointments without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. I also understand my child could or will receive a vaccine or vaccinations and give permission for child listed above to receive vaccines without my presence.

_____ _____
Parent/Guardian Signature Date Signed

Emergency Contact Number:_____</td></tr>
</table>

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PHARMACY INFORMATION

Name of Patient: _____

Name of Pharmacy: _____

Address of Pharmacy: _____

City: _____ **State:** _____ **Zip Code:** _____

Pharmacy Phone #: _____

Please pick a pharmacy that is most convenient for your family.

If you don't know where to go please choose one close to your home address.

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PATIENT INFORMATION/UPDATE

TO AVOIDMISTKES AND DELAYS IN FILING YOUR INSURANCE CLIMS, ALL QUESTIONS MUST BE ANSWERED

Today's Date:_____

PATIENT INFORMTION

Patient's Name: _____ **Sex:** _____ **D.O.B.**_____

Patient's address:_____

City: _____ **State:** _____ **Zip code**_____ **Phone:**_____

GUARDIAN INFORMATION

Mother's Name: _____ **Date Of Birth:**_____

Address:_____

City: _____ **State:** _____ **Zip Code:**_____ **Social Security#** _____

Place of Employment: _____ **Cell Number:** _____

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

Address:_____

City: _____ **State:** _____ **Zip Code:** _____ **Social Security#** _____

Place of Employment: _____ **Cell Number**_____

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Patient Name: _____ D.O.B: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone number: _____

INSURANCE INFORMATION

Insurance carrier: _____

Claims Address: _____

Policy Holder's Name: _____ D.O.B. _____

Is this plan provided by your employer: Yes:_____ No: _____

Type of Plan: HMO: _____ PPO:_____ OTHER:_____

Insurance ID#: _____ Group: _____

Effective Date of Coverage: _____

Place of Employment: _____

Co-Pay$ _____ Deductible: _____ Well child and immunizations covered in your policy? Yes____ No____

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NEW PATIENT HISTORY

Name: _____ DOB: _____

***NEWBORNS ONLY NEED TO FILL OUT SECTION 1, 4, 5 ***

1. Birth History: (Please CIRCLE appropriate answers)

Full Term Pre-Term _____weeks Birth Weight _____lbs. _____ oz

Delivery: Vaginal C-Section

Complications: _____

_____

2. Patient's Developmental History: (Please CHECK appropriate answers)

Sat alone by age 9 months?	Yes_____	No_____
Walked by age 18 months?	Yes_____	No_____
Spoke sentences by age 4?	Yes_____	No_____
School problems?	Yes_____	No_____
Learning problems?	Yes_____	No_____
Behavioral problems?	Yes_____	No_____

Other issues: _____

3. Patient's Medical History: (please CIRCLE appropriate answers)

Recurrent: Allergies Asthma Ear Infections

Pneumonia Sinus Infections Sore Throats

Has patient had Chicken Pox? Yes No (If yes, age_____)

Daily Medications: _____

Drug Allergies: _____

Others: _____

Patient Hospitalizations/ Surgeries: Yes No

(If yes, list) _____

4. Family History Illness: (please **CIRCLE** appropriate answers)

Allergies	Asthma	High Blood Pressure
High Cholesterol	Diabetes	Cancer

Others: _____

Does any person living in the household smoke? Yes No

5. Patient's Siblings:

1. Name: _____ Age: _____
2. Name: _____ Age: _____
3. Name: _____ Age: _____
4. Name: _____ Age: _____

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MEDICAL & FINANCIAL POLICY

I, Authorize Personal Pediatrics to render all necessary medical care to my child.

I, the undersigned (parent/guardian), certify that I (or my child) have insurance coverage and assign directly to Personal Pediatrics all insurance 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 doctor to release all information necessary to secure the payments of benefit. I authorize the use of this signature on all insurance submissions.

Payment is required for all services at the time they are rendered unless you are covered by an insurance plan in which we participate. For those patients all applicable copayments, deductibles , etc. are due at the time of each visit, as well as any prior balance or service that is considered non-covered by your insurance plan.

Due to the many changes in insurance policies, we are unable to interpret the benefits of each individual policy. It is your responsibility to know your individual coverage and its limitations as well as who is a provider for your plan or who your child is assigned to as a primary physician. We urge you to contact you insurance company and verify your benefits because failure to do so Could result in you , the patient or financially responsible party responsible for all costs incurred.

Parent/Guardian Signature:_____ Date:_____

Children's Name:_____

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. I authorize Personal Pediatrics to utilize a 3rd party email service to communicate with me.

These communications will only relate to policies, procedures and issues relating to the operations of the office.

Please provide your email: _____

Children's names: _____

_____

Parent's name: _____

Parent's signature: _____

Date: _____

Personal Pediatrics

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Maxine Silverman, MD Anne Van Wert, MD

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PERSONAL PEDIATRICS' VACCINE POLICY STATEMENT

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data-gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox, or know a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under-immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

The number of cases of measles in the United States has escalated to the hundreds per year, forty percent of those children requiring hospitalization.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with us in advance of your visit. In some cases, we may alter the schedule to accommodate parental concerns or reservations. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at PERSONAL PEDIATRICS. Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any of us.

Sincerely,

Marla A. Robbins, MD Lauri J. Kayaleh, MD
Maxine L. Silverman, MD

By signing below, I acknowledge that I have read and understand the vaccination policy of Personal Pediatrics.

Parent's signature: _____ Date: _____

Adapted from AAP News

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PATIENT CONSENT

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In connection with the medical services I am receiving from Personal Pediatrics, PA, I consent to and authorize the above-named physicians group to use and disclose any and all Protected Health Information (**PHI**) necessary to carry out treatment, payment, and health care operations (**TPO**) related to my medical care. I have read and understand the Notice of Privacy Practices that offers a more complete description of such uses and disclosures. Copies are available in the waiting room and exam room. This office reserves the right to review and change their Notice of Privacy Practices at any time.

Personal Pediatrics, PA may call my home or office and leave a message in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items, and any call pertaining to my health care.

Personal Pediatrics, PA may mail to my home or office any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

I have the right to request that this practice restrict how they use or disclose my protected health information (**PHI**) to carry out treatment, payment and health care operations (**TPO**). However, this office is not required to my requested restrictions, but if they do, the office is bound by this agreement.

By signing this form, I consent to the use and disclosure of my PHI to carry out treatment, payment, and health care operations (**TPO**). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, this practice may decline to provide treatment.

Date: _____

Print Patient Name: _____

Signature of Parent or Legal Guardian: _____

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As you know we are all facing difficult economic time and Personal Pediatrics is not exempt from this trend. Services that we have given to our patients as courtesy are no longer affordable.

Effective Jan. 11, 2021 we are forced to charge for after hour phone calls or when the office is closed. We currently use a nursing service at Arnold Palmer Hospital that triages our calls. **We are charged $20.00 for each call.** Unfortunately we will have no choice but to **pass this charge to you.** In the event that you are not satisfied with the nurse's response and request to be transferred to the provider on-call a charge to speak to the provider will incur a **$30.00** fee.

When appointments are scheduled we reserve the allotted time necessary for your child's medical needs exclusively. Failure to keep your scheduled appointment without adequate cancellation notice eliminates the possibility of scheduling alternative patients. Unfortunately our baseline overhead expenses continue to exist. **Therefore failure to cancel your appointment without a 24 hour notice or to not show for your well child appointment will incur a $50.00 fee. A $25.00 for sick or recheck appointments.**

We regret this change in policy but the reality of the situation is that these services incur significant debt, and we do not have the ability to absorb these costs.

Please remember the care and well-being of your child is our first concern. If there is a valid reason you cannot meet these obligations, please contact Paula. She will try to resolve any problem in a way that is acceptable to everyone.

_____

Patient or Guardian Signature (if under 18)

_____ _____

Patient Name **Date**