De La Vega Pediatrics

TODAY'S DATE

PATIENT REGISTRATION FORM - PEDIATRICS

Social Security No.: | First Name: | Middle: | Last:

Sex: ◯ Male ◯ Female

Gender Identity: ◯ Male ◯ Female ◯ Other ◯ Decline to Answer ◯ Transgender Male (Female-to-Male) ◯ Transgender Female (Male-to-Female) ◯ Genderqueer (Neither exclusively Male nor Female)

Sexual Orientation: ◯ Straight ◯ Gay ◯ Lesbian ◯ Bisexual ◯ Other ◯ Unknown ◯ Decline to Answer

Birth Date:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Legally Separated

Race: ◯ Asian ◯ Black/African American ◯ White ◯ American Ind./Alaska Nat. ◯ Native Hawaiian ◯ Pacific Islander ◯ Haitian Black ◯ Haitian White ◯ More Than One Race

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic

Preferred Language:

Employed: ◯ Yes ◯ No

Employer:

Street Address:

Home Phone:

City: | State: | ZIP Code:

Cell Phone:

Email: | Work Phone: | Preferred Method of Contact:

Referral Source: ◯ Referring Provider ◯ Ins. Company ◯ Flyer/Mailing ◯ Walk-In ◯ Hospital ◯ School ◯ Family/Friend ◯ Newspaper ◯ Health Fair/Outreach Event ◯ De La Vega Pediatrics's website ◯ Online ◯ Other/Unknown

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Ins. Carrier: | Pt's Relationship to Subscriber: | Group No.: | Policy No.:

EMERGENCY CONTACT INFORMATION

Parent | Spouse | Child | ◯ Other | Sex: ◯ M ◯ F

First Name: | Middle: | Last:

Preferred Language: | Home Phone: | Cell Phone: | Work Phone:

PARENT / GUARDIAN INFORMATION

◯ Parent | ◯ Spouse | ◯ Child | ◯ Other | Sex: ◯ M ◯ F

First Name: | Middle: | Last:

Social Security No.: | Birth Date: | Preferred Language: | Home Phone: | Cell Phone: | Work Phone:

PREFERRED PHARMACY

Pharmacy Name: | Phone: | Fax:

Street Address or Cross Street: | City: | State: | Zip Code:

De La Vega Pediatrics 

NEW PATIENT HISTORY FORM

Date _____

Name _____ DOB: _____

How were you referred to our practice? _____

Current problems/Concerns _____

Allergies (Medications, Vaccines, Food, others) _____

Current Medications _____

BIRTH HISTORY

Was this child? Full term _____ Pre-term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? Vaginal _____C-section _____ If C-section, why? _____

Any problems during the newborn period? _____

Birth weight _____ Breech? Yes _____ No _____

Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

CHILD'S PAST MEDICAL HISTORY	Yes	No
Any Hospitalizations?	☐	☐
Any Surgeries?	☐	☐
Any Emergency room or urgent care visits?	☐	☐

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:		
ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Chicken Pox	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem? _____

Has your child ever been seen by a specialist? _____ If so, please describe?

_____

De La Vega Pediatrics

HAS YOUR CHILD EVER HAD:

	Yes	No
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs. old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome (PCOS)	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

If Other, explain:

De La Vega Pediatrics

CONSENT FORM – PATIENT RESPONSIBILITIES

Our providers follow the American Academy of Pediatrics guidelines in their approach to care. We are committed to providing you with the best medical care available. The following financial policy is provided to avoid any misunderstanding and provide you with an outline of our expectations.

Please note: the party that brings the child to the office will be responsible for the visit's copay AND will also be the responsible party on record. We will not be involved in parental court cases.
Co-Pays, coinsurance and/or deductible are due at the time of service or the visit may be rescheduled.
Whoever brings the child to the office for a visit will be authorized to receive financial and medical information.

Insurance, Billing and Patient Responsibility

Please note that there are over 1000 plans and it is ***YOUR*** responsibility to become familiar with your plan. If you do not understand your specific plan coverage, please call your insurance plan or your HR department at work. The number for your plan is listed on your insurance card.

You are expected to know if vaccines, well-checks, labs or other procedures are covered or might fall into the deductible. It is your responsibility to know if your well-check is made within the timeframe allowed by your insurance company. PLEASE REMEMBER:we are contractually obligated by your insurance company to collect your co-pay at the time of service.Your co-pay is also required at each follow up visit. If you have missed making a copayment in the past, we may ask for credit card information to be held on a secure site to be used for payment prior to making your next appointment. If we have deductible information, your deductible will be due at the time of service. If you have failed to make copay, coinsuranceand/or deductible payment at the time of visit you may be charged an additional $25.00 billing fee.Medical care not covered by your plan is due in full at the time of the visit.

As a courtesy to our patients, **DVP** will bill your primary insurance company. Please remember that your insurance is a contract between you and the insurance company, not the doctor. You are responsible for balances after primary insurance has paid and payment in full is due with the receipt of the statement. We participate in most plans, but if we do not accept your insurance you will be responsible for the day's charges at the end of the visit. . Balances and/or unpaid claims over 60 days will be required to be paid in full or financial arrangements will have to be made before any future appointments can be scheduled.

*****We do not file secondary, automobile, general liability or homeowner's insurance*****

You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. INVALID INSURANCE INFORMATION causing the claim to be returned will be subject to a $25.00 refiling fee. Unless other arrangements are made with our financial department we refer unpaid bills to a collection company after 60 days. Unpaid balances that are transferred to the collection company may result in family dismissal from the practice. There will be a re-instatement fee of $35.00 once the balance has been paid in full.

We accept cash, check, MasterCard, Visa or Discover. There will be a $25.00 for all returned checks. **Proof of current, valid insurance MUST be provided at the time of each service. Failing to prove you have valid insurance will require the visit to be paid that day.**

PAYMENT PLANS: If you are having difficulty paying your balance in full, please call our financial department for arrangements. We must have a signed payment plan and you must be paying regularly to keep your account from further action.

Parent/Patient Name Signature date

Signature

HIPAA - PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **DE LA VEGA PEDIATRICS., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* _____

Patient Signature *(or legal representative; proof may be requested)* _____

Date: _____

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **DE LA VEGA PEDIATRICS., (DVP)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **DVP** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **DVP** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **DVP** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is:_____

My Consented Mobile Number For Text Messaging is:_____

Patient Signature:_____ **Date:** _____

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room*.

Do not use this way of communication for that purpose. *(5) Rev.01/22*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

RELEASE TO	
I authorize **DE LA VEGA PEDIATRICS**; **to release** the health information indicated below to: **And** for the purpose of alternative means of confidential communication the use of the following Email Address:	
Person/Organization Name:	
Address:	
Telephone No:	**Email Address:**
Dates of Medical Record Release:	

DE LA VEGA PEDIATRICS., (DVP) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **DVP** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **DVP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

REASON FOR DISCLOSURE		
☐ **Continuing Care**	☐ **Legal**	☐ **Other Purpose** *(please specify)*
☐ **Insurance**	☐ **Personal Use**	

INFORMATION TO BE RELEASED	
☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Lab Reports**	☐ **Pathology *Reports***
☐ **Radiology Reports**	☐
☐	☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS	
The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:	
☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

REQUEST TO	
Name of Healthcare Facility from which Records are Requested:	
Telephone No.:	**Fax No.:**
Address:	
Dates of Treatment Requested:	**Reason For Disclosure:**

I hereby authorize **DE LA VEGA PEDIATRICS., (DVP) to obtain** the health information indicated below ***AND*** for the purpose of alternative means of confidential communication the use of their email address. **DVP** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **DVP** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **DVP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Mail Information To: **DE LA VEGA PEDIATRICS.**	**Address: 12781 World Plaza Lane, Ste 1 Fort Myers, FL 33907**
Or Fax To: **239.277.1354**	**Email: delavegapediatrics@gmail.com**

INFORMATION TO BE RELEASED

☐ **Complete Medical Records**	☐ **Operative Reports**
☐ **Radiology Reports**	☐ **Pathology Reports**
☐ **Lab Reports**	☐

☐ **Other** *(please specify)*

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*

De La Vega Pediatrics

PARENT/PATIENT AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I, _____ (Relation to patient): _____
Hereby authorize **DE LA VEGA PEDIATRICS, CORP.** staff to perform diagnostic procedures, therapy, tests, examinations, administration of necessary treatment, or other procedures, to myself or minor child, as indicated above, while under the care of **DR. ARNALDO DE LA VEGA, MD, JANE DE LA VEGA, APRN,** and staff. I, the undersigned, also:

- Realize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by DVP.

- Hereby authorize payment to **DE LA VEGA PEDIATRICS, CORP.,** for services rendered by **DR. ARNALDO DE LA VEGA, MD,** by **JANE DE LA VEGA, APRN,** and/or any other provider or staff, to the above patient mentioned in this form. I authorize payments to **DE LA VEGA PEDIATRICS, CORP.,** of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the physician's and/or Nurse Practitioner's regular charges for this period of treatment.

- **DE LA VEGA PEDIATRICS, CORP.,** is affiliated with various educational facilities. I understand I will be notified by these personnel that they are a student and have the right to refuse to have them involved in my and/or my minor child's care. I also understand that if they are involved in my or my child's care, an employed healthcare professional of De La Vega Pediatrics, Corp. is overseeing all services and care provided.

- Authorize the release of information about my wellness, lab result, treatment, and care, when requested by my insurance provider.

- Understand and assume the responsibility for any co-payments, deductibles, and any service not covered by the insurance provider.

- Agree to notify **DE LA VEGA PEDIATRICS, CORP.,** of any change of address/phone number/or insurance provider, before receiving any care or service.

Signature: _____ Date: _____
Parent or Patient signature Date Signed

NOTICE OF PRIVACY PRACTICES

Effective Date 09/23/2013 Publication Date 09/23/2013

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

DE LA VEGA MEDICAL PEDIATRICS, CORP.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure

This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication

This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI

This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI

This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information

This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability

This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice

You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

NOTICE OF PRIVACY PRACTICES

Effective Date 09/23/2013 Publication Date 09/23/2013

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment

We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices

We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment

Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization

The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures

We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department 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 the Privacy Manager at:

We will not retaliate against you for filing a complaint.

Address: 12781 World Plaza Ln, Ste 1

City: Fort Myers

State: FL

Zip Code: 33907