Firefly After Hours Pediatrics
1011 High Ridge Road
Stamford, CT 06905
203-968-1900

Historia Medica

Nombre:_____ Fecha:_____

Sexo: F M Edad:_____ Fecha de Nacimiento:_____

Problema medico actual:

Historia Medica
Alergias

Tiene su niño/a alergia a la Penicilina? SI NO
Tiene su niño alergia a los antibióticos con Sulfa? SI NO

Otras alergias a alimentos o ambientales?_____

Cirugías y su aproximada fecha:_____

Hospitalizaciones y enfermedades graves: _____
_____

Lista de Medicamentos (tomando en este momento/ a diario)
_____

Inmunizaciones: al día? SI NO

Día de la ultima vacuna para el Tétano:_____

Nombre:_____ Fecha de Nacimiento: _____

GENERAL	SI	NO
Tiene su niño energía?		
Esta comiendo bien?		
Esta durmiendo bien?		
Nota que su niño esta creciendo?		
Su niño puede hablar bien?		
SISTEMA RESPIRATORIO	SI	NO
Tiene su niño tos?		
Sufre de asma o tiene resuello?		
Esta respirando con dificultad?		
HEENT	SI	NO
Tiene su niño dolores de cabeza?		
Tiene problemas de visión?		
Tiene problemas de audición?		
Le lloran o pican los ojos o la nariz		
CARDIOVASCULAR	SI	NO
Tiene su niño dolor de pecho?		
Latidos de corazón irregulares?		
Palpitaciones de pecho?		
HEMATOLOGIA/ENDOCRINOLOGIA	SI	NO
Sangre fácilmente o se le hacen muchos moretones?		
Tiene problemas con cambios de temperatura, mucho frio o calor?		
Tiene sed excesiva?		
Orina mas de lo normal?		
DERMATOLOGIA	SI	NO
Tiene su niño acné/sarpullidos en la piel?		
Lunares, manchas o cambios en la piel?		

NEUROLOGIA	SI	NO
Su niño se ha desmayado?		
Golpeado fuerte la cabeza?		
Tiene epilepsia o convulsiones?		
PSICOLOGIA	SI	NO
Es su niño poco colaborador y desafiante?		
Le cuesta jugar con otros niños y se lleva mal con sus maestros?		
Lo nota muy ansioso o depresivo?		
GASTROINTESTINAL	SI	NO
Tiene problemas de diarrea?		
Constipación?		
Dolor de estomago frecuentes?		
Vómitos?		
GASTROURINARIO	SI	NO
Puede su niño controla la orina?		
Puede controlar la defecación?		
Le preocupa el desarrollo sexual de su niño?		
NACIMIENTO	SI	NO
Fue este un embarazo planeado?		
Nació su niño prematuramente?		
Tubo alguna dificultad: (describa)		
INFORMACION SOCIAL	SI	NO
Va su niño a la escuela? Grado:		
Esta expuesto al humo de tabaco?		
Le preocupa que su niño pueda estar fumando?		
Usando drogas ilegales?		
Tomando alcohol?		
Quien vive en la casa con el niño/? - -		

Problemas de salud o Preocupaciones:

Firma: (Paciente, Padre, Madre, otro: _____) Fecha:

Provider's Initials:

Bienvenido a Firefly! Formulario de Inscripción del Paciente

INFORMACION DEL PACIENTE

Por favor entregue su licencia de conducir y tarjeta de seguro social con este formulario

Nombre del Paciente: _____ Fecha de Nacimiento: ____/____/____ Sexo: M/F
Apellido Nombre

Dirección: _____
Calle Ciudad Estado Código postal

Teléfono de la Casa: (____)_____-_____ Teléfono Celular (____)_____-_____

INFORMACION DE LA MADRE

Nombre: _____ Fecha de Nacimiento: ____/____/____
Apellido Nombre

Dirección: _____
Calle Ciudad Estado Código postal

Teléfono de la Casa: (____)_____-_____ Teléfono Celular (____)_____-_____

INFORMACION DEL PADRE

Nombre: _____ Fecha de Nacimiento: ____/____/____
Apellido Nombre

Dirección: _____
Calle Ciudad Estado Código postal

Teléfono de la Casa: (____)_____-_____ Teléfono Celular (____)_____-_____
Dirección de e-mail _____ Lugar de trabajo _____

INFORMACION DE CONTACTO DE EMERGENCIA

Nombre: _____
Apellido Nombre

Teléfono de la Casa: (____)_____-_____ Teléfono Celular (____)_____-_____

Como se entero de nuestra oficina? _____

Por favor complete el otro lado de este formulario

Firefly After Hours Pediatrics LLC participa con muchos distintos programas de seguros sociales. Si Firefly no participara con el seguro medico que usted posee, nuestra oficina mandara directamente su reclamo a la oficina de su seguro medico. Igualmente recuerde que el seguro medico no es lo mismo que el pago de las visita y es su responsabilidad pagar los copagos y deducibles y cualquier pago restante no cubierto por su seguro medico. Después de reconciliar los pagos con su seguro medico de haber algún restante Firefly le mandara una factura a su dirección.

Si esta visitando esta zona y no vive en los estados de New York, New Jersey o Connecticut el pago debe ser efectuado en el momento de la visita medica, Firefly mandara su reclamo a su seguro medico para que le reembolsen su pago.

Yo le doy autorización a Firefly para que tenga opción de ver los records médicos necesarios para el pago de la visita medica para poder reembolsar el reclamo medico que ha sido incurrido. Doy permiso para que mi seguro medico page los reclamos médicos o quirúrgicos en mi nombre o de mis niños. Esta asignación de pago se va a mantener en efecto hasta que yo la revoque por escrito. Una copia escaneado de esta asignación es tan valida como el original. Yo entiendo que soy financieramente responsable por el costo de la visita aunque mi seguro medico cubra o no el tratamiento medico *provisto*. Le doy permiso a Firefly After Hours Pediatrics, LLC para que provea toda la información necesaria para el reembolso y pago de las visitas medicas.

Nombre_____Firma_____Fecha_____

Dirección de e-mail_____

Aviso de Procedimientos de Privacidad

Yo, (Nombre)_____

Firmando abajo, estoy reconociendo que he recibido una copia del aviso de procedimientos de privacidad y entiendo que puedo entrar en contacto con la persona nombrada en el aviso si tengo preguntas sobre el contenido del aviso o si necesito otra copia.

Firma:_____Fecha:_____

Nombre del paciente: _____Fecha de nacimiento:____/____/____

Muestras de Laboratorio

Si fuera necesario hacer estudios de laboratorio como de orina, fecal, etc. Yo entiendo que todas las muestras para dichos estudios juntadas durante las visitas medicas van a ser mandadas al laboratorio de Quest Diagnostics. De ser necesario mandar las muestras a otro laboratorio usted será informado. Yo entiendo que al firmar este formulario estoy reconfirmando que mi seguro medico puedo NO cubrir estos estudios y en ese caso "podría" recibir una factura directamente de Quest Diagnostics. Yo entiendo que Firefly manda la mayoría de las muestras de laboratorio a Quest Diagnostics y que Quest tienen su propio centro de atención al cliente y facturación. De recibir una factura de Quest Diagnositcs yo entiendo que tengo que contactar directamente a Quest en el caso de que ellos me mandaran una factura. También entiendo que Firefly After Hours no es responsable de pagar cuentas o facturas por estudios realizados en mi nombre o de familia.

Nombre del Paciente:_____

Fecha de Nacimiento:_____

Firma del paciente/
padre/responsable:_____Fecha:_____

Patient Protection and Affordable Care Act (PPACA) of 2010

The Patient Protection and Affordable Care Act of 2010 provides for better access of patients to their medical records. In keeping with this new law, we are required to give you access to your child's electronic health record. In order for us to accomplish this and fulfill the law, we ask that you give us your email address. You will receive an email that states how you are to login to the medical record and we will print out a temporary password for you to take with you so that you can login to the medical record. You can be assured that your email will be protected within the locked medical record and that it will not be used for any other purposes. Thank you for your cooperation in this matter.

Child's Name: _____

Your email address: _____

Protección al Paciente y Cuidado de Salud Asequible (PPACA) de 2010

La protección del paciente y asequible Ley de atención de 2010 proporciona un mejor acceso de los pacientes a sus registros médicos. De acuerdo con esta nueva ley, estamos obligados a darle acceso al registro electrónico de salud de su hijo. Para que podamos lograr esto y cumplir con la ley, le pedimos que usted nos da su dirección de correo electrónico. Usted recibirá un correo electrónico que indica cómo va a acceder a la historia clínica y vamos a imprimir una contraseña temporal para que usted tome con usted para que usted puede acceder a la historia clínica. Usted puede estar seguro de que su dirección de correo electrónico será protegida en la historia clínica con llave y que no será utilizado para ningún otro propósito. Gracias por su cooperación en este asunto.

Nombre del Niño: _____

Su dirección de correo electrónico _____

Firefly
AFTER HOURS PEDIATRICS LLC ™

1011 High Ridge Road, 2nd Floor
Stamford, CT 06905
T: 203.968.1900 • F: 203.968.0151
www.fireflypediatrics.com

We appreciate your selection of our practice for your children's medical care. To prevent any possible future misunderstanding, we have prepared the following summary of our policies.

1. The **parent/guardian or guarantor (insured member)** is responsible for payment for services.
2. We will require a copy of your insurance card, a form of identification and billing information each visit.
3. **If you fail to inform us of any changes in coverage, you will be responsible for payment for services rendered.**
4. A credit card is required to be put on file and will be charged **AFTER** your claim is processed according to your insurance response.
5. RETURNED CHECK FEE - is $30
6. Records may be destroyed 7 years after last date of service per CT Law.
7. Unaccompanied minors must have written permission to be treated via email or fax from a parent or gardian.

Responsible Party's Statement, Authorization and Assignment of Benefits:

I have read all the above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I authorize payment directly to Firefly for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Firefly for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co payments, deductibles, charges not covered under my insurance benefits and the above Fees for Service.**

Should your account become delinquent and turned over to our collection agency, we will require payment from you before future treatment can be undertaken. In the event that any legal action is brought to collect my account or any portion thereof, I agree to pay a reasonable sum for attorney's fees in addition to costs and disbursements as provided by statute.

A photocopy of this authorization shall be considered as effective and valid as the original.

I authorize the release of any medical information necessary to process claims.

Date _____

Children's Names; _____

Signature _____Relationship, _____

1011 High Ridge Rd.
Stamford, CT 06905

PAYMENT AUTHORIZATION AGREEMENT

Patient/s name/s: _____
Card last four digits : _____
Cardholder name : _____ **Zip Code:**_____
Card expires on: _____ **Not to exceed: $250**
End date of authorization: _____

I hereby authorize FireFly After Hours Pediatrics to keep my debit or credit card (as indicated above) on file for payment and to initiate appropriate payment entries against the above referenced debit or credit card, as applicable, as amounts are owed by me on the Patient Name listed above. I acknowledge that the initiation of all such entries to make payments of the Patient Name listed above must comply with the provisions of U.S law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card, as applicable, periodically to pay amounts owed by me on the Patient Name listed above. I also agree to notify FireFly After Hours Pediatrics if my debit or credit card information (as indicated above) changes for any reason. This authorization shall remain in effect until the "End date of authorization" listed above or until I communicate to FireFly After Hours Pediatrics my intention to cancel authorization by calling FireFly After Hours Pediatrics at 203.968.1900 or writing to FireFly After Hours Pediatrics at the below address. I acknowledge receipt of a copy of this authorization form.

X_____ Date: _____

Parent's Signature

Firefly
AFTER HOURS PEDIATRICS LLC ™

HIPAA NOTICE OF PRIVACY PRACTICES

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 right to access and control your PHI. PH is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your PHI 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 of 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 PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Your PHI may also 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 PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves, or pay for your health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations. We may use or disclose, as needed, your PHI 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; and conducting or arranging for other business activities. For example, we may include 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your authorization. These situations include as required by Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglects; Food and Drug Administration requirement; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensations; Inmates; and Required Users and Disclosures. Under 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 requirement of Sections 164.500.

We will share your PHI with third party "business associates" that perform various activities (e.g. billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI as necessary to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your PHI to other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

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, 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. The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A designated record set contains medical and billing information and any other records that your physician and the practice use for making decisions about you. 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 PHI that is subject to law the prohibits access to PHI.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 Practice. 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at alternative locations. We will accommodate a reasonable request. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of any alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms or our notice at any time. The new notice will be effective for all PHI that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practice by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints. You may complain to us or to the Office of Civil Rights, 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. You may obtain the address of the OCR Regional Manager, Denver, CO from our Privacy Officer.

FIREFLY AFTER HOURS PEDIATRICS, LLC'S PRIVACY CONTACT: Dr. Stuart Silverstein, 1011 High Ridge Road, 2nd Floor, Stamford, CT 06905.

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 PHI. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 203-968-1900.