Welcome to Our Office!

Yanina Abaunza-Fiallos M.D.

DR. NINA'S PEDIATRICS

The Following Documents Contain:

✓ New Patient Paperwork

(Bring On Child's First Appointment)

✓ Medical Records Release

(Forward To Previous Physician)

✓ Office Policies

(For Parent to Keep)

All New Patients Must Change Their Primary Care Physician (PCP) To:
Dr. Yanina Abaunza-Fiallos M.D.
Prior to the First Office Visit.
(This can be done by calling your child's Insurance)

Please contact us with any questions at 813-964-1800.
We look forward to seeing you!

Van Dyke Commons Professional Park
17541 North Dale Mabry Hwy.
Lutz, FL 33548
Phone 813-964-1800 Fax 813-964-1880
www.doctornina.com

Yanina Abaunza-Fiallos, M.D., P.A.
Dr. Nina's Pediatrics

PATIENT DATA

Patient Name _____ Gender: __Male __ Female
Date of Birth _____Social Security # _____
Ethnicity: _____ Race: _____
Address _____
City_____ County _____
State_____ Zip Code_____
Home Phone _____ Cell Phone _____
E-Mail _____ Can we contact you at this address? ___
Patient's School _____Grade Level _____
Daycare: Y:_N:_ Languages spoken at home: _____

Marital Status of Parents (Check one) __ Married __ Single __ Divorced __Widowed
Mother's Name _____DOB: _____Work Phone _____
Mother's Employer _____ Occupation _____
Father's Name _____DOB:_____ Work Phone _____
Father's Employer _____ Occupation _____
Custodian Information (If not with Parents) _____

Insurance Information (must be fully completed and/or present Insurance Card)
Insurance Name _____
Insurance Phone _____
Policy/ID Number _____
Group Number _____
Claim Address _____
Policy Holder Name _____ Holder's Date of Birth _____
Holder's Policy/ID Number (may be SS #) _____
Secondary Insurance Name _____(we do not file secondary plans)
Person Responsible for this bill _____

***Emergency Contact Name and Phone No: _____**
Other Contacts: _____
What Information Can We Provide? _____
***Pharmacy of Choice: _____ Phone/Fax No: _____**
Location: _____

Referral Source _____
Today's Date _____ __ Person Providing Information_____

Yanina Abaunza-Fiallos, M.D., P.A.
Dr. Nina's Pediatrics

HEALTH HISTORY

Today's Date _____Person Providing Information _____
Patient Name _____Date of Birth _____ Sex: __M __F
Emergency Contact _____Phone # _____

PATIENTS HISTORY PERTAINING TO HIS/HER BIRTH:

Pregnancy or Delivery complications: _Yes _No. If yes, explain: _____
_____
Pregnancy #:__ Type of delivery: _ Vaginal _ C/S _ Term _ Premature: ____ weeks
Hospital Name _____ Birth weight _____ Length _____
Discharge weight ____ Blood Type____ Jaundice: __ Y __N
Hearing screening: __ Passed __ Failed __ Not done
Newborn metabolic screen test: __ Normal __ Abnormal

PATIENT'S PAST HISTORY:

Hospitalization Date_____ Hospital Name_____ Cause_____
Hospitalization Date_____ Hospital Name_____ Cause_____
Hospitalization Date_____ Hospital Name_____ Cause_____

Surgery Date _____ Age_____ Type of Surgery_____
Surgery Date _____ Age_____ Type of Surgery_____
Surgery Date _____ Age_____ Type of Surgery_____

PATIENT'S CURRENT HISTORY

Immunizations: Up to Date? __ Y __ N Previous Adverse Reactions? __Y __N
Comments_____

Medications: (Prescription, over the counter, vitamins, fluoride, contraceptives, alternative/natural/herbal products) _____
_____
Allergies, type of reaction: _____
_____
Other allergies_____

PATIENT'S SOCIAL HISTORY:

Persons in Household: Adults__ Kids__ Guardian: _____
Type of Home: __ House__ Apartment __Other_____
Type of Water: __Well __City Exposure to tobacco smoke: __Y __N
Firearms in the home: __Y __N Pets: _____

PATIENT'S FAMILY HISTORY:

Please Complete the Following:

Relationship to patient	Name	Age	List Chronic Health Problems	Living?
Mother				
Father				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				

Medical Family History

Check All That Apply to Immediate Family / Note Who in the family is Affected:

___Allergies/Hay fever
___Asthma/Bronchitis
___Bleeding Disorder
___Cancer
___Diabetes
___Eczema/Skin Problems
___Epilepsy/Seizures
___Congenital Disorders
___Heart Disease
___High Blood Pressure
___High Cholesterol
___Inherited Disease
___Kidney Disease
___Mental Illness
___Gastrointestinal
___Other_____

Patient's CONCERNS AND SYMPTOMS

Are you concerned about any of the following? (Patient)
__Hearing ___Speech ___Vision ___Development ___Behavior __Learning
Give detail history:
Has or does your child suffer from any of the following? Please check all that apply:

__Anemia
__Frequent Ear Infections
__Eye Problems/ uses corrective lenses__
__Frequent Throat or Tonsils Infections
__Sinusitis or Chronic Runny Nose
__Pneumonia, Asthma, Wheezing
__Allergies any type, detail
__Heart Murmur or Heart Problems
__Headaches
__Constipation or Diarrhea
__Vomiting
__Hepatitis or Liver Problems
__Bed wetting, over age 6 only
__Convulsions or seizures
__Mental illness
__Fractures or Gait Problems
__Eczema or Skin Problems
__Food Intolerance

Comments: Provide as much past medical history/explain any health concerns

_____
_____
_____
_____
_____
_____
_____

Authorization For Release of Patient Medical Records

I hereby request and authorize:

_____

(Name of Doctor or Facility that records are being requested from)

Address_____

City _____State ____ Zip _____

Phone_____ Fax_____

To release the medical records of:

Patient Full Name_____

Date of Birth_____

☐ Dates of Service_____

☐ All Medical Records

☐ ALL MEDICAL RECORDS (except HIV - AIDS records, see below) will be sent unless specifically requested to exclude certain records. Please be advised that your social history is considered to be part of your medical records. If you wish to exclude certain records, please list items to be excluded: _____

☐ Including HIV/AIDS records (if applicable)

These records are to be provided to:

Yanina Abaunza-Fiallos M.D., P.A.
17541 N. Dale Mabry Hwy.
Lutz, FL 33548
Phone 813-964-1800 Fax 813-964-1880

Authorized by:

_____ _____

Printed Name of patient or authorized representative* Contact Phone #

_____ _____

Signature of patient or authorized representative* Date Signed

Authorized Representative: ☐ Parent ☐Surviving Spouse ☐Legal Guardian
☐Administrator/Executer of Estate* ☐Other _____

*If Legal Guardian, Administrator or Executer of Estate, legal proof of this status must accompany this form.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility. This authorization will automatically expire 60 days after the date signed.

AUTHORIZATION

I authorize the release of any medical information necessary to process an insurance claim.
I authorize the insurance company to make payments on my behalf to the physician rendering service. Payment of any balance is my responsibility.
I authorize you to give me reasonable and proper medical care by today's standards of care.
I certify that all of the information given is true and correct to the best of my knowledge.
I have read and understand the office financial policy.

Signature_____ Date_____

Please list the persons authorized to bring your child in for treatment (other than parents):
_____ Relationship_____
_____ Relationship_____

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been provided with the Practice's Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for health information the Practice already has about me, as well as any they receive in the future. The practice will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

Patient/Legal Guardian's Signature _____
Date _____

OFFICE FINANCIAL POLICY

Our goal is to deliver the highest quality medical care as efficiently and effectively as possible. To maintain this standard of medical care, we must operate an efficient office from a business perspective. All HIPPA laws are complied with in this office. Measures are in force to protect your identity. The following information will provide you with some of the financial guidelines of our office:

Office Charges

Unless you have an Insurance plan this office is contracted with, payment is due at the time of service. Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Payment may be made by check, cash, VISA, MasterCard. American Express and Discover. We will bill your primary insurance company as a courtesy to you. You agree to pay any portion of the charges your insurance requires, such as deductibles etc.

Checks returned from the bank for any reason will be assessed a non-refundable service charge. We have the right to cancel your privilege to pay by check or charge against your account at any time. Future visits would then need to be paid at the time of service.

Special circumstance arrangements can be made prior to your visit, speak with the office for further questions.

Missed appointment fee: Patients who do not cancel scheduled appointments within 24 hours' notice will be charged a fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another physician.

Fees may be charged for filling out additional forms. An estimate of these charges will be made prior to completing forms.

FEES ON MONTHLY STATEMENTS ARE DUE AND PAYABLE WITHIN 30 DAYS FROM THE DATE OF THE STATEMENT AND ARE CONSIDERED DELINQUENT THEREAFTER.

Yanina Abaunza-Fiallos, M.D., P.A.
Dr. Nina's Pediatrics

Thank you to our wonderful parents and precious patients for making our practice a great success. We are continuing to add new families to our practice every day. In an effort to ensure that our practice operates efficiently and to provide you the highest standard of care, we ask that you please keep the following information in mind:

1. We do not call medication to the pharmacy without thoroughly assessing and evaluating the child's condition. We deeply care about each patient and would not consider putting a child at risk by prescribing unneeded medications or by possibly missing the opportunity to diagnose an unseen medical condition. If you feel your child is ill enough to require a prescription medication, please come to the office for an appointment.
2. Medication refills for monthly medications should be allowed 24 hours for completion. Please call in advance of your child running out of medication. Children on ADD/ADHD medications must be followed closely. A med check appointment is required every 3 months.
3. If you suspect a sibling in attendance at your sick child's appointment is also ill, please make an individual appointment for that child. This is necessary so that each child can have his/her share of time with the doctor and each child can be thoroughly checked.
4. Please be <u>on time</u> for your appointment. If you are more than 15 minutes late for your appointment, it may be necessary to reschedule. If you choose not to reschedule, you may incur a lengthy wait to be seen, as we will have to see our on-time patients prior to the late arrival.
5. We strongly discourage "walk-ins". In order for the office to run smoothly, all appointments must be scheduled in advance. Of course, if your child is experiencing an emergent situation, we will see the child ASAP. Please call on your way to the office if possible.
6. In an effort to provide all patients the opportunity for an appointment, we must insist that un-needed appointments be canceled 24 hours in advance. A "no show" appointment slot could have been utilized by a sick child who needed to be seen (if the appointment had been canceled). In the case of recurrent cancellations without sufficient notice or repeated "no shows", a fee will be assessed to your account.
7. If Blue and Gold forms, sports, and/or camp forms are needed, please let the receptionist know when you make the appointment for the child's well visit. This allows the nurse to begin preparation on the forms and have them ready for you by the end of the visit. One set of "Blue and Gold" forms are provided at no cost per well visit/per year. If additional forms are requested at a later date, there will be a fee per form. We will require 24 hours for completion of these forms.
8. Please reserve your use of the answering service for emergencies. Do not hesitate to call if your child is ill, you are concern and you think it may require immediate attention. Have all pertinent information on hand to relay to the doctor when she calls back. If you call the physician after hours, the child should be seen for an appointment the next day to be thoroughly assessed.
9. Please call during regular business hours for medication refills, medication doses, advice, and questions of non-urgent matters. Calls will be returned by the end of the business day.

Thank you for allowing us to participate in your child's care. We look forward to a continuing relationship with you and your child. Please feel free to communicate with us to offer feedback and/or suggestions on how we are doing.

Sincerely,

Dr. Yanina Abaunza-Fiallos, and Staff.

Yanina Abaunza-Fiallos, M.D., P.A.
Dr. Nina's Pediatrics

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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.

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established privacy rule ("HIPPA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Use and disclosure of protected information:

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use you medical information for health care operations without further specific notice to you or written authorization by you. For example, under you health plan, we are required to provide them with a diagnosis code for you visit and a description of the services rendered.

Federal law provides that we may use you medical information for health care operations without further specific notice to you, or written authorization by you. For example, our accountants may see you name, dates of treatment and procedure codes during audits of our books or we may use you information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose you medical information, without further notice to you, or specific authorization by you, where:

- Required by law.
- Required for public health purposes.
- Required by law to report child abuse.
- Required by a health oversight agency for oversight activities authorized by lay, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
- Required by law in judicial or administrative proceedings.
- Required by a coroner or medical examiner.
- Permitted by law to a funeral director.
- Permitted by law for organ donation purposes.
- Permitted by law to avert a serious threat to health or safety.
- Permitted by law and required by military authorities if you are a member of the U.S. armed forces

New York State law provides additional protection for information requiring HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have:

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information
(a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR §164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

You have the right to obtain a paper copy of this notice from our office.

Obligations that we have:

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to our privacy officer, Yanina Abaunza-Fiallos, M.D. You can contact her at 813-964-1800 if you desire further information or have any questions or concerns. No retaliatory action will be taken against you for any complaint you may make.