GARDENS PEDIATRICS

Patient Information

Child's Name: _____, _____ *Date of Birth:* _____ *Sex:* M [ ] F [ ]
Last First Middle

Contact No: Home: _____ *Mobile:* _____ *Email:* _____

Address: _____ *City:* _____ *Zip:* _____

Parent / Guardian:

1. *Mother:* _____ _____ *Work Ph No:* _____

2. *Father:* _____ *Work Ph No:* _____

3. *Other (Specify)* _____ *Phone No:* _____

Additional Emergency Contacts: _____ _____ _____
Name Relationship Phone Number

Guarantor (Person Financially Responsible): ☐ *Father.* ☐ *Mother.* ☐ *Other (Specify)* _____

Guarantor Address (if different from above): _____

Besides parents/guardian who else is authorized to bring the child for medical treatment? / Relation to the child:

_____ / _____

WHO REFFERED YOU? ☐ *Friend / Relative* ☐ *Sibling is Practice Patient* ☐ *Brochure,* ☐ *School/ Daycare* ☐*OBGYN,*

☐ *Yellow Pages,* ☐ *Hospital,* ☐ *Advertisement,* ☐ *Other*

If referrer is Friend/Relative/School/OBGYN off/Other, we would like to thank them. Give details. _____

INSURANCE INFORMATION

Insurance Name: _____ Name of Insured: _____ Date of Birth: _____

Policy No: _____ Group Number: _____ S S N# of Insured: _____

Release and Assignment

I hereby give permission to Dr.Gowda at Gardens Pediatrics to examine and administer treatment as may be deemed necessary and assign insurance benefits if any otherwise payable to me for services rendered directly to Dr.Gowda at Gardens Pediatrics. The undersigned agrees that all services are rendered on a paid basis only. If collections become necessary, the undersigned shall pay all costs including attorney's fee. I hereby authorize the doctors to release all information necessary to secure the payments and benefits. I authorize the use of this signature on all my Insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/ Guardian ***Date:***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I have received a copy of the GARDENS PEDIATRICS' Notice of Privacy Practices.
I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

_____ _____

Signature of Parent / Guardian ***Date***

GARDENS PEDIATRICS NEW PATIENT INFORMATION

Dated: _____

Child's Name: _____ Age_____

List Siblings & Ages.

1._____ _____ 3._____ _____

2._____ _____ 4._____ _____

1. Known ALLERGIES : _____

2. Pregnancy and Birth History: (Fill in if patient is <2 yrs)

Hospital:_____ OB Doctor: _____Birth Weight: ___lbs. ___ oz

Was baby premature? ☐ N, ☐ Y, Was baby born by C- Section ? ☐ N, ☐ Y,

Were there any health problems during pregnancy, labor and delivery? ☐ N, ☐ Y,

Did baby have to stay in nursery longer than expected after delivery? ☐ N, ☐ Y,

Explain all 'Yes' answers. _____

_____

3. Family History of Following Disorders.

Asthma - ☐ N, ☐ Y, Seasonal Allergies - ☐ N, ☐ Y, Seizures - ☐ N, ☐ Y,

Diabetes - ☐ N, ☐ Y, Heart Disease/ Early Death - ☐ N, ☐ Y, Other - ☐ N, ☐ Y,

Explain all 'Yes' answers._____

_____

4. Immunizations: Are your child's immunizations up to date? ☐ **N,** ☐ **Y,**

5. Past Medical History: Previous Hospitalizations: ☐ N, ☐ Y, Previous Surgeries : ☐ N, ☐ Y,

Chronic illnesses: ☐ N, ☐ Y, Frequent illnesses: ☐ N, ☐ Y, Serious illness: ☐ N, ☐ Y,

Learning Impairment: ☐ N, ☐ Y, Behavioral Problems: ☐ N, ☐ Y, Mental Health issues: ☐ N, ☐ Y,

Explain all 'Yes' answers._____

_____

6. List all Medications taken on a regular basis: _____

_____

7a. Developmental History (Fill out if child is < 3 years).

Did child sit alone by 7 months? ☐ N, ☐ Y, Did child walk independently by 14 months.☐ N, ☐ Y,

Vocabulary: 3 words by 15 months? ☐ N, ☐ Y, Any concerns of Child's social skills? ☐ N, ☐ Y,

7b.Has your child shown any Developmental or Speech or Fine Motor or Social skills delay or slowing? ☐ **N** ☐ **Y.**

Explain all 'Yes' answers. _____

_____

8. Miscellaneous: Language spoken at home: ☐ English, ☐ Spanish ☐ Other _____

PLEASE FURNISH A COPY OF VACCINATION RECORDS AT FRONT DESK.

PCMH (Patient Centered Medical Home) Supplemental Clinical History Form

Child Name: _____ **DOB:**_____

Email: _____

Family:

Child lives with:

☐ Both Parents ☐ Shares Custody with parents

☐ Mother ☐ Father

Guardian/ Other: _____

Number of Siblings:

☐ One ☐ Two

☐ Three ☐ Other

Parent Occupation: Mother _____ Father _____

Parent Education Level: Mother: ☐ Some Schooling ☐ High School ☐ College ☐ Masters ☐ Doctorate

Father: ☐ Some Schooling ☐ High School ☐ College ☐ Masters ☐ Doctorate

Social:

Child goes to: ☐ Baby Sitter ☐ Day Care ☐ Preschool ☐ School ☐ Stays home ☐ Home School

Preschool/ Day Care/ School Name: _____

House: ☐ Single Family Home ☐ Town Home ☐ Apt. Building ☐ Mobile Home ☐ Other

Smoking: Does anyone living in the household with the child smoke? ☐ Yes ☐ No

If Yes, Who: _____

Mental Illness/ Substance Abuse:

Family History of Mental Illness: ☐ Yes ☐ No If Yes: ☐ Mother ☐ Father ☐ Relative

Substance Abuse/ Alcoholism: ☐ Yes ☐ No If Yes: ☐ Mother ☐ Father ☐ Relative

Other:

Pets: ☐ Dog ☐ Cat ☐ Other: _____

Does primary caregiver have any hearing or communication deficit? ☐ Yes ☐ No

If Yes, please explain: _____

Does primary caregiver have any barriers with purchasing medications? ☐ Yes ☐ No

Does primary caregiver have any barriers with purchasing food? ☐ Yes ☐ No

Does primary caregiver have any religious beliefs that present barriers to health care? ☐ Yes ☐ No

If Yes, please explain: _____

Primary Language Spoken at home: ☐ English ☐ Spanish Other, please specify: _____

Race/ Ethnicity:

☐ Caucasian ☐ Latino ☐ Mediterranean ☐ Asian Indian

☐ African American ☐ American Indian ☐ Asian ☐ Other

Misc. Significant Information Deemed Important by parent: _____

_____

Gardens Pediatrics
500 University Blvd. Suite 102
Jupiter, FL 33458.

Financial and Office Policy

Patient Name_____**Date of Birth**_____

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read carefully and initial.

FOR PATIENTS WITH PRIVATE INSURANCE:

Option A: Credit Card on File . See the Credit Card On File Policy.

Option B: Credit on your account of $ 70 for charges not covered by your Insurance.

According to your insurance plan, you are responsible for any and all co-pays, deductibles, and co insurances. Co-pays are due at the time of service. It is your responsibility to keep us updated with your insurance information. It is your responsibility to understand your benefit plan. Patient balances are billed monthly via e-mail, we ask that you pay your statement balance after receiving email using online bill pay. Otherwise we will charge Credit Card On File (option A) or use your credit towards the unpaid balance. **Initials:**_____

SELF-PAY PATIENTS are expected to pay for services in full at the time of visit. **Initials:**_____

NON COVERED SERVICES: Any service not covered by your existing insurance will require payment in full at the time of service.

FORMS: There is **no charge for shot record and physical form and School Medication form given at the time of your child's visit,** this service is included. There will be a $2.00 fee for each form requested any time after physical / visit is done.
Forms via Fax: There will be a fee of **$5.00 for any form to be faxed and payment is due at the time of request over the phone.** Any **additional school, camp, or sports forms are subject to a $5 flat fee.** We require a 48 hour turnaround time.
FMLA forms have a fee of $15.00 and we request 2 weeks from the day of request. Payment is due at the time your request.

Initials:_____

MEDICAL RECORDS: Copies of medical records are available with a $10.00 flat fee. Please note this is for patients and continuity of care only. For other entities charges are different. **Initials:**_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

PARENT/GUARDIAN NAME:_____RELATIONSHIP:_____

PARENT/GUARDIAN SIGNATURE_____DATE:_____

Gardens Pediatrics

Office Policy / Referrals / Lab Results / Refills / Walk Ins / No Shows.

Patient Name_____**Date of Birth**_____

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read carefully and initial.

WALK-INS We recommend that you schedule an appointment to keep consistent flow and avoid longer wait. If you do walk-in with out appointment, it is not guaranteed that you will be seen or you might be asked to schedule an appointment for a later time. **Initials:**_____

REFERRALS: If patients have a managed care products (HMO, POS, EPO), their insurance does not allow them to self refer. Our office must coordinate, document and approve all specialty visits. Patients are responsible for understanding their insurance coverage.

All patients requesting referrals must be referred by one of our providers. **This is done through a visit or telephone call if emergency and follow up visit with the provider.** The Referral Department can only process referrals approved by a Provider.

The patient will be given a list of specialists. If it is via the telephone, the patient will receive the names and phone numbers of the specialists that they may choose using that same list.

Once you have the name of the specialist, make an appointment and please contact our referral department. to arrange a referral. Please note different specialists have different process.

Referral requests are processed in the order of which they are received and nature of condition. In some cases it may take up to a week to get referral authorized by Managed Care Insurance / HMO.

If you opt to see a specialist, without PCP approval, you may be responsible for all charges incurred.

Emergency Room or Urgent care may refer a patient to a specialist. If you require referrals then you must contact our office and arrange follow up appointment to process the referral.

Advance notice is needed for all non-emergency referrals, typically 5 business days. It is your responsibility to know if a selected specialist participates with your insurance. **Initials:**_____

LAB RESULTS : Normal results for routine labs done at 10 years and 16 years (lipid profile & CBC) may be conveyed over the telephone. **Non routine labs either abnormal or normal will be discussed during follow up office visit with a provider.** **Initials:**_____

PRESCRIPTION REFILLS: For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

FREQUENT NO SHOWS / NON ADHERENCE TO MEDICAL ADVISE: Repeated NO SHOWS without calling in advance and non adherence to medical advice and office policies may result in dismissal from practice.

I have read and understand this office policy regarding referrals, lab results , refills and walk ins / no shows and agree to comply as outlined in this document.

PARENT/GUARDIAN NAME:_____RELATIONSHIP:_____

PARENT/GUARDIAN SIGNATURE_____DATE:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION TO GARDENS PEDIATRICS

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Above listed patient's parent / Guardian authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested: Vaccinations / Physical
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To:

Gardens Pediatrics. 500 University Blvd. Ste 102. Jupiter, FL 33458

PH: 561-622-6610 **FAX: 561-622-6091**

☐ **Please mail records.**
☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship to patient

_____

Address and telephone number of authorized representative

WELCOME TO OUR OFFICE!

Gardens Pediatrics – Nagaraj Gowda, MD and Nirali Patel, PA-C

500 University Blvd. Suite 102, Jupiter FL 33458

Phone 561-622-6610 / Fax 561-622-6091

Appointment hours / Mon- Fri 8am- 4:30pm (closed for lunch 11:30am-1:00pm)

Gardens Pediatrics has been serving families in the Northern Palm Beach County area since 2002. Our goal is to provide high quality medical care to your family in the setting of a personalized, patient-focused practice. At Gardens Pediatrics, your family has providers that care for your children from birth through age 18. Our office is committed to maintaining a small, personalized practice in which we build the ongoing relationships with your family to keep your children healthy and thriving. We generally offer same day sick appointments and remind you when routine physicals are due.

Our office follows the vaccination schedule as recommended by the American Academy of Pediatrics. We do not follow any alternative or delayed vaccination schedule.

For your reference, the vaccination/ physical schedule that our practice follows is below:

Gardens Pediatrics Visit and Vaccination Schedule.

- 1 week, 2 week, 1 month – Well checkup (no shots administered)
- 2 months - Pentacel (DTAP+HIB+IPV), Prevnar, Hep-b, Rota (by mouth)
- 4 months – Pentacel (DTAP+HIB+IPV), Prevnar, Hep-b, Rota (by mouth)
- 6 months - Pentacel (DTAP+HIB+IPV), Prevnar, Hep-b, Rota (by mouth)
- 9 months – Well checkup (no shots administered)
- 1 year - MMR, Varivax (Chickenpox), Hep-A. Blood test - Hemoglobin (Iron) and Lead
- 15 months - Pentacel, Prevnar
- 18 months - Hep-A
- 2 years - Hemoglobin (Iron) and Lead test
- 2 1/2 Years and 3 years- Well checkup (no shots administered)
- 4 years - DTAP, IPV, MMR, Varivax (Chickenpox)
- 5 years - Hemoglobin (Iron) test, UA (Urine Analysis)
- 6 years to 10 years – Annual well checkup (no shots administered)
- 11 years - TDAP, Menactra - 1
- 12 years - HPV-1
- 13 years - HPV-2
- 14 years - 15 years - Annual well checkup
- 16 years - Menactra - 2
- 17 years - 18 years - Annual well checkup.

We are here to help! If you have an **URGENT** non-routine matter after normal office hours, please call our main number and dial "0" to be connected to our answering service. The answering service will page the on call doctor to assist you. **If you have an EMERGENCY, dial 911 or go to your nearest Emergency Room.**

We need your help to keep your child healthy! We require a 2 week follow up after illnesses especially if there are ear or lung issues. At this visit we reevaluate symptoms and go over any non-routine testing that may have been ordered. This visit also gives us a chance to discuss medications and order more if necessary.

Notes to remember-

-Messages and/or prescription requests for the doctor or clinical staff are handled in order of calls received and urgency of matter. Our staff will get back with you within 1-2 business days. If your child has a pressing medical issue, it is best that you schedule an appointment so they can be evaluated.

- If you are unable to keep a scheduled appointment, please call our office to cancel as soon as possible so we will be able to schedule other sick children who need to be seen that day.

- Due to the vast array of insurance plans offered today, it is no longer an easy task for offices to be familiar with each policy. We urge you to learn about and understand your individualized health insurance coverage. It is your responsibility to know how your plan works as well as its coverages and limitations. Please remember that your policy is a contract between you and your insurance company.

- Copays and any past due balances are due at the time of visit at check in. Appointments for Physicals (Well Visits) **may not require copay with most insurance plans**. Other appointment types such as sick visit and follow up visit generally require copay at the time of service.

-Please report any change of insurance, address or other vital information when you come in for an appointment. It is important that we have all accurate updated information in our system to process your insurance claims correctly.

- If your insurance requires a referral or authorization for services, please contact us as soon as possible. **It may take up to a week or more to receive an approval from your insurance company once we submit all required information**.

- If you have a sudden lapse of insurance, please inquire about our self pay rates for appointments.

Please "Like" Gardens Pediatrics on Facebook!
We post valuable health news and office updates on our page.
You can find us at www.facebook.com/gardenspediatrics