Primary Care Pediatrics

Revati Narahari, MD.

1507 South Hiawassee Rd. Suite 105
Orlando, FL. 32835
Phone: 407-445-9224
Fax: 407-445-6236

New Patient Information

*** To avoid mistakes and delays in filing your insurance claim all questions must be answered completely and clearly. ***

Patient Name _____

SSN # _____ Date of Birth_____ Sex: M or F

Home Address _____

City _____ State _____Zip _____

Home Phone _____ Cell _____

Work _____ Emergency Contact _____

Please Circle One: Biological Parent Adoptive Parent Legal Guardian (Please Provide Proper Court Documents)

Biological Parent/Adoptive Parent/Legal Guardian Name _____

Date of Birth _____ SSN#_____ Sex: M or F

Married: Yes or No Divorced: Yes or No Unmarried Live Together: Yes or No

Does the child reside with: Mother Only Father Only Other: _____

If Unmarried/ Divorced/ Other do both parents share parental rights of the child: Yes or No

If NO please explain:

_____
_____
_____
_____
_____
_____

I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service(s) rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request payment of benefits, if any were made to Primary Care Pediatrics the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Primary Care Pediatrics P.A *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that PCP may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of PCP's *Notice of Privacy Practices* by submitting a request in writing for a current copy of PCP's *Notice of Privacy Practices.*

_____
Print Patient Name

_____ _____
Parent Signature Date

If completed by patient's parent or legal guardian, please print and sign name below.

_____ _____
Print Parent/Legal Guardian Name Relationship to Patient

_____ _____
Signature Parent/Legal Guardian Name Date

For Primary Care Pediatrics, P.A. Official Use Only

Complete this form if unable to obtain signature of patient or patient's representative.

PCP made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

□ Patient or Patients representative refused to sign

□ Patient or Patients representative unable to sign

□ Other _____

_____
Printed Employee Name

_____

_____

Employee Signature Date

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information ("protested health information") and medical record information by ***Primary Care Pediatrics*** (" the practice") in order to carry out treatment, payment, or health care operations. You should review the practice Notice of Privacy Practice for a more complete description of the potential release and is of such information, and you have the right to review such Notice prior to signing this Consent form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of is Notice of Privacy Practice, you may obtain a copy of the revised Notice.

You retained the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

_____
_____

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial** the appropriate categories listed below)

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manners (**please initial** the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) _____

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

_____ Via fax to my designated number which is: _____

at all times, you retain the right to revoke this consent. Such a revocation must be submitted to the Practice **in writing.** The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat you if you are (or an authorized representative) does not sign this consent form. If you (or authorized representative) sign this consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand that information in this consent. I have received a copy of this and I am the patient of the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Date:_____

_____

Signature of Patient or Authorized Representative

_____

Child/Patient Name

• Please explain representative's relationship to the patient and include a description of representative's
authority to act on behalf of the patient:

_____

_____

_____

_____

_____

_____

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I _____ herby authorize the following individual(s) listed

(Parent/ Legal Guardian Name)

permission to bring in my child _____for doctor visits.

(Patient/Child Name)

Name: _____ Relation To Patient:

_____

Name: _____ Relation To Patient:

_____

Name: _____ Relation To Patient:

_____

Name: _____ Relation To Patient:

_____

Name: _____ Relation To Patient:

_____

Name: _____ Relation To Patient:

_____

_____ _____

Parent/Legal Guardian Signature Date

Revati Narahari, MD.

Primary Care Pediatrics

Date _____

Patient Name _____
_____
(First Name) (Last Name)

DOB _____ S.S.N# _____-_____-_____
Phone_____

Patient Address _____

_____

I hereby authorize my child's previous doctor, hospital, or group practice:

Name: _____

Address: _____

Phone: _____ Fax: _____ to release my child's

medical records to:

Name: **Revati Narahari M.D.**
Address: **1507 South Hiawassee Road Ste 105**
Orlando, FL 32835
Phone: **407-445-9224** Fax: **407-445-6236**

SPECIFIED DOCUMENTS TO BE RELEASED:

( ) ALL Records ( ) Face Sheet ( ) Discharge Summary ( ) Vaccination Record Only
( ) History/Physical ( ) Operative Report ( ) Consultation ( ) Other:_____
( ) Labs ( ) Radiology Reports ( ) Progress Notes
( ) Physical Orders ( ) Nurse Notes ( ) Medications
( ) Psychiatric ( ) HIV/AIDS ( ) Drug/Alcohol
( ) Specified Date(s)of service _____
( ) Hand Carry ( ) Mail ( ) Fax

PURPOSE FOR INFORMATION:
( ) Continued Medical Care ( ) Insurance ( ) Personal

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/or 397.50(3) records of minor client.

NOTICE TO REQUESTING PARTY: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement. Your signature authorizes this form to be valid for one year from date and maybe revoked by verbal or written consent.

I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentially rules.

I hereby release ***Primary Care Pediatrics*** and their employees, agents, officer, and affiliates, from any and all liability, responsibility, claim and damages, which may result in the release of information authorized by the consent for release of information.

Parent/Legal Guardian
Sign:_____Date:_____

Form of ID verified_____

Witness: _____ Date: _____

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Consent for evaluation and treatment

Date _____

I _____ hereby give ***Primary Care Pediatrics, P.A./ Dr.***

Revati Narahari consent to give _____ his / her physical exam
(Child Name)
and any vaccines needed. Vaccine information is provide for each patient, vaccine and physical

records are given upon request. I understand if any labs or test (x-rays, ultrasound, EKG,

ECHO etc.) are ordered and I do not hear from the office within 72 hours after getting them

done I will call the office about my child's results.

Parent/ Legal Guardian Sign:_____
Date:_____

Witness: _____Date:_____

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Medication History Consent

Date _____

I _____ hereby give ***Primary Care Pediatrics*** consent to
(Parent/Legal Guardian Name)

access my child's medication history through Rx Hub.

Patient Name _____ DOB: _____

Parent/ Legal Guardian Sign:_____
Date:_____

Witness: _____ Date: _____

Vaccination Education Websites

Parents if you would like to educate yourself about the vaccines your child(ren) receive please visit the following sites:

- Vaccine statements are available for download from the Centers for Disease Control and Prevention web site www.cdc.gov/vaccines/hcp/vis/index.html

- Vaccine statements are available in several languages through the Immunization Action Coalition www.immunize.org/vis/

- The AAP healthychildren.org website has information for families on vaccines, www.healthychildren.org/english/safety-prevention/immunizations/Pages/default.aspx. The website also provides an audio for articles

You will also receive a copy of the information for each of the vaccines your child will receive at their office visit.

_____ _____

Parent/Legal Guardian Signature Date