MILESTONES PEDIATRICS
Patient Demographics

PATIENT INFORMATION

Patient: Last First Middle (Nickname)

M ( ) F ( )

BIRTH DATE Sex

Child's Social Security # (must be registered for proper filing of insurance(s)

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Race/Ethnicity

❑ American Indian/Alaskan ❑ Asian ❑ African American/Black
❑Hawaiian/Pacific Islander ❑Caucasian/White ❑Decline/other

Primary Language______________________________

Does this child live with: Father? ❑ Mother? ❑ Other Adult

GUARDIAN INFORMATION

Mother: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

Father: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

EMERGENCY CONTACT INFORMATION

Nearest Relative: Last First Relationship

Phone (1) Phone (2)

PARTY RESPONSIBLE FOR BILLING

(Must be present at this appointment, provide picture ID card and sign bottom of this sheet)

Last First Middle Relationship to Patient

❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Email: (optional)

INSURANCE INFORMATION

Subscriber Name L/F/M *(Primary Insurance Holder)* Relationship to Pt.

❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Insurance Company Name Plan Type (PPO,HMO, Options, etc)

Subscriber ID # (Member ID) Group #

Insurance Company Address (Back of Card)

Insurance Company Phone Number (Back of Card)

Employer providing Insurance Phone

Brothers and Sisters DOB Health Issues?

Pharmacy Name: Location

Previous Dr :

Phone & Address :

PLEASE READ THE FOLLOWING NOTES AND SIGN YOUR CONCURRENCE BELOW. I "THE PARENT" OR "GUARDIAN" AGREE THAT

1) ALL ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

2) I AM RESPONSIBLE FOR PAYMENT, CO-INSURANCE PAYMENT, AND/OR COPAYMENT TO MILESTONES PEDIATRICS FOR THE SERVICES PROVIDED.

3) I WILL IMMEDIATELY INFORM MILESTONES PEDIATRICS OF ANY CHANGE OF ADDRESS, PHONE #, OR INSURANCE.

4) WHEN INSURANCE DOES NOT PAY FOR THE SERVICES RENDERED FOR REASONS SUCH AS DEDUCTIBLE NOT REACHED, INELIGIBILITY, TERMINATION OF POLICY, ETC, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR SUCH SERVICES AND RELATED PAYMENTS, IT WILL BE MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFIT COVERAGE. I hereby give annual authorization for payment of insurance benefits to be made directly to Milestones Pediatrics for services rendered. I authorize the provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original. I also consent to receive calls, texts and emails from Milestones Pediatrics for my protected healthcare and other services.

Guarantor's Signature: ______________________________ Date: ______________

Milestones Pediatrics
New Patient History

Patient's Name: ______________________________ Today's Date: ______________

Date of Birth: ______________________________ ☐ Male ☐ Female

Form Completed by: __________________________ Child's Previous Doctor: ______________________

How did you hear about us? ____

Medications/Supplements/Vitamins:

Names, doses, and frequency: ____

____

Allergies:

☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ Latex

☐ Dye ☐ Tetracycline ☐ Peanuts ☐ Other: __________________

Reaction to allergens: ____

Has the Patient ever had surgery? ☐Yes ☐No

Type and dates: ____

Has the Patient ever been hospitalized? ☐Yes ☐No

Reason and dates: ____

Birth History:

☐Full term _______ weeks of gestation

Describe any problems during pregnancy: ____

Describe any problems during birth: ____

Describe any problems after birth: ____

Patient's birth weight: ____________ Name of Hospital: __________________________

Immunization History:

☐Up to date on immunizations ☐Under-immunized ☐Not immunized at all

Family Demographics:

Parents are: ☐Married ☐Separated ☐Divorced ☐Unmarried ☐Significant other ☐Single Parent

Siblings Name:	DOB	Health Issues

Person(s) with primary custody and legal decision making rights for the patient:

Name(s): ____

Relationship: ____

Members of child's household: ____

____

Questionnaire:

Do you feel safe in the home? ☐Yes ☐No

Does the entire family regularly use seat belts? ☐Yes ☐No

Does someone in the home smoke? ☐Yes ☐No

Name(s) and relationship of person: ______________________________

Where they smoke: ☐Inside home ☐Outside home ☐Both inside and outside ☐In the car

Any drug or alcohol abuse in the patient or household? ☐Yes ☐No

Any mental illness in the patient or the household? ☐Yes ☐No

Is the child in daycare? ☐Yes ☐No

If yes, how many days a week? __________

Type of water used in the household ☐Well ☐City water ☐Bottled

Is it Fluorinated? ☐Yes ☐No ☐Unsure

Patient's Past or Current Medical History:

☐ ADHD
☐ Anemia
☐ Asthma
☐ Bleeding Disorder
☐ Chickenpox
☐ Constipation
☐ Depression/suicidal
☐ Diabetes (☐Type 1 ☐Type 2)
☐ Eczema
☐ Elevated cholesterol
☐ Frequent Ear Infections
☐ Glasses/contacts
☐ Headaches
☐ Heart Murmur
☐ Heart Disease
☐ Hepatitis
☐ Learning Disorder
☐ Pneumonia
☐ Seasonal Allergies
☐ Seizure disorder
☐ Stomach Pain
☐ Thyroid problems
☐ Urinary tract infections
Other: ______________________

Please describe timelines of any positive marks: ______________________________

____

Family Medical History:

Does anyone in the family (including parents, grandparents, and siblings) have:

☐ Anemia
☐ Asthma
☐ Anesthesia reaction
☐ Bleeding disorder
☐ Cancer, Type: ______________________
☐ Developmental/learning disorder
☐ Diabetes (☐Type 1 ☐Type 2)
☐ Elevated cholesterol
☐ Heart disease
☐ Heart attack
☐ Psychological disorders
☐ Early/unexplained death
☐ Seasonal allergies
☐ Thyroid disease
☐ Other: ______________________
☐ Other: ______________________

Please state relationships for any positive findings: ______________________________

____

Tuberculosis (TB) Questionnaire:

Was either parent or the child born in a foreign country? ☐Yes ☐No

Is there a family history of TB? ☐Yes ☐No

Is there a family member who has been in jail within the last 5-10 years? ☐Yes ☐No

Do you have or care for foster children who may be at risk for TB, or whose medical histories are missing? ☐Yes ☐No

Do you live in a high risk neighborhood or in one with exposure to migrant families or the homeless? ☐Yes ☐No

Lead Questionnaire:

Does your child live in or regularly visit a house built before 1960 with peeling/chipping paint or a recent renovation? ☐Yes ☐No

Does your child have a sibling, housemate or playmate with lead poisoning or high lead level? ☐Yes ☐No

Is there an adult in the home whose job or hobby involves lead exposure? ☐Yes ☐No

Does your child live near an active smelter, battery recycling plant or other industry likely to release lead? ☐Yes ☐No

Milestones Pediatrics

Insurance Assignments and Authorization To Release Information

Patient Name________________________________Date of Birth ____________________

I. Release Of Information: I, the below named patient (or legal representative), do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. Physician Insurance Assignment: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

III. Medicare/Medicaid: Patient's (or legal representative's), certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I permit a copy of this authorization and assignments to be used in place of the original which is on file at the physician's office.

I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.

Today's Date__________________________Subscriber______________________________

Responsible Party ______________________________ ____________________________

Printed Name Signature

Original signature on file at physician's office

Financial and Office Appointment Policies

Milestones Pediatrics is committed to providing you with the best possible quality medical care. In order to achieve this goal, we need your assistance, and your understanding of our office policies.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE Payment is required at the time services are rendered. Copayments are contractually set by the insurance companies based on the policy you and your family have chosen, and we are contractually bound to collect them. The person bringing the patient to the clinic for their appointment is responsible for paying the copayment and any outstanding balances on the account at the time of service unless previous arrangements have been made. In case of children of divorced parents, payment is still due at the time of check-in regardless of who is responsible by order of the divorce decree.

MISSED APPOINTMENTS/LATE CANCELLATIONS Missed appointments represent a financial cost to our organization and keep us from being able to see emergent patients. If you are going to need to cancel or reschedule an appointment, please give us a minimum of 24 hours' notice. If you miss three appointments with no effort to cancel or reschedule within 24 hours, you may be dismissed from the practice. Please arrive on time for your appointments. If you are more than 10 min late for your well visits or ADHD then we will have to reschedule but if your child is sick, your child will be seen as a "work-in"as soon as possible but we must keep scheduled time for our patients that arrived on time for their appointments. We do not feel that any one child is more important than another but do respect our scheduling needs and the needs of all our patients and their families. Thank you in advance for your cooperation and understanding with this matter.

TYPES OF PAYMENT ACCEPTED Milestones Pediatrics accepts cash payments, Visa, Master Card, Discover, and personal checks. Returned checks are subject to a $25 'returned check fee' or 5% of the face value of check, whichever is greater, and you will lose your privilege to write checks in our office.

SELF PAY If you do not have insurance, you are considered to be self-pay. This means when checking out, the guardian present will be responsible for paying all charges billed for the appointment. We will apply a 30% courtesy discount if you are able to pay in full. Otherwise, a budget plan will be set in place to collect an agreed upon monthly amount for the balance to be paid off in no more than 6 months.

INSURANCE As a courtesy to our patients, Milestones Pediatrics will file all patient claims to the insurance company for reimbursement. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. Not all services are a covered benefit in all contracts. All charges for non -covered services will be billed to the guarantor and will be his/her responsibility to pay them. The guarantor is responsible for paying the co-payment and any outstanding deductible/co-insurance charges at the time of service. Claims that are denied due to non -payment of the insurance premium are your responsibility. It is the policy holder's responsibility to make sure that claims are paid in a timely fashion. We realize that emergencies do arise and may affect your timely payment. If such extreme cases do occur, please contact us promptly for assistance in management of your account. We are more than happy to work with you and your insurance company to resolve any issues if needed.

OUTSTANDING BALANCES Milestones Pediatrics makes every effort to collect what is owed to us, including engaging the services of a professional collection agency for unpaid patient balances. Therefore, if a balance goes unpaid for 90 days from the date of service, including those that insurance has not paid then the account may be turned to a collection agency. There will be a $30 or 30% service fee, whichever is greater ;to all accounts being forwarded to an outside collection agency. If the account is turned to a collection agency, the guarantor will be responsible for paying all collection and legal fees. Once an account has been turned, the family will be dismissed for the practice. If you have any questions , please do not hesitate to ask us. We are here to help you and your family.

By signing below, I agree that I have read, understand, and will abide by the above financial and office policies.

PATIENT/PARENT SIGNATURE ____________________ DATE ____________

PATIENT NAME ____________________ DOB ____________

WITNESS SIGNATURE ____________________ DATE ____________

Privacy Policy

Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any significant new right to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how e may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation

This Notice Describes Our Practices and Those Of:

- Any medical staff member and any healthcare professional who participates in your care;
- Any volunteer we allow to help you while you are here; and
- All employees of any hospital, clinic, laboratory, or other facility affiliated with Milestones Pediatrics & PCPG.

All of these people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment, or healthcare operations as described in this notice.

Our Pledge Regarding Health Information:

We understand health information about you and your health is personal. We are committed to protecting your health information. This notice will tell you about the ways we may use and disclose your health information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacyprotections.

We Are Required by Law to:

- Maintain the privacy of health information that identifies you;
- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information;
- Follow the terms of the notice that is currently in effect; and
- Notify affected individuals in the event of a breach involving unsecured protected health information.

How We May Use and Disclose Your Health Information:

- For Treatment. We may use and disclose your health information to provide you with medical treatment or services. For example, a healthcare provider, such as a physician, nurse, or other person providing health services will access your health information to understand your medical condition and history. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. This information is necessary for healthcare providers to determine what treatment you should receive and to coordinate your care.
- For Payment. We may use and disclose your health information for purposes of receiving payment for treatment and services you receive. For example, we may disclose your information to health plans or other payers to determine whether you are enrolled with the payer or eligible for health benefits or to submit claims for payment. The information on our bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may provide health information to entities that help us submit bills and collect amounts owed, such as a collection agency.
- For Healthcare Operations. We may use and disclose your health information for operational purposes. For example, your health information may be used by, and disclosed to, members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, to assess the quality of care and outcomes in your case and similar cases, to learn how to improve our facilities and services, for training, to arrange for legal or risk management services, and to determine how to continually improve the quality and effectiveness of the healthcare we provide.

Privacy Policy

- Others Involved In Your Care. We may disclose relevant health Information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or payment related to your care. We may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status, and location.
- Fundraising. We do not use or disclose your information for fundraising.
- Required By Law. We may use and disclose information about you as required by law. For example, we may disclose information to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (e.g, state health department, Center for Disease Control, etc.) to prevent or control disease, injury, or disability, or for other public health activities.
- Law Enforcement Purposes. Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.
- Judicial and Administrative Proceedings. We may disclose information in response to an appropriate subpoena, discovery request, or court order.
- Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections to monitor the healthcare system.
- Decedents. Health information may be disclosed to funeral directors, medical examiners, or coroners to enable them to carry out their lawful duties.
- Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.
- Research. We may use or disclose your health information for research purposes after a receipt of authorization from you or when an institutional review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. We may also review your health information to assist in the preparation of a research study.
- Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
- Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.
- Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- Business Associates. We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
- Other Uses and Disclosures. We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail, or through other methods. Except for uses and disclosures described above, we will only use and disclose your health information with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes, or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

Privacy Policy

Your Health Information Rights:

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically;
- Inspect and obtain a copy of your health information that we maintained;
- Request an amendment to your health information under certain circumstances;
- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised this request for alternative means or locations of communications applies only to this provider or location;
- Receive an accounting of certain disclosures made of your health information; and
- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or healthcare operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

Changes to This Notice:

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by Milestones Pediatrics. We will post a copy of the current notice in our facility. You may also get a current copy by contacting our Privacy Officer at the address at end of this notice. The effective date of the notice is notated on page one and the bottom header of each page.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with Milestones Pediatrics or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Milestones Pediatrics, submit your written complaint to our Privacy Officer at the address at end of this notice. You will not be penalized for filing a complaint.

Contact Information for Questions or to File a Complaint:

If you have any questions about this notice, want to exercise one of your rights described in this notice, or want to file a complaint, please contact the Privacy Officer for Milestones Pediatrics, Dr Priyanka Vyas. Address: 100 SW 75th, Suite 101, Gainesville, FL -32607

PATIENT/PARENT SIGNATURE	DATE
PATIENT NAME	DOB
WITNESS SIGNATURE	DATE

Milestones Pediatrics

Consent to (1) Discuss Health/Medical Information (if somebody else calls) and/or (2) Obtain Medical Treatment (if somebody else brings them to office)

Patient's Full Name:____DOB:_____________

Patient's Full Name:____DOB:_____________

Patient's Full Name:____DOB:_____________

Today's Date: ___________________________

Name of person filling out form: _____________________________________

Relationship to Patient: ____

I,____, give my consent to:

(1) Yes [ ] No [ ] allow Milestones Pediatrics to discuss my child(ren)'s health and/or medical information with ____

(2) Yes [ ] No [ ] allow____to bring my child(ren) to Milestones Pediatrics to receive medical care or treatment.

- **Please Be Aware:** This consent will be valid until the patient(s) named on this form are 18 years of age – unless permission is rescinded before that

Signature_______________________________ Date: _______________

Staff Witness:___________________________ Date: _______________

If not witnessed in office, must be notarized:

Signature_______________________________ Date: _______________

Notary:_________________________________ Date: _______________

Medical Records Release

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: ______________________________ **DOB:** __________

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name & Address of Individual/Facility/Company to Receive PHI	Name & Address of Individual/Facility/Company to Disclose PHI
Milestones Pediatrics 100 SW 75th St, Suite 101, Gainesville, FL 32607 Phone: 352-559-8911 Fax: 352-559-8877	______________________ ______________________ ______________________

Information authorized for use or disclosure or to be obtained:

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ ER Record
- ☐ Consultation
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ X-Ray Reports
- ☐ Growth charts
- ☐ Immunization Record
- ☐ Other_
- ☐ Medical Information Between ______________________ to ______________________

The information will be obtained, uses, or disclosed for the following purposes only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐ Other (Please Specify): _

I understand the following:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event: ______________________.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

______________________________ ______________

SIGNATURE OF PATIENT DATE

______________________________ ______________

SIGNATURE OF PERSONAL REPRESENTATIVE DATE

____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.