FIFTH AVENUE PEDIATRICS, P.A.

CONFIDENTIAL PATIENT INFORMATION

Today's date _____

Father's full name _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Business _____

Occupation _____ Employer _____

Social security no._____

Mother's full name _____ Date of birth_____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Business _____

Occupation _____ Employer _____

Social security no._____

Children and Newborns DOB M/F S.S.#

1. _____
2. _____
3. _____
4. _____

In case of emergency, notify _____ Phone _____

Insurance? Y/N Name of insured _____

Name of insurance company_____

Address _____ City_____ ST _____ Zip _____

Insurance ID#_____ Group #_____ PPO/HMO/PVT

Allergies?_____

_____

Referred to us by _____

CONFIDENTIAL PATIENT INFORMATION

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING PROBLEMS?
PLEASE CHECK YES OR NO

	YES	NO		YES	NO
HEART DISEASE	___	___	ABDOMINAL PROBLEMS	___	___
HIGH CHOLESTEROL	___	___	MIGRAINES	___	___
DIABETES	___	___	PSYCHIATRIC ILLNESS		
ALLERGIES/HAY FEVER	___	___	INCLUDING DRUG & OR		
LUNG DISEASE	___	___	ALCOHOL DEPENDENCE	___	___
KIDNEY DISEASE	___	___	EYE / VISION PROBLEMS	___	___
LIVER DISEASE	___	___	HEARING PROBLEMS	___	___
THYROID DISEASE	___	___	IMMUNE DISORDERS / HIV	___	___
CYSTIC FIBROSIS	___	___	BLOOD DISORDERS	___	___
CANCER	___	___	SICKLE CELL	___	___

SOCIAL HISTORY :
WHO LIVES AT HOME WITH PATIENT? _____
ANY PETS? IF SO WHAT KIND? _____
ANY SMOKERS? _____
DO YOU LIVE IN AN AREA WITH FLUORIDATED WATER? _____
ANY ALCOHOL CONSUMPTION AT HOME? _____ AVERAGE INTAKE _____

PREVIOUS MEDICAL PROBLEMS: _____

HAS YOUR CHILD HAD CHICKEN POX? _____
HAS YOUR CHILD BEEN EXPOSED TO TUBERCULOSIS? _____
HAS YOUR CHILD BEEN EXPOSED TO HEPATITIS? _____

PREVIOUS SURGERY:
PROCEDURE DATE

PREVIOUS HOSPITALIZATIONS (OTHER THAN SURGERY)
PROBLEM DATE

ALLERGIES: _____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER) : _____

ARE YOUR CHILDS IMMUNIZATIONS UP TO DATE? _____

FIFTH AVENUE PEDIATRICS, P.A.

Pamela M. Patranella, M.D.
Kelli Cross, M.D.
Julie D. Johnson, M.D.
Sally Smith, M.D.
Lyssa Logue, D.O.

PRACTICE LIMITED TO INFANTS AND CHILDREN
2855 5TH Avenue North, St. Petersburg, Florida 33713
(727)323-2727 * FAX (727) 327-8101

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I grant consent to Fifth Avenue Pediatrics, P.A. to use and disclose my protected health information and the protected health information of my child/children for the purpose of diagnosing or providing treatment, obtaining payment for my health care bills, and conducting health care operations. Please refer to Fifth Avenue Pediatrics, P.A.'s Notice of Privacy Practices for a more complete description of uses and disclosures.

I grant consent to Fifth Avenue Pediatrics, P.A. to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. I consent protected health information may be mailed to my home or other designated location, such as appointment change notices and patient statements. I consent protected health information may be disclosed to schools, camps or other institutions to the extent of completing school physical forms, immunization forms, or camp physical forms.

I understand I have the right to review Fifth Avenue Pediatrics, P.A.'s Notice of Privacy Practices prior to signing this consent. This Notice of Privacy Practices is subject to change at any time. I may obtain a copy of the revised notice by written quest to our office manager at 2855 5th Avenue North St. Petersburg, Fl. 33713, or by calling our office at 727-323-2727, or asking for one at the time of my next appointment.

I understand that diagnosis or treatment of me or of my child/children may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent in writing, except to the extent my protected health information has already been disclosed in reliance on this consent.

Patient Name: _____ _____ _____ **DOB:** _____
First **Middle** **Last**

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Print name of Patient or Legal Representative **Relationship to Patient**

NOTICE OF PRIVACY PRACTICES FOR FIFTH AVENUE PEDIATRICS, P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND YOUR CHILD/CHILDREN MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required to protect the privacy of health information about you and that can be identified with you, which we call "protected health information", or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning you PHI:

* How we may use and disclose your PHI
* Your privacy rights in regard to your PHI
* Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

1. **Treatment.** Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider or to others who may assist in your care, such as your spouse or parent.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the treatment, services, and items provided to you. For example, we may contact your health plan(s) to certify that you are eligible for benefits (and for what range of benefits), and we may provide your health plan(s) with details regarding your treatment to determine if your health plan(s) will cover or pay for your treatment We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as a family member. Also, we may use your PHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality and efficiency of care that we provide, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and reschedule or remind you of an appointment.
5. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter bring their child to our office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.
6. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
7. **Emergency Treatment.** Your PHI may be used or disclosed for emergency treatment.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Risk.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect the information. Such examples might be reporting child abuse or neglect, preventing or controlling diseases, and reporting reactions to drugs or vaccines.
2. **Health Oversight Activities.** Our practice may disclose your PHI to a state or federal health oversight agency which is authorized by law to oversee our operation.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court order, subpoena, or other similar legal process.

YOUR RIGHTS REGARDING YOUR PHI

1. **Confidential Communications**. You have the right to request how and where we contact you about PHI. For example, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to our office. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **Requesting Restrictions**. You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we do agree there may be situations where required by law, in emergencies, or when the information is necessary to treat you your restrictions may not be followed. In order to request a restriction, you must make your request in writing to our office describing in detail the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both, and to whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. Our office may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary if you agree in advance to the form and cost of the summary. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. **Amendment**. You have the right to request that we make amendments to clinical, billing and other records about you kept by our practice. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI which you would be permitted to inspect and copy; (c) not created by our practice (unless you prove the creator of the information is no longer available to amend the record); (d) the information is not part of the records used to make decisions about you.
5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures you must submit your request in writing to our office. All requests for an accounting of disclosures must state a time period, which may not be longer man six (6) years from the date of disclosure and may not include dates before April 14,2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period.
6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
7. **Right to file a complaint**. You may complain to us or to the Health & Human Services secretary if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager with written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks, and we will not retaliate for any allegations you make.
8. **Authorizations**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You may revoke in writing any authorization you make, except to the extent that it was already relied on.

EFFECTIVE DATE OF THIS NOTICE

This Notice of Privacy Practices is effective on April 14,2003.

If you have any questions regarding this notice please contact our office manager at 727-323-2727 or contact us in writing: Fifth Avenue Pediatrics, PA
2855 5th Ave North
St Petersburg, FL 33713.