PSJ Pediatrics
Shivani Mitra, MD
Tarun Jain, MD
3765 Kings Hwy, PSJ FL 32927
Phone:321-507-4572
Fax: 321-507-4417

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ Sex: M/F

City: _____ State: ____ Zip: _____ Pronouns (*if applies*): _____

Social Security: _____ Preferred Language: _____

Primary Phone: _____ Secondary Phone: _____

RACE:

- □ White
- □ Asian
- □ Black/African American
- □ Native Hawaiian/other pacific islander
- □ Refuse to report

ETHNICITY:

- □ Hispanic/Latino
- □ Not Hispanic/Latino
- □ Refuse to report

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____ Social Security: _____

City: _____ State: ____ Zip: _____ Occupation: _____

Email: _____ Phone: _____

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____ Social Security: _____

City: _____ State: ____ Zip: _____ Occupation: _____

Email: _____ Phone: _____

Insurance Company: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Policy/Member ID #: _____

Group #: _____

We appreciate you considering us for your child's healthcare. PSJ Pediatrics is a Patient Centered Medical Home (PCMH). We are here to facilitate a personal partnership with you and your family and to provide you with the best quality medical are in a "true spirit of caring". We believe this is possible only by seeking to care for all the aspects of disease in our patients, without regard for their race, color, religion, sex, national origin, handicap or monetary status. The practice specializes in the treatment of infants, children's and teens. Our pediatricians and staff are all here to serve your needs.

A PCMH is an approach to providing comprehensive health care. A medical Home is called a "Home" because we'd like our office to be the first place you think of for all your medical needs. Our goal is to make it easy and comfortable to get the care you need in a way that works best for you. As a PCMH provider we are focused on the "Whole Person" by providing all of your health care needs to arranging appropriate care with other qualified professionals.

As a Primary Care Provider our responsibilities are:

- Explain diseases, treatments and results in an easy way to understand
- Listen to your feelings and questions which help us make decisions about your child's care
- Keep your child's treatments, discussions and records confidential
- Provide same day appointments
- Provide instructions on how to meet your child's healthcare needs when our office is not open
- Give you clear directions about your child's medicine and treatments
- Refer you to a trusted specialist as needed

As a parent/guardian your responsibilities are:

- Asking questions, sharing your feelings and taking an active part in your child's care
- Being honest about your history and child's history, symptoms and other important information
- Ensuring your child's medications are all taken as directed and if it is a controlled substance that it is locked in a safe place out of reach of visitors or other family members
- Inform us of any problems with medications that your child is taking or if their condition worsens
- Make health decisions about you and your child's daily habits and lifestyle
- Keeping you scheduled appointments or reschedule in advance if needed
- Call our office with your child's health concerns unless it is an emergency
- Being sure you leave our office with a clear understanding of our expectations, treatment and goals

APPOINTMENTS:

We offer appointments from 9:00am to 4:30pm Monday through Friday except during daily lunch hour from 12:00pm to 1:00pm. Our office accommodates same day appointments for sick visits and urgent care. Appointments for problems of long duration should be scheduled in advance. Our staff attempts to see all patients with minimal wait time; however, we ask for your patience in accommodating medical emergencies and busy days. If you are unable to keep an appointment, please call as soon as possible so that we may be able give that appointment to someone else needing it. ALL PATIENTS UNDER THE AGE OF 16 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN.

If you call our office for advice and the doctor is busy with another patient, you will be asked to leave the child's name, date of birth, your name and the number where you can be reached. One of our providers will access your child's medical record and refer to it when giving advice as well as document the advice given. Generally morning calls are returned by 12:30 and afternoon calls by 5:30.

We ask that you please be courteous of the language you use in the office. Profanity towards anyone in the office or over the phone will not be tolerated and will be brought to the respective physicians' attention.

If you are a parent coming in to discuss issues/concerns with the doctor as an office visit and the child is not present, we will still bill your insurance as an office visit.

We do provide ADHD and behavioral health care. We do refer patients out to providers in your medical network.

SCHOOL EXCUSES:

We will NOT be providing a school excuse without the child being seen in our office. We will only excuse the child from school for appropriate number of days.

We ask that all family members remain in the same practice, to avoid conflict of interest we will not tolerate managing care for one child's care is being managed in a different practice.

MEDICATION REFILLS:

For the ease of refilling some medications, please call 72hours in advance of needing the medication.

EMERGENCIES:

There is a pediatrician available 24hours per day for emergencies and attention to acute illnesses. When the office is closed, your call will direct you to a recorded message giving you the option to speak with one of our physicians. Once prompted, the call will be forwarded to the doctor's cell phone. In the event of a severe emergency, go directly to the emergency department. Often our patients can avoid emergency room visit and the unnecessary expense by first reaching the physician.

EXAMINATION:

Routine physical examinations recommended by the American Academy of Pediatrics are encouraged by our staff for general health maintenance and education as well as disease prevention. These appointments should be scheduled weeks in advance especially at the time of year when school and camp physicals are in high demand. Routine physicals as recommended by the AAP are scheduled as follows:

Newborn	2 weeks	2 months	4 months	6 months	9 months
12 months	15 months	18 months	21 months	24 months	2 years
2 ½ years	3 years	4 years	5 years	6 years	

Every year thereafter unless otherwise instructed.

INSURANCE:

Health insurance is designed to help you meet the cost of medical services. Your insurance contract defines the specific limitations of your policy and it is always your responsibility to understand the coverage your insurance program provides and its referral authorization process. Please present all insurance information on your first visit to our office. We will assist our patients with insurance in any way we can. Patients are responsible for non-covered services and all charges until the deductible has been met.

ACCOUNT MANAGEMENT:

Payment for services is due at the time services are rendered. We accept MasterCard, American Express, Discover, Visa as well as local personal checks and cash. If you have insurance, please pay your copay at the time of service and you will be billed for the remainder after your insurance claim has been processed. If your financial situation causes your medical expenses to be a burden, our office manager will be glad to discuss payment arrangements with you. This is done on an individual basis and requires a commitment to an agreed upon monthly payment. Please bring this to our attention before your account becomes past due to avoid any misunderstanding. In situations involving shared custody or medical expenses between divorced or separated parents, only one parent can be billed. It is our policy to bill the parent with primary custody who brings the child in. Parents must make arrangements between themselves to manage their child(ren's) account. Ultimately, both parents are responsible for their children's medical expenses. If there is a question about your bill, please discuss it with our office manager. Every attempt is made to contact parents regarding unpaid bills, but unless other arrangements are made, overdue accounts are turned over to our collection agency after 90 days. If a non-sufficient fund check (nsf) is returned the account will results in the balance plus $25 returned check fee. We will flag the account and no further check will be accepted, all future payments will only be accepted in the form of credit card or cash.

CONFIDENTIALITY:

Your child's medical records are held in the strictest confidence. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard patient information. Information will not be released without written authorization from the parent or legal guardian.

Exchange of information between school teachers or counselors and our staff also requires a written authorization. A full copy of our privacy policy is posted in our waiting room and a copy can be given to you upon request. We ask that you request prior medical records to be as complete as possible. Should any changes in your medical status, name, address or phone number occur, please let us know as soon as possible.

SOCIAL MEDIA:

Social media (including personal and professional websites, blogs, chat rooms and bulletin boards) social networks such as Facebook, Google, Twitter, Instagram, LinkedIn. These are all common means of communication and self-expression. Because negative online postings can conflict with the interest of PSJ Pediatrics and its employees, it will result in discharge from practice. You will be given 30 days of emergency care and we will forward your child's records upon request.

SOCIAL MEDIA POLICY

The health of your child is the top priority of our Doctors and Staff. We work hard to make sure everyone's expectations are met, however there may be times where circumstances are out of our hands. For example, technical issues, insurance issues and the office being busy with sick children.

Of course, you have a right to express yourself on any site you wish, you should be aware that if you are using these sites to communicate indirectly with us about your feelings there is a good possibility, we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our office directly. This can be an important part of interactions, even if you decide we are not a good fit.

Negative or demoralizing comments on Facebook, Google, Twitter, Instagram, LinkedIn or any other social media platform, breeches the trust between the family and the office staff that are working hard in the background for you and your family. If any such postings will result in discharge from the office, with emergency care for 30 days.

Parent/Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Person Completing Form: _____ Relationship: _____

CURRENT MEDICATIONS:

Medication	Dose	Frequency

PATIENT'S MEDICAL HISTORY: *(mark all that apply)*

- □ ADD/ADHD
- □ Anemia
- □ Kidney Disease
- □ Liver Disease
- □ Hepatitis
- □ Bleeding/clotting disorder
- □ Allergies
- □ Asthma
- □ Disability
- □ Headaches
- □ Chicken Pox
- □ High blood pressure
- □ Seizures
- □ Heart Murmur
- □ Dental Decay
- □ Eczema
- □ Vision Problem
- □ Hearing Problem
- □ Reflux
- □ Recurrent ear infections
- □ Other:

HOSPITALIZATIONS/SURGICAL HISTORY:

Hospitalization/Surgery/Procedure:	Year:

FAMILY HISTORY:

Please indicate if there is a family history of the following:

Medical Condition	Family Member	Medical Condition	Family Member
ADD/ADHD		Hearing Disability	
Alcohol/Drug Abuse		High Cholesterol	
Allergies		High Blood Pressure	
Asthma		HIV/AIDS	
Birth Defects		Learning Disability	
Blood Disorder		Mental Illness	
Cancer		Migraines	
Heart Disease		Scoliosis	
Seizure Disorders		Speech Problems	
Developmental Delay		TB/Lung Disease	
Diabetes		Stroke	
Genetic Disorder		Thyroid Disease	
Hepatitis/Liver Disease		Other	

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PLEASE PRINT LEGIBLY

Patient's Full Name: _____ Date of Birth:_____

Address: _____ City: _____ St._____ Zip: _____

Cell/Home phone: _____ Work Phone_____

PLEASE CHECK ONE: ☐ Sending Records to ☐ Obtaining Records from

Physician/Facility Name: _____

PLEASE CHECK ONE: ☐ Primary Care Physician ☐ Specialist ☐ Hospital

Address: _____ City: _____ St._____ Zip: _____

Phone Number: _____ Fax Number: _____

Information to be sent or received: *(Check all that apply)*

☐ **Standard Record Release** *(All records within the last two (2) years including all immunization records)*
☐ **All immunization records**
☐ **X-Ray Reports** *(within the last 2 years)*
☐ **Laboratory Reports** *(within the last 2 years)*
☐ **Other Specify:** _____

Reason for transfer:

☐ Continuing care with another physician/hospital ☐ Transfer of Care ☐ Personal Copy

The patient or patient's representative must read and initial the following statements:

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, and AIDS information.
Initial _____

I understand that this authorization will expire in 12 months
Initial _____

I, the undersigned, have read the above and authorized the staff of PSJ Pediatrics to disclose such information as herein contained. I understand that this consent may be withdrawn by me, in writing, at any time except to the extent that action has been taken in reliance upon it. I understand the re-disclosure of this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Medical Information".

Signature of Patient, Parent/Guardian: _____ Date: _____

Witness signature _____

In compliance with State and Federal laws there may be costs associated with this request.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Physician: _____

Date of Birth: _____ Phone: _____

Please list all individuals (besides mom or dad) who are authorized to have access to this patient's medical care/treatment.

I, _____ parent/guardian of _____

Authorize the following individuals to have access to this patient's medical care. This will include verbal communications, prescriptions pick up, access to diagnostic test results and all diagnostic orders given by the physician.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will not expire.

This facility, its employees and physicians hereby release from any legal responsibility or liability for disclosure to the above listed individuals, to the extent indicated and authorized herein.

The following information WILL NOT be disclosed without power of attorney of healthcare surrogates' authorization: acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency (HIV), behavior health services/psychiatric care, and treatment for alcohol and or drug abuse.

Parent/ Guardian Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:

We are required to provide you with a copy of our notice of privacy practices, which states how we may use and/or disclose your health information. A copy of our notice of privacy practices is posted in the office. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement if you wish.

I acknowledge that I have received a copy of this office's notice of privacy practices.

Print name: _____

Signature: _____

Date: _____