VIERA PEDIATRICS

Dr. Preeti Bimbrahw,
8095 Spyglass Hill Road – Suite 104 ● Melbourne, FL 32940
Ph (321) 241-6400 ● Fax (321) 428-3945

PATIENT INFORMATION		
Patient's Full Name (Last, First):		Nickname/Preferred Name:
Date of Birth:	Sex: □ Male □ Female □ Other: _____ □ Declined to specify	Social Security #:
Race: □ White □ Black/African American □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Pacific Islander □ Other: _____ □ Declined to specify		
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Declined to specify		
Preferred Language: □ English □ Spanish □ Other: _____		
Street Address:		
City:	State:	Zip Code:
Home Phone #:	Cell Phone #:	Work Phone #:
Siblings (Names and Birthdates): #1: _____ #2: _____ #3: _____		

PHARMACY		
Pharmacy Name:	Address:	Phone #:

MOTHER/LEGAL GUARDIAN	FATHER/LEGAL GUARDIAN
Name:	Name:
Relationship: □ Biological □ Adoptive □ Guardian □ Foster □ Step-Mom	Relationship: □ Biological □ Adoptive □ Guardian □ Foster □ Step-Dad
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
E-mail Address:	E-mail Address:
Mailing Address: □ Same as Patient	Mailing Address: □ Same as Patient
Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:
Work Phone #:	Work Phone #:
Employer:	Employer:
Occupation:	Occupation:

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EMERGENCY CONTACT	
Name:	Relationship:
Address:	Phone #:

PRIMARY INSURANCE INFORMATION		
Insurance Company:		Policy #:
Policy Holder's Name:	DOB:	S.S. #:
SECONDARY INSURANCE INFORMATION		
Insurance Company:		Policy #:
Policy Holder's Name:	DOB:	S.S. #:

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FINANCIAL POLICY

- It is the parent/guardian's responsibility to **bring and keep updated the following at every visit:**

_____ Initial

- Current health insurance card
- Photo ID
- Updated demographics
- Payment in the form of cash or credit card

INSURANCE:

- Health insurance is a contract between patient/parent, employer, and insurance company. It is the patient's responsibility to be familiar with the insurance policy, including, but not limited to: vaccine and visit coverage, referral/authorization requirements for specialty care, radiology, lab tests, and emergency and/or hospital care.

_____ Initial

- Full payment, including co-payments, coinsurance, and deductibles are required at the time of service.

_____ Initial

- It is the responsibility of parent/guardian to contact their human resources department or insurance plan to add their newborn to their insurance plan. This is not done automatically. *Newborns not added to insurance policies within 30 days may be subject to self-payment.*

_____ Initial

- Failure to disclose all insurance plans child is covered under may result in insurance plan rejecting claims and payment for services rendered will be charged to parent/guardian.

_____ Initial

PAYMENTS:

_____ Initial

Co-pays and coinsurance payments are due at the time of service. In the case of domestic separation or divorce, the parent accompanying child is responsible for payment of copays, or other fees related to services rendered.

RETURNED CHECKS:

_____ Initial

There will be a fee of $25 for any returned checks or payments.

NO SHOW POLICY:

_____ Initial

Missed, no showed, or cancelled appointments with less than 24-hour notice may be subjected to a $25 fee. Multiple missed appointments or late cancellations may result in discharge from the practice.

PAST DUE ACCOUNTS:

_____ Initial

We will attempt to work out a payment schedule with you, however seriously delinquent accounts will be referred to a collection agency. Any legal fees that we pay to secure past due balances will be added to your account.

I understand that I am financially responsible for all charges for services to me, including co-payments, coinsurance, out of pocket, deductibles and non-covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Viera Pediatrics/Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Viera Pediatrics/Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

Patient Name: _____ **D.O.B: _____**

Parent/Guardian Signature: _____ **Date: _____**

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AUTHORIZATION TO TREAT/HIPAA RELEASE OF INFORMATION

I, _____ phone # _____parent/legal guardian of:

_____authorize Viera Pediatrics to provide medical treatment to said child. I authorize the following adult(s), acting as my agent to accompany and consent for treatment, testing, and immunizations for my child.

I authorize Viera Pediatrics/Medical Associates of Brevard to release medical information regarding my child to the following person(s):

***I understand that this person may be required present proper ID when bringing my child for Treatment.**

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

□ **I authorize Viera Pediatrics to leave a detailed message on voicemail.**

_____ DATE ___/___/___

Parent/Guardian signature

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been received a copy of the Provider Notice of Privacy Practices for Viera Pediatrics/ Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the duties of Viera Pediatrics/Medical Associates of Brevard with respect to my protected health information.

Patient Name_____ DOB: ___/___/___

Parent/Guardian Signature_____ Date: ___/___/___

Witness Signature_____ Date: ___/___/___

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MEDICAL HISTORY

Child's Name: _____ Date of Birth: _____

Person Completing Form: _____ Relationship: _____

CURRENT MEDICATIONS:

Medication Name		Dose	How many times a day?

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

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

HOSPITALIZATIONS AND SURGICAL HISTORY:

Hospitalization/Surgery/Procedure:	Year:

FAMILY HISTORY:

Please indicate if there is a family history of any 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	*(please include what type)*		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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VACCINE POLICY

At Viera Pediatrics, we are committed to promoting the health and well-being of children in our care. In accordance with guidelines from the American Academy of Pediatrics (AAP), we have developed the following vaccination policy:

1. Vaccination Requirement: All children are required to be up-to-date on their recommended vaccinations as per AAP guidelines. In respect to a guardian's educated decision, in the situation a non-mandated vaccination is refused by the guardian, our providers will provide education on the vaccination.
2. Vaccine Schedule: We follow the AAP-recommended immunization schedule for infants, children, and adolescents, including catch-up schedules for those who may have missed vaccinations or are behind schedule. Please be advised that delaying or breaking up the vaccines to give one to two at a time goes against the expert recommendations. The diversion from the recommended vaccination schedule can put your child at risk for serious illness and potential death. Any deviation from the recommended vaccination schedule goes against the medical advice from Viera Pediatrics. We encourage open dialogue and address any concerns or questions parents may have about vaccines during the appointment.
3. Parental Education: We provide parents with information (including Vaccine Information Sheets-V.I.S.) and resources regarding the importance, safety, and efficacy of childhood vaccines.

VACCINE POLICY ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read Viera Pediatrics Vaccine Policy and I agree to vaccinate my child with immunizations as recommended by the AAP (this includes vaccines required for entry into school). I understand that all vaccines will be discussed prior to administration and that a separate consent form will be signed before any vaccine is given to my child.

Patient Name: _____ D.O.B.: _____

Parent/Guardian Signature: _____ Date: _____

NO SHOW/MISSED APPOINTMENT POLICY

We at Viera Pediatrics understand that sometimes you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please call us as soon as possible (at least 24 hours in advance). To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call and text message are made/sent one business day prior to your scheduled appointment. It is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING:

1. Please cancel your appointment with at least 24 hours' notice. There is a waiting list to see the providers at Viera Pediatrics and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than 24-hour cancellation is given the appointment will be documented as a "No Show" appointment.
3. If you do not present to the office for your appointment, it will be documented as a "No Show" appointment.
4. After the first "No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Show" policy. Viera Pediatrics will assist you to reschedule this appointment if needed.
5. If you have two "No Show" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25 no show fee.
6. If you have three "No Show" appointments within a one-year time period, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered. *I have read and understand the Viera Pediatrics No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly*

Patient Name: _____ DOB: _____

Parent/Guardian Signature: _____ DATE: _____

Witness: _____ DATE: _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

NO DISK RECORDS PLEASE

I, _____ (PRINT PARENT/GUARDIAN NAME), authorize the release of medical records of _____ (PRINT NAME OF PATIENT), _____ (PATIENT'S DOB)

□ Obtaining Records From: **OR** □ Releasing Records To:

_____

Recipient Name Street Address City, State, ZIP code

_____

Phone Number Fax Number

INFORMATION TO RELEASE (CHECK ALL THAT APPLY):

□ Last 2 years of Medical Records	□ Immunization	□ Laboratory Reports
□ Imaging	□ Consultation Documentation	□ Hospital Records
□ Prescription Data	□ Other (Specify): _____	

If my record contains the following, it will be released if box is checked:

□ Substance Abuse □ Mental Health □ HIV/STD Testing/Treatment □ Pregnancy Testing

PURPOSE OF DISCLOSURE:

□Transfer of Care □ Continuing Care □ Personal Copy □ Other_____

This authorization is valid for 1 (one) year from date of signature unless otherwise specified. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released. 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.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

NOTICE: There may be costs associated with this request in compliance with State and Federal laws.