JAMIL H. KHAN, M.D., F.A.A.P

DAVENPORT Pediatrics Clermont, P.A.
Pediatric & Adolescent Medicine

Welcome

PATIENT INFORMATION

Patient's Name _____ Male/Female Birth Date _____

Patient's Name _____ Male/Female Birth Date _____

Patient's Name _____ Male/Female Birth Date _____

Ethnicity/Race _____ Primary Language: ☐ English ☐ Spanish Other _____

Moms Cell Phone _____ Dad Cell Phone _____

Mailing Address _____ City _____ Zip Code _____

Email Address _____

PERSON RESPONSIBLE FOR ACCOUNT (Parent/Legal Guardian)

Primary Parent _____ Male/Female SS# _____ Birth Date _____

Address _____ City _____ Zip Code _____

Second Parent _____ Male/Female SS# _____ Birth Date _____

Address _____ City _____ Zip Code _____

Legal Guardian _____ Male/Female SS# _____ Birth Date _____

Address _____ City _____ Zip Code _____

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PERSONS LISTED ABOVE)

Name: _____ Relationship to Patient: _____ Cell Phone _____

Address _____ City _____ Zip Code _____

CONSENT FOR TREATMENT

- I certify that the information I have provided above is current and correct.
- I hereby authorize DAVENPORT PEDIATRICS CLERMONT, P.A., its physicians and support staff to provide medical care to the patient named above. I voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician in charge. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to result of any examination or treatment received from DAVENPORT PEDIATRICS CLERMONT, P.A.
- This consent is valid for the entire duration of my association with DAVENPORT PEDIATRICS CLERMONT, P.A., and may be relied upon by DAVENPORT PEDIATRICS CLERMONT, P.A., unless and until such consent is revoked in writing.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

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INITIAL PEDIATRIC HISTORY FORM

Patient's Name _____ Birth Date _____

A. BIRTH HISTORY

Birthplace _____ Birth Weight _____ Birth Length _____

Was pregnancy normal? No Yes Other _____ Was the delivery normal? No Yes Other _____
Was the baby full term? No Yes Other _____ Any nursing problems? No Yes Other _____

B. GROWTH AND DEVELOPMENT

Discipline or behavior problems? _____ Developmental Delayed? No Yes

Ever seen by a psychologist, speech, therapist or special teachers?

_____

C. PAST MEDICAL/HOSPITALIZATIONS HISTORY

Any problems with: Sleeping: No Yes Other _____ Bedwetting: No Yes Other _____
Weight/Height: No Yes Other _____ Nail Biting: No Yes Other _____
Nightmares: No Yes Other _____

Diet: Nursed: No Yes Other _____ Bottle fed No Yes Other _____
Colic problems No Yes Other _____ Special diets No Yes Other _____

Was you child ever diagnosed with any of the following? (at what age)

Seizures: No Yes Age _____ Asthma: No Yes Age _____
Bronchitis: No Yes Age _____ Pneumonia: No Yes Age _____
Ear Infections: No Yes Age _____ Any Other: _____

Medications: Does your child currently take any medications now? No Yes
Medications: _____ Dosage _____
Medications: _____ Dosage _____

Hospitalizations/Surgeries: No Yes
Hospitalizations _____ _____ _____
When Where Why
Surgeries: _____ _____ _____
When Where Why

Allergic Reactions:
Does the patient have any allergies/allergic reactions to environmental, medications and food? No Yes

Allergies	Reaction
_____	_____
_____	_____
_____	_____

D. Any special comments/treatment about your child? _____

_____

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INSURANCE INFORMATION

CREDIT AND FINANCIAL POLICY

Primary Insurance _____ Policyholder Name _____

Policyholder Birth Date _____ Relationship to Patient _____

Policy ID # _____ Group #_____ Policyholder SS# _____

Secondary Insurance _____ Policyholder Name _____

Policyholder Birth Date _____ Relationship to Patient _____

Policy ID # _____ Group # _____ Policyholder SS# _____

CREDIT AND FINANCIAL POLICY

Davenport Pediatrics Clermont, P.A., wishes to notify you of its policies regarding financial responsibilities associated with services rendered to you or to a member of you household/family.

INSURNACE

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to you responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorizations, deductibles and limitations on well child visits, lab services, immunizations and any other procedures done in office.

You shall also be responsible for any claim denied by the insurance company. The insurance company may deny a claim for any of the following reasons:

1. Davenport Pediatrics Clermont, P.A. is an out-of-network provider or Davenport Pediatrics Clermont, P.A. does not participate with your insurance company.
2. The claim is rejected because there was no insurance coverage at the time of service.
3. Davenport Pediatrics Clermont, P.A., was not assigned primary care physician for the patient or for your insurance company.
4. The procedure/lab work done is not covered service or benefit by your insurance company.
5. Your insurance company is still waiting for additional information that they have requested from the parent/guardian of the patient.
6. Your insurance company has already made the payment and the remaining balance is your responsibility.
7. Only hospital charges are covered by your insurance company.

There may be other reasons that the insurance company may reject a claim filed on you behalf. If there are any questions regarding their decision(s), you must contact your insurance company immediately.

CASH ACCOUNT

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at time of service.

At this time, even if you are able to subsequently provide verifiable insurance information and the time frame for billing the insurance has not expired (generally 45 days), we will not be able to bill the charges to your insurance company for you.

BILLING

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement.

APPOINTMENTS

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hours notice, consider that another child could have been seen at the time. We reserve the right to charge a $25 cancellation or 'no show' fee. In order to see each patient on time, you appointment may need to be rescheduled if you arrive 10 minutes or more late.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I hereby authorize Davenport Pediatrics Clermont, P.A., to collect on my behalf any insurance/medical benefits payable to me for the service(s) they have provided and assign to them the payment thereof. I authorize and assign the payment of any insurance/medical benefits applicable to the service(s) cited on the claim form to DAVENPORT PEDIATRICS CLERMONT, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is considered as valid and effective as the original.

I understand that this assignment does not relieve me of any responsibility I may have for any payment of charges that are not covered by the insurance company. I understand that I may be held responsible for any or all unpaid charges on this account.

I have read and understand the financial policy of DAVENPORT PEDIATRICS CLERMONT, P.A., and I agree to be bound by its terms I also understand and agree that such terms may be amended by DAVENPORT PEDIATRICS CLERMONT, P.A., at any time.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

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CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PROTECTED HEALTH INFORMATION

Information about your childs health is called "protected health information." It includes any information that DAVENPORT PEDIATRICS CLERMONT, P.A. receives or creates that identifies (or Could indentify) you child and deals with you child's physical and/or mental health and any medical care we provide your child and/or payment for such medical care.

DAVENPORT PEDIATRICS CLERMONT, P.A., understands the important of privacy and is committed to maintaining the confidentiality of your child's medical information. We make a record of the medical care provided to your child and may receive other medical records from others. We use these records to provide and enable us and other healthcare providers to provide quality medical care, to obtain payment for medical services provided to you child and to enable us to meet our professional and legal obligations to properly operate our medical practice. We have a "Notice of Privacy Practice" (the "Notice"). The Notice describes in great detail how we might use or disclose protected health information. The Notice also discusses your rights and our duties with respect to protected health information. You have the right to review the Notice before signing this consent. This Notice can be requested from our front office staff.

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am consenting to DAVENPORT PEDIATRICS CLERMONT, P.A.'s use and disclosure of my child's health information in order to carry out treatment, payment or health care operations.

I understand that I have the right to revoke this authorization at any time by notifying DAVENPORT PEDIATRICS CLERMONT, P.A. in writing. However, if I do revoke this authorization, my revocation would not have any effect on action(s) previously taken in reliance o my prior consent.

I understand that I have the right to request that DAVENPORT PEDIATRICS CLERMONT, P.A. restrict how my child's protected health information is used or disclosed for purpose of treatment, payment or health care operations. However, I also understand that DAVENPORT PEDIATRICS CLERMONT, P.A. is not required to agree to any restriction I requested.

I understand that DAVENPORT PEDIATRICS CLERMONT, P.A. has the right to amend their privacy practices at any time in the future. I understand that after an amendment is made by DAVENPORT PEDIATRICS CLERMONT, P.A., the revised privacy practices will apply to all protected health information maintained, regardless of when it was created of when it was created or received.

I acknowledge that I have been presented with a copy of DAVENPORT PEDIATRICS CLERMONT, P.A.'s Notice of Privacy Practices and have been provided an opportunity to review it. I am aware that I may request a copy of the Notice of Privacy Practices to keep in my possession.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

Name(s) of patient(s) in practice:

Patient's Name _____ Birth Date _____

Patient's Name _____ Birth Date _____

Patient's Name _____ Birth Date _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release information may no longer be protected by federal privacy regulations.

Patient's Name _____ Birth Date _____

Patient's Name _____ Birth Date _____

Patient's Name _____ Birth Date _____

To: Davenport Pediatrics Clermont, P.A.
1528 Sunrise Plaza Drive, Ste. 1
Clermont, Fl 34714
Fax: 1-877-765-8076

From: Organization to release the information:
_____
_____
_____

Specific description of Information (including dates)

Check One
_____ Last Well Child visit **ONLY**/Physical/Growth Chart/Immunization Chart
_____ Immunization Record Only
_____ Other (Specify) _____

SECTION B: Must be completed for all authorizations

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

1. I understand that this authorization will expire on _____ (or one year from date from signature.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing but if I do, it would not have any effect on any actions they took before they received the revocation.
3. If a health care provider is receiving these records, the information will be used for continuity of care purposes only.
4. I understand that I may have a copy of this form at any time when requested.
5. I understand that my health care and payment for my health care will not be affected by signing this form.

X _____ _____ _____

Signature of patient or patient representative (Form MUST be completed before signing) | Phone Number | Date

Printed Name of patient's representative _____

Relationship to Patient _____



Treatment of Consent Form

I, _____ parent/legal guardian of

_____ _____

Patient Name Date of birth

Only authorize the following individuals listed below to bring my child to Davenport Pediatrics Clermont, P.A. to receive medical treatment without my presence. Any authorized person to bring my child in must bring in a photo ID to the visit or the appointment will have to be rescheduled. I understand that by signing below I will be responsible for any medical information which may be misinterpreted by the individual who brought my child in for the office visit. I authorize the below named individual to make any medical decisions and/or for the administration of vaccines, or the refusal of vaccines for my child. I will also make sure they bring insurance cards and are responsible for copays/deductibles on the appointment date.
This form is valid for one year only.

Authorized Individuals:

Name:	Relationship to patient:
1._____	_____
2._____	_____
3._____	_____
4._____	_____

_____I ***DO NOT*** authorize anyone to bring in my child.

_____ _____

Parent/Guardian Signature Date

Davenportpedsclermont@gmail.com