Sunshine Pediatrics of Florida

TAMPA OFFICE Coming July 1st.
1213 W Hillsborough Ave,
Tampa, FL 33603
Phone: (813)-234-1315
Fax: (813)-234-3354

LUTZ OFFICE
18934 N Dale Mabry Hwy, Lutz,
FL 33548
Phone: (813)-948-2679 Fax:
(813)-9480-2694

WESLEY CHAPEL/
ZEPHYRHILLS OFFICE
COMING SOON!
33921 SR-54,
Wesley Chapel, FL 33543

New Patient Registration

Patient Information

Last name _____ First Name _____ MI____

Pt. SSN_____ Date of Birth_____ Male or Female

Ethnicity (circle one) White African American Latino Asian American Indian/Alaskan Other Home

Address _____

City_____ Zip Code_____ email address_____

Phone _____ Emergency Contact & Phone _____

Siblings (Name, age, sex) _____

Are Parents Married _____ Separated _____ Divorced ____ Single _____ Widowed _____

Preferred Pharmacy Name and Phone _____

Parent Information

Mother _____ Date of Birth _____ SSN _____

Address: _____ Phone _____

Employer & Phone _____ Occupation _____

Father _____ Date of Birth _____ SSN _____

Address: _____ Phone _____

Employer & Phone _____ Occupation _____

Who may we thank for referring you to our practice? _____

Insurance Information

Policy Holder _____ SSN _____ Date of Birth _____

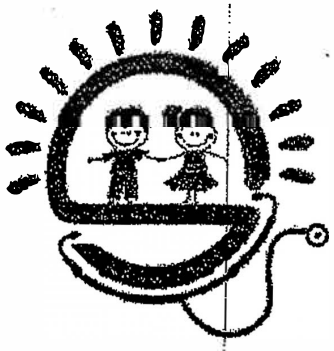
Primary Insurance Name _____ Policy # _____ Group # _____

Secondary Insurance Name _____ Policy# _____ Group# _____

Employer _____ Ins. Phone _____

1. I agree to pay in full to all medical services rendered by Sunshine Pediatrics of Lutz as they are received by me, my spouse or my dependents.
2. I hereby authorize the release of Medical Information for Review and Process Claim.
3. I hereby authorize any insurance company to pay the proceeds of my benefits directly to Sunshine Pediatrics of Lutz.
4. A copy of this agreement can be considered as an original for Medicaid and Insurance purposes.

Signature _____ Date_____



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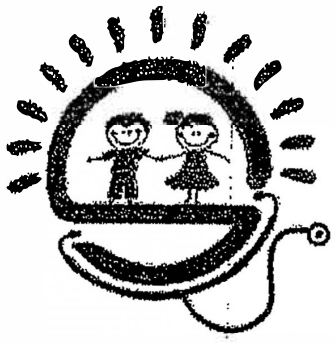
PATIENT NAME:_____ DOB:_____ DATE:_____

PEDIATRIC AND ADOLESCENT HEALTH HISTORY

IDENTIFICATION	BIRTH HISTORY	YES	NO	DON'T KNOW
Name and relationship of person filling out form:	Did the child's mother have any illnesses or problems during pregnancy, labor or delivery?			
Is this child adopted: YES____ NO____	Was the baby premature?			
FAMILY HISTORY	Was the baby delivered Cesarean Section?			
Child's mother's name:	Did the baby have Jaundice (yellowing)?			
Child's father's name:	Did the baby have seizures (convulsions)?			
Parents are Married __ Single __ Divorced __ Separated __ Remarried __	Did the baby have any other problems at birth or in the first few weeks of life?			
Who does child live with: Mother __ Father __ Both __ Other ____	Was your baby's discharge delayed for any reason?			
Others at home (Name, Age, Relationship):	Birth weight of Baby: ____lbs ____oz			
1	HAS YOUR CHILD EVER:			
2	Been in a hospital overnight?			
3	Had Surgery/Operation?			
4	Been seen in an Emergency Room?			
5	Has seen a Medical Specialist?			
Who cares for the child during the day or after school?	Had an allergic reaction to medicine or food?			

FAMILY HISTORY: Has any family member had these conditions?

	Yes	No	Don't know		Yes	No	Don't know
Birth Defect/Deformity				High Cholesterol			
Mental Illness				Hypertension			
Convulsions/Seizures				Peptic Ulcer			
Family/Inherited Diseases				Kidney Problems			
Serious/Fatal Childhood Illnesses				Blood/Bleeding diseases/Sickle Cell Anemia			
Eye or Hearing Problems				Cancer			
Asthma, Hay Fever, Eczema, Allergies				Immune Disorders			
Tuberculosis				Accidental Poisoning			
Diabetes				Smoke Regularly			
Thyroid Disease				Drinking Problem			
Heart Attacks under age 50				Drug Problem			
Heart Disease at Birth				Other Health Problems			



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PATIENT NAME:_____ DOB:_____ DATE:_____

HEALTH HISTORY (Do not complete this page for infants)

MEDICAL HISTORY: Has your child ever had or does have...	YES	NO	DON'T KNOW	BEHAVIORAL ISSUES	YES	NO	DON'T KNOW
Chicken Pox				Frequent Headaches			
Rheumatic Fever				Discipline Problems			
Tuberculosis or Positive TB test				Trouble getting along with others			
Hepatitis				Restless, Fidgety or Destructive			
Eye or Vision Problems				Nervousness or Unusually fearful			
Ear or Hearing Problems				Persistently Sad or Depressed			
Dental Problems				Use of Tobacco, Drugs or Alcohol			
Speech Problems				Sexual activity or Victim of Sex Abuse			
Recurrent Sore throat or Tonsillitis				Other Problems with behavior			
Bronchitis/Pneumonia				Sleep Problems			
Wheezing/Asthma				FOR FEMALES ONLY:			
Allergic Problems				Vaginal Discharge			
Frequent Runny Nose				Menstrual Problems			
Recurrent Nose Bleeds				Age at first Menses:_____			
Recurrent Skin Rashes or Eczema				GENERAL HISTORY: Does pt. have			
Stomach or Bowel Problems				All needed Immunizations			
Hernia				Take Medicine Regularly			
Bedwetting/Soiling				Take Fluoride in Vitamins or Water			
Urine/Kidney Problems/Infections				See Dentist Regularly			
Anemia or Blood Problem				Receive Sex Education at home			
Heart Condition				WOULD YOU LIKE INFORMATION:			
High Blood Pressure				School Problems			
Fainting Spells				Family/Marital Problems			
Joint Pain or Swelling				Sex Education			
Bone Problems/Fractures				Drugs, Alcohol or Smoking			
Convulsions/Seizures				Other			
ADD/ADHD/Learning Disabilities							
Other Health Problems							

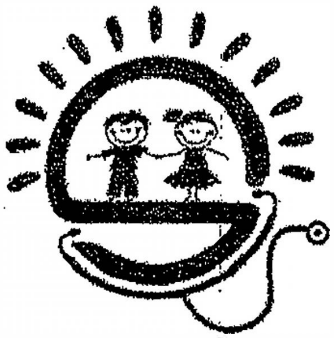
ADDITIONAL COMMENTS:

_____

_____

_____

_____



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ MRN# _____

SSN: _____ DOB: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Name of previous physician _____
   Address: _____ Phone: _____
   _____ Fax: _____
3. The type and amount of information to be disclosed is as follows:

☐	Complete Medical Record	☐	List of allergies	☐	X-Ray Reports
☐	Physician Progress Notes	☐	Problem List	☐	EKG
☐	Immunization Record	☐	Lab Reports	☐	Medication List
☐	Consultation Reports from:	☐		☐	Other
☐		☐		☐	

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box.

☐	Alcohol Abuse	☐	Mental Health Notes	☐	Drug/Substance Abuse
☐	Testing for HIV antibodies and/or treatment of AIDS				

5. This information may be released to and used by the following individual(s) or organization(s):
   Name: _____
   Address: _____
   For the purpose of: _____
6. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition: _____.
   If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information (for a nominal fee) to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information any not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager.

_____ _____

Signature of Patient/Legal Representative (Specify relationship to patient) Date

FOR OFFICE USE ONLY

Purpose for transfer: ☐ Insurance Change ☐ Relocation ☐ Other

Compliant with HIPAA Regulations

03/2017

Sunshine Pediatrics of Florida
Dr. Payal Patel & Dr. Saumeel Mehta

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Office Policy on Payments/Co-Payments

All payments or co payments are to be paid prior to the office visit.

We appreciate your cooperation and are grateful that you are our patient.

We look forward for a long healthy relationship.

Thank You,

Sunshine Pediatrics of Lutz

Initial: _____

Date: _____

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HIPPA Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access the information. Please review it carefully.

At Sunshine Pediatrics of Lutz, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may us or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose our health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request, in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact our Privacy Office, Payal Patel, MD at (813) 948-2679.

This notice goes into effect as of June 1, 2007.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways.
We can use your health information and share it with other professionals who are treating you.
We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through one (1) of 3 systems listed:

1) Lab Corp 2) Quest 3) Beyond

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications

Do research. Comply with the law. Respond to organ and tissue donation requests. Work with a medical examiner or funeral director.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated
- If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notify you of the actions our office will take.
- Or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

Sunshine Pediatrics of Florida
HIPAA Compliance Officer: Saumeel Mehta
Phone: 813-948-2679

This Notice of Privacy Practices is effective March 1, 2017

Sunshine Pediazrics of Florida

Patient education provided Dr. Payal Patel & Dr. Saumeel Mehta

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF RECEIPT OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Sunshine Pediatrics of Lutz's notice of privacy practices

Name(Please Print)	Signature	Date

If signing as a parent or guardian, please note the name of the patient:

FOR INTERNAL OFFICE USE ONLY:

Date Acknowledgment Received

OR

Reason Acknowledgment was not obtained:

Name(Please Print):_____Signature:_____Date:_____

Sunshine Pediatrics of Florida

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Fax: (813)-234-3354	(813)-9480-2694	Wesley Chapel, FL 33543

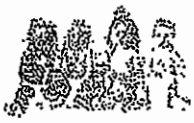
In Order to server out Patients to the best of our ability and assure that all of our patients have an opportunity at an appointment when needed, we will be enforcing a NO SHOW policy as of 10/01/2011. A fee of 25.00 will be charged to anyone who dose not gives 24 HOURS NOTICE BEFORE canceling an appointments.

Sign _____ Date _____

Thank-You

Sunshine Pediatrics of Florida
Payal Patel M.D.
Saumeel Mehta M.D.
Pediatrics and Adolescent Medicine
18928 N. Dale Mabry Hwy. Ste 102
Lutz, FL 33548
(813) 948-2679
(813) 948-2694
sunpedsfl.com

Doctor(s)
Payel Patel,MD
Saumeel Mehta, MD



Sunshine Pediatrics
16528 N. Dale Mabry Hwy
Ste 102 Lutz, FL 33548

We are happy to support your healthy life style. We are not responsible for adverse events/death due to over the counter medication / herbal supplements/ Vaccine refusal/ delayed vaccine schedule /any natural or herbal supplement written by us upon your request.

I _____ understand the consequences of medications/supplements/vaccine refusal/delayed vaccine schedule and any such treatments not limited to ones mentioned. Also this includes responsibility for written treatments that are not formally prescribed by Dr Patel/Dr Mehta and has been written upon my request. I take full responsibility for adverse events/death that may occur due to my own decision.

Signed on Date:

BY :

Signature:

Relation to Patient: