Shores
PEDIATRICS

Preferred Doctor: ☐ **Dr. Laura Fernandez Ortiz** ☐ **Rubens de la Pena Mir, ARNP**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Creole** ☐ **Other:** _____

Patient's First Name:_____ Last Name:_____

SEX: ☐ MALE ☐ FEMALE **DOB**:_____ **ETHNICITY:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACE: ☐ Am-Indian/Alaskan ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Black/African American
☐ White ☐ Hispanic ☐ Other

PATIENT RESIDES WITH: ☐ Mom ☐ Dad ☐ Both Parents

MOTHER'S FULL NAME: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____

ZIP: _____ **EMAIL**: _____

PRIMARY PHONE NUMBER: _____ **ALTERNATE PHONE NUMBER**:_____

FATHER'S FULL NAME: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____

ZIP: _____ **EMAIL**: _____

PRIMARY PHONE NUMBER: _____ **ALTERNATE PHONE NUMBER**: _____

PRIMARY INSURANCE: _____ **ID#** _____

GROUP# _____ **SUBSCRIBER:**_____

PHARMACY NAME _____ **PHONE:**_____

Physicians Release and Assignment: I authorize release of medical and other information necessary to process and receive payment on health insurance claims and request payment of benefits be made to the provider. A copy of this authorization may be used in lieu of the original.

Financial Agreement: I understand that I am financially responsible for any charges incurred for services provider. If I have health insurance coverage and my provider is in network, I understand that I am financially responsible for co-payments, deductibles, and co-insurance associated with covered services. If my provider is out of network, I understand that I may be responsible for higher out of pocket amounts. I understand if I choose to have non-covered services done I will be responsible for payment in full. If my account is sent to collection s due to non-payment I agree to pay all fees and expenses incurred in collecting any such amount, including without limitation, attorney fees and costs. I hereby consent to receive marketing materials from Shores Pediatrics periodically.

Recorded Messages: ☐ YES ☐ NO ☐ Do not leave message other than "RETURN CALL"

Print Name _____Signature _____ Date_____

CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Shores Pediatrics, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and /or take photographs of the appearance of (print name)_____, (age of minor)_____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes I hereby freely and voluntary consent of the use and publication of my name, participation, picture, and/or likeness by Shores Pediatrics, LLC and/or its employees or agents, as well as the entity seeking this content and photographs, video, and/or audio for any and all purposes including, but not limited to educational, promotional, advertising and trade, through any medium or format, including but not limited to film, photograph, television, radio, digital, internet, or exhibition, at any time from this day forward until I revoke this consent in writing.

I acknowledge that Shores Pediatrics, LLC is the sole owner of all rights in, and to this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that has the right used to produce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs video and/or audio maybe use indefinitely by television, radio, newspapers, magazines, newsletters, brochures, internet, intranet, or in other media once released.

Shores Pediatrics, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation and said productions. I agree to hold Shores pediatrics, LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from my participation in this production.

I have read this consent before signing and fully understand the contents, meeting, and impact of this consent
I understand that I am free to address any specific questions that I have done so prior to signing this consent.

Name: _____

Address: _____

Telephone: _____ Email Address:_____

Signature:_____ Date:_____

Name of Parent/Legal Custodian (under age 18) _____

Signature of Parent/Legal Custodian (under age 18) _____

Witness Name: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable time timeframe. I also understand this file may have been copy without permission and I agree not to hold Shores Pediatrics, LLC responsible for instances of these violations.

Signature _____ Date_____

Shores
PEDIATRICS

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Shores Pediatrics. When you schedule an appointment with Shores Pediatrics we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than **24 hours prior** to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. With that in mind please take note of our Appointment Cancellation /No Show policy found below:

Any patient who fails to show up or cancel/reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25 fee.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager who may be able to waive the No Show fee.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature of Parent/Legal Guardian *Relationship to Patient*

_____ _____

Printed Name *Date*

Shores
PEDIATRICS

E-MAIL CONSENT FORM

Name:_____ Date of Birth:_____

Risk of using e-mail:
You and your Healthcare provider have agreed to correspond using electronic mail (e-mail). This form provides guidelines for the intended use of this type of communication and documents your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL, CALL 911

E-mail Use:
Generally, e-mail correspondence should be between the provider and an adult patient 18 years older, or parent or legal guardian of a minor.

Privacy and Confidentiality:
Unless your provider tells you specifically that the e-mail will be conducted via a secure server, consider e-mail like a postcard that can be viewed by unintended persons. In addition, the content of the email may be monitored by Shores Pediatrics to ensure appropriate use. Discuss with your provider who will process your e-mail messages during business hours, vacations or illness. All e-mails regarding your care will be included in your medical record.

Creating a Message:
On the "Subject" line, include the general topic of the message, for example, Prescription or Appointment or Advice. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.

Content of the Message:
E-mail should be used only for non-sensitive and non-urgent issues. Types of information appropriate for e-mail include:

- Routine follow-up inquiries
- Appointment scheduling
- Medical Record

Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number below.

Ending E-mail Relationship:
Either you or your provider may request via e-mail or letter to discontinue using e-mail as a means of communication.

Please note that in order to account for the time spent communicating with your healthcare provider, a $75 fee will be charged per consultation (several separate exchanges on the same topic will be charges as one consultation).

Disclaimer: Shores Pediatrics, and Dr. Laura Fernandez Ortiz, M.D. are not responsible for e-mail message that are lost due to technical failure during composition, transmission and/or storage.

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for e-mail communication.

Patient/Parent/Legal Guardian Signature:_____Date:_____

Email:_____

Shores
PEDIATRICS

CONSENT FOR CHILD'S MEDICAL / EMERGENCY TREATMENT AND MEDICAL INFORMATION

Name: _____ ☐ Mother ☐ Father ☐ Legal Guardian

Child 1:_____ ☐ Son ☐ Daughter DOB:_____Allergies:_____

Child 2:_____ ☐ Son ☐ Daughter DOB:_____Allergies:_____

Child 3:_____ ☐ Son ☐ Daughter DOB:_____Allergies:_____

Child 4:_____ ☐ Son ☐ Daughter DOB:_____Allergies:_____

In presenting my son/daughter for diagnosis and treatment I hereby voluntarily consent to the rendering of such care, including diagnostic procedures, by authorized staff of Shores Pediatrics of their designees as maybe necessary in my absence.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.
I/We Hereby give my (our) consent to:

1._____ (Name of person/agency)

2._____ (Name of person/agency)

WHO may bring my child to Shores Pediatrics for medical attention as described above for my child/children aforementioned.

I/We acknowledge that I/We are responsible for all reasonable charges in connection with care and treatment rendered during this period. Any co-payments and/or deductibles will still need to be paid.

In case of emergency, I can be reached at: _____

Signature:_____Driver's License #:_____

Date: _____

Shores
PEDIATRICS

MEDICAL RECORDS RELEASE AND REQUEST FORM

Records from Medical Office/Practitioner:_____

Address:_____

City:_____State:_____ Zip Code: _____

Telephone: _____ Fax: _____

Patient Name: _____Date of Birth: _____

Patient Address:_____City/State/Zip:_____

____I request that the above-named office/practitioner provide a copy of the specific health and medical information for the patient(s) named to Shores Pediatrics.

____ I authorize Shores Pediatrics to release the specific health and medical information for the patient(s) named to the outside medical office/practitioner above.

<u>This request applies to the following information to be provided:</u>

____ Abstract (Health Summary only) ____ Consultation Reports _____Progress Notes
____History and Physical ____ Vaccine Records _____Complete Record _____HIV
____ Mental and Behavioral Health information pertaining to any medical history, mental or physical condition, and treatment received.

This authorization will expire on: _____if date not specified, this release will expire 1 year from date of signature.

I understand that there is a charge of $1.00 per page for first 25 pages and $0.25 for every page thereafter for the release of my records. (This only applies if you are requesting us to make copies of records). I understand that if I refuse to consent to disclosure of information, Shores Pediatrics may be unable to serve my child and/or may be unable to provide the most suitable care for my child.

I understand that once Shores Pediatrics releases my health information to the recipient, Shores Pediatrics cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal Florida law governing the use and disclosure of my health information.

Name of Parent or legal guardian: _____Date: _____

Name of Parent or legal guardian: _____Date: _____

Name of Parent or legal guardian: _____Date: _____

[Shores Pediatrics Staff has checked the ID of the signer and ensured that this is the legal representation who has access rights.]

(HIPPA) NOTICE OF PRIVACY PRACTICES

HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's place of employment instead of the individual's home.

I understand that I will upon request receive a copy of the HIPPA statement at Shores Pediatrics.
I understand HIPPA privacy practices are also posted in the office waiting area.

Please let us know who we may share **your** or **your child's** PHI with:

MOM: _____

DAD: _____

OTHER: _____

Please let us know if it is OK to leave a detailed message containing PHI at:
☐ HOME VOICEMAIL ☐ CELL PHONE VOICEMAIL ☐ EMAIL

CHILD'S NAME: _____ DOB: _____

PATIENT, PARENT OR LEGAL GUARDIAN: _____
SIGNATURE

DATE: _____

WITNESS: _____

Notice of Privacy Practices
Shores Pediatrics, LLC

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the pediatric care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Shores Pediatrics, LLC
9715 NE 2nd Avenue
Miami Shores FL 33138
Office: (305) 757-8040
Fax: (305) 757-2011

2013

Reference Policy # 201