Grace Pediatrics

CHILDS INFORMATION

Social Security Number: Sex: DOB:

First Name: ***Email***:

Middle Name: Suffix: Language:

Last Name: Ethnicity: Other Latin/Hispanic Refused

Address: **Race: Caucasian, Black/African, Asian, Native American, Other Race, Asian Pacific, American Pacific Islander, Subcontinent Asian American, American Indian/Alaskan Native, Native Hawaiian, More than one Race**

City:

Zip: State:

Child's Pharmacy:

MOTHER OR GUARDIAN'S INFORMATION		**FATHER OR GUARDIAN'S INFORMATION**	
If Guardian Relationship to Child:		If Guardian Relationship to Child:	
First Name:		First Name:	
Middle Name:	Last Name:	Middle Name:	Last Name:
Birth date:	SS. No.:	Birth date	SS. No.:
Address:		Address:	
City:		City:	
State:	Zip:	State:	Zip:
Home Phone: ( )		Home Phone: ( )	
Cell Phone: ( )		Cell Phone: ( )	
Work Phone: ( )		Work Phone: ( )	
Emergency Contact:	Phone:	Relationship to Child:	
Mothers Race:	Ethnicity:	Fathers Race:	Ethnicity:

Child lives with: **Mother Father Both Other** If Other (Please specify):

Primary Insurance:

Name of Insured:		Name of Insured:	
Relationship to patient:		Relationship to patient:	
Employer Name:		Employer Name:	
Address:		Address:	
City:		City:	
State:	Zip:	State:	Zip:
ID Number:		ID Number:	
Payor ID:		Payor ID:	
Ins. Telephone No:		Ins. Telephone No:	

Name Signature: Date:

Grace Pediatrics

Appointment of Parent Substitute to Authorize Care and Treatment for Minor Patient

I, _____ the parent/legal guardian of

Patient Name: _____ DOB: _____

Hereby authorize:

Name	Relationship to Minor	Phone Number

To accompany the above-named child to office visits with Grace Pediatrics and to consent to the examination, diagnostic testing, immunization, and/or treatment of my child during office visits.

_____ This authorization is effective from _____ to _____

_____ This authorization is effective until revoked by me in writing.

I reserve the right to revoke this authorization at anytime in writing to Grace Pediatrics.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____ Witness: _____

Grace Pediatrics

Childs Name: DOB:

PREGNANCY AND BIRTH

Birth Weight_____ Length _____

Delivery: Vaginal C-Section

Mother Treated for Infection: Y N

Infant treated for infection: Y N

Any antibiotics given to mother: Y N

Any antibiotics given to infant: Y N

Jaundice: Y N

Low birth weight: Y N

Any trouble at birth: Y N

Prematurity: Y N

<u>Mothers History</u>

Age at time of Birth: _____

Total # of Pregnancy's: _____

Total of live births: _____

During Pregnancy did you:

Smoke? Y N

Drink? Y N

Drugs? Y N

What hospital was Child born? _____

What day did baby go home? _____

Please Explain any Yes answers:_____

_____

NUTRITIONAL ASSESSMENT:

a. Newborn: formula or breast

if formula, which one _____ how many ounces_____

how often does the baby eat_____

b. Infants: have you started cereal Y N

have you started juices Y N

have you started solids Y N

c. Toddlers: any food allergies Y N

other concerns Y N

d. All patients: are there any concerns/questions regarding feeding/eating habits

_____

DENTAL

If your child is over three years, have they seen a dentist: Y N

Does your child brush his/her teeth Y N

Is there fluoride in your water supply Y N

VISION/HEARING

Any concerns with your Childs vision or hearing Y N

Has your child been evaluated by any eye doctor Y N

If School Aged:

What school is your child currently attending? _____

What grade is your child currently in? _____

DEVELOPMENT:

Do you have any concerns with your Childs growth or development Y N

Have you been told your child is developmentally delayed? Y N

If Yes please explain: _____

_____

_____

_____

_____

_____

Social History

HAS THIS CHILD BEEN EXPOSED TO: (please circle one)

SMOKING	Y	N
ALCOHOL/DRUGS	Y	N
PHYSICAL ABUSE	Y	N
MENTAL ABUSE	Y	N
SEXUAL ABUSE	Y	N
TUBERCULOSIS	Y	N
HIV/AIDS	Y	N

OTHER: _____

ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH THE PRACTITIONER?

_____

_____

Who all lives with child: _____

What is Primary Language in household? _____

If not English, do you have an interpreter that you can provide?

_____

If yes, Name _____ Phone number: _____

Grace Pediatrics

Past Medical History

Family History (please include parents, siblings, and grandparents)

DIABETES	SICKLE CELL ANEMIA
HEART DISEASE	LEUKEMIA
HIGH BLOOD PRESSURE	SEIZURES
CANCER	DEATH IN THE IST YEAR OF LIFE
ASTHMA	THYROID DISORDERS
ANEMIA	BEHAVIOR/DEVELOPMENTAL
TUBERCULOSIS	ADD/ADHD

Childs History (please circle any medical conditions your child may have)

DIABETES	TUBERCULOSIS	HIV/AIDS
ALLERGIES	HEART PROBLEMS	STD'S
ASTHMA	SICKLE CELL ANEMIA	BEHAVIORAL PROBLEMS
HIGH BLOOD PRESSURE	SICKLE CELLDISEASE	ADD/ADHD
CANCER	LEUKEMIA	DEVELOPMENTAL PROBLEMS
EPILESY	SCHOOL PROBLEMS	Hospital (overnight stays)

Other (Please Explain): _____

Please list all surgical procedures your child has had and the year they were performed:

Year	Procedure

Parent's Signature Date

Grace Pediatrics

Informed Consent and Medical Authorization for a Minor

I hereby acknowledge that I have been informed that medical care received at Grace Pediatrics will be provided by the practitioners and the staff of Grace Pediatrics.

l hereby authorize and consent to any and all medical care and treatment for the minor named below which is deemed necessary and appropriate by Provider licensed in the state of Florida on or behalf of Grace Pediatrics. This consent includes but is not limited to medical and surgical intervention and elective as well as emergency care.

Child's Name :	DOB:
Parent/Guardian Name:	
Parent/Guardian Signature:	
Date:	Witness Signature:

Assignment of Benefits

1) I hereby give authorization for payment of insurance benefits to be made directly Grace Pediatrics. This authorization will be good for one year.
2) I understand that I am financially responsible for all charges whether or not they are covered by my insurance company. In the event of default, if this account is assigned to an attorney, collection agency, or small claims court, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.
3) I authorize this office to release all information necessary including medical records to secure payment of benefits for all services rendered to my child(ren).
4) I further agree that a photocopy of this agreement shall be valid as the original. I understand that I have the right to withdraw this authorization by written consent at any time.
5) Return check policy; for all returned checks, we will charge a $35 fee that will not be paid by your insurance company.

NO SHOW POLICY: If you are unable to keep you appointment, please give a 24 hour notice of cancellation, otherwise a no show fee of $35 for new patients and $25 for established patients will be incurred. This will not be paid by your insurance company and payment is expected at, or by time of your next office visit.

I have read and understand the above.

Parent/Guardian Name:	Date:
Parent/Guardian Signature:	
Witness Signature:	

Grace Pediatrics

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

**Please note Grace Pediatrics Privacy practices policy is posted in the lobby area and is available upon request.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

GracePediatrics

4196 West US Highway 90 Suite 105

Lake City, Florida 32055

386-243-8474 phone

386-438-5945 fax

Vaccine Policy

The providers of Grace Pediatrics firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines. We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Center for Disease Control and the American Academy of Pediatrics.

At this time, if you refuse vaccinations for our child you will be required to sign a vaccination refusal form. Non-vaccinating patients will not be seen without a signed refusal form.

I have read and understand the above.

Parent Signature: _____ **Date**: _____

GracePediatrics

4196 West US Highway 90 Suite 105

Lake City, Florida 32055

386-243-8474 phone

386-438-5945 fax

Photo Release Form

Patient name: _____

Date of Birth: _____

I hereby consent to my child(ren) being photographed for medical record keeping. This photo will not be used outside of our medical records without written permission from parent/guardian.

I hereby release Grace Pediatrics PL from any and all claims, demands, cost and liability that may arise from the use of these photographs as described above.

I acknowledge that I have read this consent form in its entirety, or it had been read (or translated) to me, and I have had the opportunity to ask questions and understand the above.

Date: _____

Name (please print): _____

Signature: _____

*Parent or legal guardian name if patient under 18 years old (please print):

_____

*Parent or legal guardian signature: _____

Witness: _____

CONSENT FOR SMS COMPLIANCE

By acknowledging and signing this consent form, you are granting permission to Grace Pediatrics and any related affiliates to contact you on the mobile phone number(s) listed below.

You may choose to grant permission to contact you via phone call and text message, or phone call only (no texts). Consent is not required and additionally, you retain the right to revoke permission at any time.

By consenting via this form, you grant permission to Grace Pediatrics and related affiliates or third parties to contact you for any reason. Some examples of reasons we may contact you include: reminders for appointments, scheduling issues, insurance and billing issues.

By signing this form, you represent that you are the wireless subscriber or customary user with respect to the wireless number(s) provided and that you have the authority to provide consent. Please note that depending on your mobile service plan, message and data rates may be assessed by your mobile provider.

Should you choose to grant consent to contact your cell phone, you may withdraw consent or opt-out at any time by any reasonable means, including providing written notice to Grace Pediatrics at 4196 W US HWY 90, SUITE 105, Lake City FL, 32055, or by calling our office at 386-243-8474.

Please note all texts and calls are done as a courtesy only. You are solely responsible for keeping and maintaining your appointment times and are responsible for notifying us of cancellations with no less then 24 hour notice of your scheduled appointment time.

Please make your selection below, Sign and Date.

Parent/Guardian:

☐ I grant permission to contact my cell phone for calls and text messages

☐ I grant permission to contact my cell phone for calls only (no texts)

☐ I do not grant permission to contact my cell phone

_____ _____

Patient Name **Parent/Guardian Name (PRINT)**

_____ _____

Parent/Guardian Signature **Cell Phone Number You Are Authorizing Us to Contact**

_____

Date

COVID-19 Informed Consent Form Addendum

Practice Name: Grace Pediatrics
Phone Number: 3862438474
Address: 4196 W US Hwy 90, Lake City, Florida, 32055

You are currently receiving treatment from Grace Pediatrics. In addition to the benefits and risks of treatment outlined in Grace Pediatrics's informed consent form, and as discussed with you, all those receiving any form of treatment are at an increased risk of becoming infected with novel coronavirus (also known as "COVID-19"). It is important that you understand this addendum and you may ask questions at any time

Grace Pediatrics is taking recommended precautions to avoid transmission of COVID-19 by and between their employees and patients and as outlined in Grace Pediatrics's COVID-19 Preparedness and Response Plan. However, while these precautions lower your risk of infection with COVID-19, even with these precautions you may become infected. By consenting to undergo treatment you are acknowledging this risk and waiving any claims against Grace Pediatrics for any and all damages that may result from COVID-19 infection. You acknowledge that the risks associated with COVID-19 infection range from mild cold and flu-like symptoms to death. All statements contained in the previous/concurrent informed consent form are still valid, including all potential benefits and risks, in addition to the risk of COVID-19 infection.

Parent/Guardian Signature:_____

Grace Pediatrics PL

www.gracepediatrics.net

386-243-8474

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Grace Pediatrics **Phone #:** 386-243-8474

METHOD OF DISCLOSURE:

_____ **Pick up at Clinic/Facility**

_____ **Address:** _____

__X__ **Fax #:** 386-438-5945

_____ **Email Address: (please note that emailing may not be a secured method of communication)**

_____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s) _____STD Records _____ TB Records _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Progress Notes

_____ Diagnostic Test Reports (Specify Type of test(s) _____

__X__ Other: (specify) All Medical Records

I specifically authorize release of information relating to: (initial selection)

_____HIV test results _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

__X__ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Legal Representative Signature Date

_____ _____

Printed Name Legal Representative's Relationship to Client

Patient Name:_____ DOB:_____

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).