emerald coast PEDIATRICS

Date:_____

Name:_____ Date of Birth: _____ Age:_____ M{ } F{ }

Race: { } White { } African American { } American Indian/Alaskan Native { } Asian { } Hispanic/Latino
{ } Native Hawaiian/Pacific Islander

Ethnicity: { } Hispanic or Latino { } Not Hispanic or Latino

Preferred Language: { } English { } Spanish { } other: _____

Child SS#:_____ School:_____ Referred by:_____ Home PH#:( )_____

Street Address:_____ City/State:_____ Zip:_____

Parent #1 M{ } Occupation/
Name:_____F{ } Employer:_____ Work PH#:( )_____DOB: _____ SS#:_____

Parent #2 M{ } Occupation/
Name:_____F{ } Employer:_____ Work PH#:( )_____DOB:_____ SS#: _____

Guardian (*if other than Parents*):_____Occupation/
Employer:_____Work PH#:( )_____DOB:_____ SS#: _____

Emergency Contact
(*Other than parents*):_____ Address:_____ Phone#:( )_____

Closest Relatives
(*not at your address*):_____ Address:_____ Phone#:( )_____

Insurance and Billing Information

Person Responsible:_____ Address: _____

Effective Date:_____ Billing Address: _____

Payment Required at the time of service – Unless prior arrangements have been made

1) Insurance Company:_____ Address:_____Effective Date: _____

Subscriber's Name:_____ I.D.#:_____ Group#: _____

1) Insurance Company:_____ Address:_____Effective Date: _____

Subscriber's Name:_____ I.D.#:_____ Group#: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Eehab A. Kenawy, M.D.for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization To Release Information

I hereby authorize Dr. Eehab A. Kenawy, M.D., to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
A photocopy of these assignments shall be valid as the original.

Patient(please print):_____ Date:_____

Parent/Guardian (please print):_____ Signature:_____

Patient's Name:_____ DOB:_____ Reason for today's visit:_____

Please check {Y} yes or {N} no, explain where required.

Pregnancy/Birth: Mother's age at pregnancy:_____ Any illness during pregnancy? {Y} {N} Medications during pregnancy? {Y} {N}

Smoking/alcohol/street drugs during pregnancy? {Y} {N} Was baby early/late/on time? _____ Any complications?_____

Type of delivery?_____ Birth Weight:_____ Birth Length:_____ Problems soon after birth? Nursery or Home:_____

Past Medical History: Allergic reaction {Y} {N} Food {Y} {N} Animals {Y} {N} Insect Bites {Y} {N} Medicine:_____

Medication taken on a regular
basis? (*Exclude vitamins*)_____ Immunizations: Up to date {Y} {N} Do you have a record? {Y} {N}

Hospitalizations? (*when,where,why*):_____

Serious Injuries? (*when, why*):_____

Red Measles	{Y} {N}	Mumps	{Y} {N}	German Measles	{Y} {N}
Chicken Pox	{Y} {N}	Whooping Cough	{Y} {N}	Rheumatic Fever	{Y} {N}
Scarlet Fever	{Y} {N}	Ear Infections	{Y} {N}	Strep Throat	{Y} {N}
Asthma/Wheezing	{Y} {N}	Eczema/Hives	{Y} {N}	Seizures	{Y} {N}
Anemia	{Y} {N}	Urinary Infections	{Y} {N}	**Problem With:**	{Y} {N}
Bleeding Tendency	{Y} {N}	Joint Injury	{Y} {N}	Hearing	{Y} {N}
Blood Transfusions	{Y} {N}	ADHD/ADD	{Y} {N}	Vision	{Y} {N}

Feeding & Nutrition: Food Allergies:_____ Appetite usually good? {Y} {N}

Colic or feeding problems during the first 3 months? {Y} {N} Breast fed? {Y} {N} Number of months?_____

Formula? {Y} {N} Current brand:_____ Vitamins? {Y} {N} What brand?_____ Special diet? {Y} {N} Fluoride? {Y} {N}

Family Profile: (*Parent*s) Married { } Separated { } Divorced { }

Parent #1 Age:_____ M{ } F{ } Highest Level of Education Achieved?_____ Health?_____

Parent #2 Age:_____ M{ } F{ } Highest Level of Education Achieved?_____ Health?_____

List of Child's Brothers, Sisters, and their ages:_____

Family Medical History: List of all blood relatives of your child who have the following problems-use abbrav: {F} father, {M} mother, {B} brother, {S} sister, {MM} mother's mother. {MF} mother's father, {FM} father's mother, {FF} father's father, {A} aunt, {U} uncle, {C} cousin

Anemia/Blood Dis:_____ Asthma:_____ Mental Retardation:_____
Drug Problem:_____ Alcoholism:_____ Cancer:_____
Aids:_____ Cystic Fibrosis:_____ Musc. Dystrophy:_____
Tuberculosis:_____ Arthritis:_____ Epilepsy/Seizures:_____
Heart Disease:_____ High Blood Pressure:_____ Cholesterol Problem:_____
Migraine:_____ Sudden Infant Death:_____ Birth Defect:_____
Early Deafness:_____ Diabetes:_____

Development & Behavior: Age at which child: Sat alone:_____ Walked:_____ Used Sentences:_____ Toilet trained:_____

Bicycled:_____ Grade in school:_____ Problems in school:_____

Learning Problems? {Y} {N} Getting along with other children? {Y} {N} Behavior problems? {Y} {N} Bad Habits? {Y} {N} Bedwetting? {Y} {N}

Nail biting? {Y} {N} Hobbies? {Y} {N} Sports? {Y} {N} Use of street or illegal drugs? {Y} {N}

Parent Signature:_____ Date:_____

emerald coast PEDIATRICS

Pediatric Clinic Polices

Please read these polices carefully as they will serve as standards in our practice. If you have any questions please refer them to the office staff.

1. There will be no walk-in appointments accepted. If your child needs to be seen for an acute problem or illness, please call the office to schedule an appointment. If the office is closed or if your child is experiencing an emergency, go to the local emergency room.

2. Missed/Late Appointments. After 3 missed or broken appointments you will be dismissed from the practice. Patients arriving more than 15 minutes late for their appointment will be asked to reschedule.

3. Restrooms. For convenience restrooms are located just down the hall from our office. We reserve the restroom located near the exam rooms for patients in exam rooms and for specimen collection.

4. Please NO Food or Drinks in our office.

5. Due to limited space, NO MORE than 2 adults should accompany each child. If you have more than 1 child visiting our office we still ask that only 2 adults attend each visit.

6. We understand that waiting can be difficult for children, however, we ask that you be courteous to the other parents by controlling your children. We also ask that when visiting our office you ensure your children are clean and neat.

7. Return Check Policy. You will be charged a $25.00 fee for any check returned by your bank for Insufficient Funds or Closed Account. Once notified, you will be expected to make full payment within 10 days. Repeated offenses will result in CASH ONLY payment arrangements.

8. Co-Pays and Fees. Fees and other financial obligations are due when services are rendered.

9. Nurse/Triage Calls. Please remember that our nurses are busy taking care of scheduled patients. All attempts will be made to return calls as soon as possible. If you feel your concern can't wait please make an appointment to see the physician, or if the situation is urgent/emergent go to the emergency room.

10. Medication Refills. Please allow 72 hours for ALL medication refills. To ensure your child does not run out of his/her medication(s), please monitor their supply closely. For certain medications, such as those to treat ADHD and Asthma, your child may need to be seen before a refill can be authorized.

11. Shot records/Physical Forms. Our office observes a 72 hour policy for all shot record and physical form requests. Please keep this in mind when requesting for these items. Also, we do not routinely fax these documents. You will need to stop by our office and pick-up these items.

12. Medical Records. For copies of medical records given to the parents/patient there will be a $1.00/page charge. Records forward to other physicians will be done as a courtesy. Please allow 7 days for these copies.

13. Same Day Call In Appointments. Will be fit in with a minimum of a 45-60 minute wait time.

I have read and understand the above polices. I understand a copy of this letter will be placed in my child's record.

_____	_____	_____
Parent or Guardian Signature	Parent or Guardian Printed Name	Date

Name of Patient(s):_____

This is to certify that I,_____, have received a copy of the

Notice of Privacy Practice Act.

Signature:_____ Date:_____

I,_____(Print your name) authorize the following

_____(Person's name &relationship to client) and

_____(Person's name &relationship to client)

to bring my child _____(Print name of child),

to Dr, Kenawy at Emerald Coast Pediatrics for medical care and treatment in my absence.

SIGNED:_____ Date:_____

Relationship to Patient:_____

Witnessed By:

Print name:_____

SIGNED:_____ Date:_____

Notice of HIPAA Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. .

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HiPAA), you have a right to adequate notice of the uses and disclosures of your protected health information ("PHI")(i.e. information that discloses your child's identity or leads to disclosure of their identity) that may be made by this medical practice. You are also entitled to a notice of your rights and the policy of this practice with respect to your child's PHI.

Our office is committed to treating and using PHI about your child responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your child's PHI. This Notice is effective April14, 2003, and applies to all PHI as defined by federal regulations.

REQUIRED BY LAW

Our practice has the following duties with respect to your child's PHI:

1. We are required by law to maintain the privacy of your child's PHI.
2. We must provide you with notice of our legal duties and privacy practices with respect to your child's PHI.
3. We must abide by the terms of the Notice of Privacy Practices that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR CHILD'S INFORMATION

The following describes how our practice is permitted by law to share your child's PHI with others in order to provide your child with medical care. This notice does not describe every use or disclosure our practice makes; it is intended as a general overview.

1. Medical treatment. We may need to share information about your child in order to provide medical care to them. For example, we may share with other physicians, nurses or healthcare professionals entering information into your child's medical records relating to their medical care and treatment. We may share information about your child including x-rays, prescriptions and requests for lab work. We may share information about your child to a laboratory, hospital, or center we refer them to for tests. We may also provide a subsequent or current healthcare provider with copies of various records that should assist him or her in treating your child. We may share information about your child to a pharmacist who is responsible for filling your child's prescriptions.

2. Payment. We may need to disclose information about the treatment, procedures or care our practice provided to your child in order to bill and receive payment for services we provided. We may share this information with you, an insurance company or any third party responsible for payment. We may also need to disclose PHI about your child with your health plan and/or referring physician in order to obtain prior authorization for treatment, to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

3. Healthcare operations. In order to help us run our practice more efficiently and provide better patient care, we may use and disclose your child's PHI to Business Associates who need to use or disclose your child's information to provide a service for our medical practice, such as our software vendors who provide assistance with data management on our behalf. Examples include the use of a copy service when making copies of your child's PHI or a service to shred protected records. To protect your child's PHI, however, we require the Business Associate to appropriately safeguard your child's PHI and to sign a business agreement stating they agree to the safeguards.

4. Required by law. We will disclose medical information related to your child if required to do so by state, federal or local law.

5. Public health activities risks. Your child's PHI may be disclosed to a public health authority that is authorized by law to collect or receive such information for public health activities. Certain disclosures may be made for public health activities in the following circumstances:
   a) to prevent or control disease, injury or disability;
   b) to report births or deaths;
   c) to report child abuse or neglect;

Parent's Initials _____

d) to report reactions indications or product defects;
e) to notify individuals of product recalls;
f) to notify a person who may have been exposed to a communicable disease or are at risk of contracting or spreading a disease or condition;
g) if our practice reasonably believes a person is the victim of abuse, neglect or domestic violence, we may disclose PHI to the appropriate authority. We will only make this disclosure if you agree to the disclosure or we are required or authorized to do so by law without your permission.

6. Appointment reminders or treatment alternatives. Our practice may use and disclose medical information about your child to provide you with reminders that your child is due for care or has an upcoming appointment. We may also wish to provide you with information on treatment alternatives or other health related benefits that may be of interest to you. We may contact you by phone, fax or e-mail. We will make every effort to protect your child's privacy when leaving a message for you and try to reveal as little confidential information as possible (i.e., when leaving a message on your answering machine that may be heard by others).

7. Research. Under certain circumstances, our practice may use or disclose your child's PHI for research purposes. Our practice cannot use or disclose information about your child without your written authorization, but we may if the authorization requirement has been waived by a Review Board who has assessed the effect of the research protocol on your privacy rights and interests and certified that there are adequate controls in place to protect your child's PHI from improper use and disclosure. Our practice may also disclose information about your child in preparing to conduct research (i.e., to help-them find patients who may be qualified to participate in a particular study), but your child's PHI will not leave our practice. We will make all attempts to make your child's PHI non-identifiable, but we may not always be able to guarantee this. If, however, the researcher will have access to information that will identify your child, we will seek to obtain your permission (though we cannot guarantee this). We will always obtain your specific authorization if required by law.

8. To avert serious threat to health or safety. If our practice believes, in good faith, that a use or disclosure of your child's PHI is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, we may disclose their PHI.

9. Health oversight activities. Your child's PHI may be disclosed to federal, state or local authorities as part of an investigation or government activity authorized by law. This may include audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions or other activities necessary for the oversight of the healthcare system, government benefit programs and compliance with government regulatory programs or civil rights laws.

10. Law enforcement. We may disclose your child's PHI to law enforcement individuals if we are required to do so by law. We may also disclose PHI about your child in compliance with a court order, warrant or subpoena issued by the court. We may also use such information to defend ourselves in actions or threatened actions that may be brought against our practice.

11. Coroners, medical examiners and funeral directors. We may release PHI to a coroner or medical examiner for the purposes of identification, determining cause of death or other duties as authorized by law. We may also release PHI to funeral directors as necessary to carry out their duties with respect to the deceased.

12. Organ, eye, tissue donation. If your child is an organ donor, we may disclose their PHI organ procurement organizations, or other entities that facilitate tissue donation or transplantation.

13. Inmates. If your child is an inmate of a correctional institution or within the custody of law enforcement officials, we may disclose PHI about your child to allow the institution to provide your child with medical care, to protect the health and safety of your child and others or for the safety and security of the correctional institution. Other uses and disclosures will be made only with your written authorization and you may revoke your authorization at any time.

I have read and understand the above polices. I understand a copy of this letter will be placed in my child's record.

_____	_____	_____
Parent or Guardian Signature	Parent or Guardian Printed Name	Date

Eehad A. Kenawy, M.D.
Emerald Coast Pediatrics
621 West Baldwin Rd, Panama City, FL 32405
Phone: (850) 747-3661 Fax: (850) 747-0194

Vaccine Policy

Patient Name: _____

Patient DOB: _____/_____/_____

Emerald Coast Pediatrics is strictly a vaccine-only practice. We only accept patient that intend to vaccinate.

_____
Parent Signature

_____
Parent Printed Name

_____/_____/_____
Date

emerald coast PEDIATRICS

Lactation Consultation

Covered By Most Insurances

Patient Name: _____

Patient DOB: _____

Date of Service: _____

Age: _____ Weight: _____

Please fill out portion below with Mothers Information

Name: _____

(Please Print)

Date of birth:_____

Insurance Carrier: _____

Member ID/Policy Number: _____

Policy Holders Name: _____

Policy Holders DOB: _____

For Office Use Only

99401 - 15 Minutes (Dx Z39.1)

99402 - 30 Minutes (Dx Z39.1)

99403 - 45 Minutes (Dx Z39.1)

99404 - 60 Minutes (Dx Z39.1)

Lactation Consultant Signature

X_____

Physician Signature

X_____

Follow Up Lactation Consultation

_____ Days

_____ Weeks

_____ Months

By signing below, I _____ give authorization for Emerald Coast Pediatrics to bill my insurance for lactation consultation services. I acknowledge and understand I will be financially responsible for any portion not covered by my insurance.

Signature: _____ Date: _____

Print Name: _____