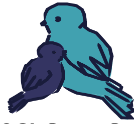

Weiss Pediatric Care

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PATIENT INFORMATION

Name of Patient and all Siblings (First, Middle, Last Name)	*Sex*	*Birth Date*
1.______________________________	☐M ☐F	___________
2.______________________________	☐M ☐F	___________
3.______________________________	☐M ☐F	___________
4.______________________________	☐M ☐F	___________
5.______________________________	☐M ☐F	___________

Preferred Language* (Patient) ☐English ☐Spanish ☐Other _____________

Race* ☐American Indian or Alaskan Native ☐Asian ☐Black ☐Hawaiian Native or Pacific Islander ☐White ☐Declined to Answer

Ethnicity* ☐Hispanic ☐Non-Hispanic ☐Other ___________

Preferred Contact Method for general messages: ☐Phone ☐Text ☐Home Email ☐Work Email

Preferred Contact Method for appointment reminders & recalls: ☐Phone ☐Text ☐Home Email ☐Work Email

Best telephone contact number: _________________ ☐ home ☐cell ☐work

*WPC requests information of Language/Ethnicity/Race to meet Federal Meaningful Use criteria.

PARENT OR GUARDIAN INFORMATION

Responsible Party Name ____________________ *Other Parent or Guardian*__________________________

Relationship to Patient _____________________ Relationship to Patient__________________________

Birth Date _______________ SS#____________ Birth Date _______________ SS#_________________

Address___________________________________ Address___________________________________

City_______________ State ____ Zip ________ City________________ State ____ Zip______________

Occupation ______________________________ Occupation ______________________________

Employer ________________________________ Employer _________________________________

Home Phone ______________________________ Home Phone _______________________________

Work Phone ______________________________ Work Phone _______________________________

Cell Phone _______________________________ Cell Phone ________________________________

Email ___________________________________ Email ____________________________________

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Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, Weiss Pediatric Care may use and disclose protected health information ("PHI") about me to carry out treatment, payment and healthcare operations ("TPO"). Please refer to Weiss Pediatric Care Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Weiss Pediatric Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Weiss Pediatric Care Privacy Officer at 2201 Cantu Court, Ste 117, Sarasota, FL 34232.

With my consent, Weiss Pediatric Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Weiss Pediatric Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Weiss Pediatric Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Weiss Pediatric Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, Weiss Pediatric Care may disclose personal photographs/cards with or without names or other identifiable information that I have provided or sent to the office for the purpose of posting on our bulletin board, Weiss Pediatric Care Facebook page or Weiss Pediatric Care website. I understand that I have the right to revoke this authorization in writing.

By signing this form, I am consenting to Weiss Pediatric Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Weiss Pediatric Care may decline to provide treatment.

________________________________ Patient's Name	______________________ Today's Date
________________________________ Parent or Legal Guardian or Patient (over 18) Signature	______________________ Parent/Legal Guardian or Patient (over 18) Please Print

HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

I acknowledge that I have received a copy of **Weiss Pediatric Care** Notice of Privacy Practices located on the office clipboard with the effective date of May 11, 2018. I am aware that I may also review the Notice of Privacy Practices on Weiss Pediatric Care's website, www.weisscare.com.

Initial __________

Authorization for Other Individuals
To Accompany My Child to Visits & Receive Information

The following individual(s) are authorized to bring my child to appointments, and to receive written and/or oral communications about my child's medical condition, care, appointments, etc. Examples: grandparents, stepparents, other relatives, nannies, etc.

____

Patient Name

Authorized Individual(s), including Parents (Please Print Names)

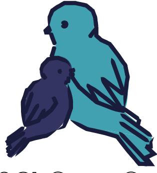
______________________	______________________	______________________
Name	Relationship	Phone #
______________________	______________________	______________________
Name	Relationship	Phone #
______________________	______________________	______________________
Name	Relationship	Phone #
______________________	______________________	______________________
Name	Relationship	Phone #

______________________________	______________________	____________
Signature **(Parent or guardian if patient is a minor)**	**Printed Name**	**Date**

EMERGENCY CONTACT INFORMATION

In an emergency please contact (other than above) ____

Relationship______________________________ Phone (____) ______________________________________



Weiss Pediatric Care

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IMMUNIZATION POLICY & AGREEMENT

- We strongly believe all children and young adults should receive all of the recommended vaccines according to the schedule published by the Center for Disease Control and Prevention and by the American Academy of Pediatrics.
- We strongly believe in the effectiveness of vaccines to prevent serious illnesses and save lives.
- We strongly believe in the safety of vaccines.

We respect the right of all parents/guardians to make decisions about their children's health. We recognize the choice to vaccinate may be an emotional one. We understand that you also want what is best for your children.

We encourage all our patients to understand the safety and effectiveness of vaccines. We will help to educate you on vaccines and ease your concerns.

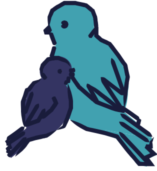
To ensure the safety of our patients, we will not treat children who are unvaccinated. We will not amend the recommended schedule of vaccines by delaying or splitting. We will not accept new patients who have chosen not to vaccinate.

If you feel that you cannot adhere to the expert recommended vaccine schedule, we ask that you find another health care provider.

By signing below, I understand and agree to follow Weiss Pediatric Care's Immunization Policy by completing all required vaccines **in accordance with the timing and schedule published by the American Academy of Pediatrics and the Centers for Disease Control.**

______________________________	______________________________
Patient's Name	Today's Date
______________________________	______________________________
Parent/Legal Guardian **Please print**	**Parent/Legal Guardian** **Signature**

Over for Immunization Schedule →



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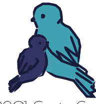
AGE	IMMUNIZATION SCHEDULE
BIRTH	Hepatitis B (given in hospital or at first office visit)
2 MONTHS	DTaP-IPV-HIB-Hep B (one injection), Pneumococcal, Rotavirus
4 MONTHS	DTaP-IPV-HIB-Hep B (one injection), Pneumococcal, Rotavirus
6 MONTHS	DTaP-IPV-HIB-Hep B (one injection), Pneumococcal, Rotavirus
12 MONTHS	MMR, Varicella, Pneumococcal, HIB
15 MONTHS	DTaP, Hepatitis A
2 YEARS	Hepatitis A
4 YEARS	MMR-Varicella, DTaP-IPV
11 YEARS	HPV series (2 immunizations over 6-month period), Meningococcal ACWY, Tdap
16 YEARS	Meningococcal ACWY, Meningococcal MenB (2 immunizations over 1-month period)
19 Years	Tdap Booster
MULTI-AGES	Influenza (over 6 months of age; administered annually), COVID-19 Pfizer-Biontech 5 years and older, COVID-19 Moderna 6 months-4 years

Immunization Key:

DTaP - Diphtheria, Tetanus, Pertussis
IPV – Inactivated Polio
HIB – Haemophilus Influenza
Hep B- Hepatitis B
Pneumococcal - Pneumonia
MMR – Measles, Mumps, Rubella
Varicella – Chicken Pox
HPV – Human Papillomavirus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FINANCIAL & OFFICE POLICY

Please read each section carefully and initial. We are happy to answer any questions!

Appointments:

- Children sixteen and older may come alone for *sick visits only* with a written *authorization for treatment* on file. Children over 18 may come to all visits without an adult.

Initial:________________

Insurance Plans:

- Make sure we have your correct insurance. You must **show your current insurance card at every visit** to protect you from a getting a bill because we did not have the correct information. We will try to validate your insurance benefits at the tine of each visit. If we cannot validate your coverage, you will be asked to pay in full at the time of the visit.
- Be sure that your insurance plan lists **Weiss Pediatric Care as your child's Primary Care Provider (PCP).** If we are not listed as PCP with your insurance company, you must pay for the visit or reschedule.
- **Know your insurance benefits**. Not all plans cover well child visits, vision and hearing screenings, immunizations, developmental and health surveys, and other services. You will have to pay for any services not covered by your plan.
- If your insurance plan only pays for a certain number of visits per year, you will have to pay for any additional visits beyond that number.
- Most insurance plans allow 30 days to add newborns to family plans. **After 30 days, newborns who have not been added to a plan are considered SELF PAY patients**. This means you will be responsible for paying the bills until we can verify insurance. If your newborn is covered by insurance, please give us the name of the plan, the subscriber's name, and ID number so we can bill your insurance rather than you.
- If your child is covered by more than one insurance policy, you must let both companies know who the primary insurer is. This is called ***Coordination of Benefits.*** It you do not do this, neither policy will pay and you will be responsible for the bill.

Initial:________________

Financial Responsibility:

- You are responsible for co-payments, deductibles, and coinsurances. **Co-pays are due at the time of the visit. Whoever brings the child for an appointment is expected to pay the co-pay.**
- **Self-pay patients and those with plans that we do not accept must pay in full at the time of visit.** If you have an out-of-network plan, we can provide what you need so that you may request the insurance company to reimburse you.
- Bills are sent out monthly. We ask that you **pay your bill when you receive the first statement**.
- **Bills not paid by 90 days are sent to a collection agency**. If your account is sent to collection, you will be asked to transfer to another doctor.
- **Outstanding bills must be paid before being** seen for a scheduled visit or you will be asked to reschedule.
- We accept cash, check, and all major credit cards.

- There is a $10 fee for returned checks.

- **We do not get involved with family disputes or custody issues.** Whoever brings the child for an appointment is expected to pay at the time of the visit. Both parents are responsible for paying balances due upon receipt of bills.

- Weiss Pediatric Care reserves the right to change fees without notice.

Initial:________________

Referrals:

- Please allow 3 business days for us to complete referral requests.

- Every plan is different. It is your job to know if a specialist or lab is on your insurance plan. If you go to a specialist or lab who does not take your insurance, you will be responsible to pay for the service.

Initial:________________

Forms:

- We need 3 business days to complete requested forms.

- Health and immunization forms are free in your patient portal. You can print as many copies as you need. We put updated forms in your portal after yearly well visits.

- Additional forms such as camp, sports, college, boy scouts, etc. are available for a $15 fee.

- If you need a form same or next day, there is a $25 “rush” fee.

Initial:______________

Medical Records:

- There is no charge for medical records sent by fax to another doctor’s office.

- Printed copies of medical records are charged based on current Florida guidelines. The fee must be paid when you pick up the records.

- Any patient over 18 must give us written permission to release records to anyone other than themselves.

Initial:______________

Prescription Refills:

- We need 3 business days to refill prescriptions. Please plan accordingly.

Initial:______________

- ☐ **I understand and agree to follow the Financial and Office Policies.**
- ☐ **I agree to pay all charges that are my responsibility.**
- ☐ **I authorize payment of medical benefits directly to Weiss Pediatric Care.**
- ☐ **I give permission to release medical information needed to process insurance claims.**

Please list names and dates of birth of all children that are patients at Weiss Pediatric Care:

_____________________________ **DOB**_________ _____________________________ **DOB**_________

_____________________________ **DOB**_________ _____________________________ **DOB**_________

Responsible Party's Name: ____ **Relationship:** _____________________

Responsible Party' Signature: ____ **Date:**___________________________

WEISS PEDIATRIC CARE
No Show – Late Cancellation – Late Arrival
Policies & Fees

Our goal is to provide you and your child with convenient, accessible, high quality medical care. To do that it is important that you arrive on time for scheduled appointments or cancel appointments in advance.

WHAT IS A NO SHOW or LATE CANCELLATION?
Any scheduled appointment for which a patient…
- **does not show for an appointment.**
- **calls to cancel after the appointment time.**
- **cancels without required notice.**

NO-SHOW & LATE CANCELLATION POLICY….

- We require 24-hour notice to cancel well visits, asthma, and ADHD appointments.
- We require at least 2 hours' notice to cancel a sick appointment.
- If multiple children in a family miss appointments on the same day, they will not be scheduled on the same day for a year.
- After 3 missed appointments per family in a year, you may be asked to find another doctor.

WHAT ABOUT…. LATE ARRIVALS?
If you are more than 15 minutes late, we will do our best to reschedule your appointment for later in the day or offer you the first available appointment on a future day.

NO-SHOW/LATE CANCELLATION/LATE ARRIVAL FEES…

• Missed sick appointment	$30
• Missed well visit	$50
• Missed *new patient* well/asthma/ADHD appointment	$75
• Late arrival for appointment (more than 15 minutes after scheduled start)	"Missed" fee + reschedule appt

By signing below, I acknowledge that I have read and understand the No Show, Late Cancellation, Late Arrival policy and fees.

______________________________ ______________________
Parent (Patient over 18) Signature **Date**

____
Child's Name (Please Print)

07.22.2022

Weiss Pediatric Care

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Optional Credit Card on File Program

Weiss Pediatric Care offers an *optional* Credit Card on File Program for those who would like the convenience of having balances paid in full and up to date using a dedicated credit card. ***Here's how it works…***

When charges are applied to patient responsibility by your insurance company, you will receive an email from **Instamed**, the program that manages our automated credit card payments.

The email notifies you of the amount to be charged 10 days later. If you have any questions, you can call us before your card is charged.

The best part of the Credit Card on File Program is that it saves you the hassle of getting bills. Your account is always paid in full and up to date.

☐ **I do not wish to use a credit card on file for payments due.**

☐ **Please remove the card on file for our family. I no longer wish to use the credit card on file program.**

Please list names and dates of birth of all children that are patients at Weiss Pediatric Care:

________________________ DOB________ ________________________ DOB________
________________________ DOB________ ________________________ DOB________

COMPLETE THE AUTHORIZATION FORM TO TAKE ADVANTAGE OF THIS CONVENIENT SERVICE.

AUTHORIZATION FORM

☐ **I wish to use the credit card on file for payments due.**

☐ **I authorize Weiss Pediatric Care to charge the amount deemed patient responsibility by my insurance to the following credit card:**

First Name: ________________________ Last Name:________________________________
Card Holder Name: ____ Zip Code: ____________
Email Address: ____
Card Number: __________________________________ Expiration Date: ____________________

I understand that after my health plan has paid their part for my child's care, I will get an Explanation of Benefits (EOB) from my insurance company. The EOB will show the amount to be paid by me. I will receive an email 10 days before my card is charged. Once my card is charged, I will be emailed a receipt of payment.

Patient/Guarantor Signature: ________________________________ Date:____________
Patient/Guarantor Printed Name:____

Weiss Pediatric Care

Cell Phone Policy

Cell phones must be stored while in our exam rooms to avoid possible privacy violations.

If you need to take a call while in the exam room, please feel free to step outside. We will move on to the next patient and work your child back into the schedule as soon as you have returned.

With your help we can ensure that we are honoring all privacy standards.

Dr. Weiss & The Weiss Pediatric Care Team

By signing below, I acknowledge that I have received and agree to **Weiss Pediatric Care's Cell Phone Policy**.

____ _______________
Print Name of Patient — Date of Birth

____ _______________
Signature of Parent or Legal Guardian or Patient (over 18) — Date

____
Print Name of Parent/Legal Guardian or Patient (over 18)

NEW PATIENT MEDICAL HISTORY
Newborns to 6 Months

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: ______________________________ **Birth date:** ___/__/_____
Where was your child born? ______________________ **Is child adopted or fostered?** Y__ N__
Has your child *ever* previously been seen *in this practice*? Y__ N__

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	NO	YES	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal	Maternal	Paternal	Paternal
						Gr Mth	Gr Fth	Gr Mth	Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY	No	Yes	
Lives with both mother and father in same house			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			
Other issues:			

IF BABY WAS BORN AT SARASOTA MEMORIAL HOSPITAL YOU MAY SKIP THE NEWBORN HISTORY QUESTIONS AND PROCEED TO THE MOTHERS PRENATAL HISTORY			
Birth Weight:________lb_____oz Birth Length:________inches			
NEWBORN HISTORY – while in hospital	**No**	**Yes**	**If YES - explain**
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Did NOT get vitamin K and / or eye prophylaxis			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening labwork (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first bowel movement			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopping breathing)			
Needed head ultrasound			
Needed ophthalmologic (eye) exam			
Other issues:			
MOTHERS PRENATAL HISTORY	**No**	**Yes**	**If Yes - explain**
Was this an assisted conception (required help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before birth?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Other Issues:			

What else, if anything, would you like us to know regarding your baby's health?

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: ________________________________ **Relationship to patient:** ________________

Print Name: ________________________________ **Today's Date:** ______/________/________

NEW PATIENT MEDICAL HISTORY
6 Months & Older

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: ____ Birth date: ___/__/_____
Where was your child born? ___________________________________ Is child adopted or fostered? Y__ N__
Has your child *ever* previously been seen *in this practice*? Y__ N__

BIRTH HISTORY
Birth Weight: lbs. oz. Vaginal birth? C-section?
Was the baby: (circle one) Full term Early Late
If early, how many weeks gestation?
Did the baby have any problems right after birth?
Did mother have any problems with the pregnancy?

PATIENT ALLERGIES	**No**	**Yes**	If No - explain
This child does not have any known Drug Allergies			
If you answered No - Is your child allergic to:			
Penicillin (Amoxicillin, Augmentin)			
Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax)			
Sulpha (Septra/Bactrim)			
Zithromax/erythromycin			
Other Antibiotics or medications? Give name:			Reaction:
Peanuts or other nuts – Give name or Group:			Reaction:
Milk			
Eggs			
Seafood			
Other Foods – give name here:			Reaction:
Bees / Wasps			
Indoor Allergens (pets, molds, dust)			
Outdoor Allergens (trees, weeds, pollens)			
Latex			
Other Allergies:			Name:

PATIENT SOCIAL HISTORY	**No**	**Yes**	
Does patient live with both mother and father in same house?			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			

PATIENT - PAST MEDICAL HISTORY	No	Yes	If Yes – explain
Serious accidents or injuries			
Surgeries			
Hospitalizations			
Chicken Pox Disease			What age:
Frequent ear infections or sinus infections			
Frequent sore throats or tonsillitis			
Other infection illnesses			
Allergic rhinitis or other allergy			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Abdominal pain/reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other urologic problem			
Bed-wetting (after age 5)			
Eye conditions / wear corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems/ acne			
Anemia or bleeding problem			
Past blood transfusion			
Frequent headaches			
Convulsions, seizures, or past concussions?			
Mental health concerns			
Seizures, developmental delays, ADD/ADHD or other neurological disorders			
Orthopedic problems			
Diabetes			
Thyroid, diabetes or other endocrine problems			
If female, have menstrual periods started?			
If female, any problems with periods?			
Use of alcohol or drugs			
Emotional or mental health problems			
Other significant issues:			

Current Medications and Dosage: (include any over the counter, herbal, or supplements)

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Does your child see any specialists? If so, who and where?

____

____

Child's name: ____ **Birth date:** ___/___/_____

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	**NO**	**YES**	If **YES** - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Developmental Disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

Is there anything else regarding your child's health that you think we should know that has not already been asked?

____

____

I attest that all the medical history information is true and correct to the best of my knowledge:

________________________ ________________________ ____/____/____

Signature **Relationship to patient** **Date**

________________________ ________________________ ____/____/____

Print Name **Child's name** **Birth date**