3401 PGA Blvd, Suite 300
Palm Beach Gardens
FL 33410
561.627.0100

1025 Military Trail
Suite 109, Jupiter
FL 33458
561.741.0000

5458 Town Center Rd.
Suite 101, Boca Raton
FL, 33486
561.393.8555

Welcome,

Thank you for choosing Pediatric Partners for your child's care. Our physicians and staff appreciate the trust you have placed in us and look forward to developing a long and healthy relationship with you and your child(ren). Our goal is to provide exceptional care in a comfortable, welcoming and unique environment for children.

At Pediatric Partners, we know that when we treat a child, we treat a family as well. We believe that in every visit, phone call or procedure we partner with our families in the care of each child. Parent and patient education is always a priority in our dedication to promoting the health and well being of children and their families. Whether your visit to our office is due to an illness or to monitor growth and development, Pediatric Partners is ready to guide parents through the journey of raising children. Our team's goal is to *treat* your child well, *make* your child well and help your child *stay* well during their lifetime. We accomplish this by teaching children at a young age the importance of healthy habits.

All of our pediatricians are board-certified, with many years of experience. The providers and the rest of our staff that make up Pediatric Partners all share a common mission. They desire to make a difference in the lives of children and feel very fortunate to have the opportunity to do work they love.

For your convenience, we've included a patient registration form, a medical history form, HIPAA privacy form for you to complete before your child's appointment, along with information about our office procedures. We've also included a brochure about our practice and its philosophy and services and biographies on our providers.

We look forward to greeting your family and working together to achieve your child's optimal health. If you have any questions now – or after you've become a part of our practice, please do not hesitate to call me. My direct line is 561.745.4224 and my mobile number is 386.986.0452.

Pediatric Partners remains…….*with you, for your child…for years to come.*

Sincerely,

Laura Lipsey
Practice Administrator

Dear Patient:

Physicians have always protected the confidentiality of health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" (HIPAA) protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

This new regulation protects virtually all patients, regardless of where they live or where they receive their healthcare. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital or other healthcare provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as email) are protected by the privacy rule.

The Notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. Listed below is our contact information.

Privacy Officer
Pediatric Partners
1025 Military Trail, Jupiter, Florida 33458
Telephone: (561) 741-0000

NOTICE OF PRIVACY PRACTICES

Pediatric Partners of Palm Beach County, P.A.

Deirdre A Kiley, Practice Administrator 561.745.4224

September 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers,

health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have

agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment 2) to defend ourselves if you sue us or bring some other legal proceeding, 3) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 4) in response to health oversight activities concerning your psychotherapist, 5) to avert a serious and imminent threat to health or safety, or 6) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized

government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (800) 368-1019
FAX (404) 562-7881
TDD (800) 537-7697

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

PEDIATRIC PARTNERS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ or _____
Patient Name Parent or Guardian Name

am the parents of the following child:_____.

and have received a copy of Pediatric Partners' notice of Privacy Practices.

_____
Signature of Patient

_____ _____
Signature of Parent Date

3401 PGA Blvd, Suite 300
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FL 33410
561.627.0100

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FL 33458
561.741.0000

5458 Town Center Rd.
Suite 101, Boca Raton
FL, 33486
561.393.8555

PAYMENT POLICY & OFFICE PROCEDURES

Thank you for choosing Pediatric Partners and welcome to our practice. We want you to understand our patient payment and office policies in advance so any misunderstandings may be avoided. It is our intent to explain to you and to inform you of procedures, options, and fees associated with your child's care. If you have any questions, please call and speak to one of our billing specialists at 561.745.4230.

Our Payment Policy

Payment for services provided is due at the time of your office visit. We will not deny care to any patient due to uncertainty of insurance coverage, but please understand you are responsible for any non-covered services.

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
- Well child check-ups, camp and sports PE's, immunizations, as well as other routine services may not be covered by some insurance plans. It is the responsibility of the patient to verify coverage.
- You should receive a bill for any patient responsibility within 30 days or an explanation of Benefits (EOB) from your insurance carrier. If you do not please contact the billing office.
- You are responsible for all balances not paid by your insurance carrier.
- If you have a co-payment or deductible, payment is expected at time services are rendered.
- Any co-pays or deductibles that are not paid on the day of the visit will be subject to a $10 fee.
- We accept payment by cash, check, debit cards, Visa, MasterCard and American Express
- Evening, weekend and holiday appointments are billed at a higher rate.
- Patients with an outstanding balance over 60 days must make arrangements for payment prior to scheduling well child exams, consults and immunizations. If your child is ill, we will always care for her/him.

Insurance Billing

As a courtesy, Pediatric Partners will bill your insurance plan for you. However; if we do not receive payment within 60 days, it becomes your responsibility to pay your balance and recover that payment from your insurance. If you have not provided us with the correct and current insurance information at the time of service and payment by the insurance is refused because of untimely filing, then the payment becomes your responsibility.

- Self-Paying Patients- Payment in full is expected for all services rendered at the time of your office visit. Please inquire about *Sunshine Kids*, our program for uninsured children.
- Private or commercial insurance- If you provide a current insurance ID card with a plan we participate with, we will bill services to your primary insurance at no charge to you. Please call the business office for a current listing of insurance plans that we accept.
- Visitors- We are happy to care for children visiting from out of town but payment is expected in full at time of visit. We will provide you with appropriate forms for you to obtain reimbursement from your insurance carrier.
- HMO Plans- We will bill your insurance carrier if we are contracted as your child's in-network provider.
- Medicaid/Healthy Kids- We accept Medicaid, MediPass, Healthy Kids and some Medicaid HMOs. Please contact the billing office if you need assistance.

Sunshine Kids

Pediatric Partners believes that all children should have access to health care; therefore we have created an in-house plan for children in our practice without any medical insurance coverage. This does not include those patients who have a high deductible or insurance we do not accept. Please contact our receptionist or business office to see if your child qualifies. If payment is made at time of service, Pediatric Partners will reduce our fees by at least 25%.

Unpaid Accounts & Returned Checks

If your balance has not been paid after 90 days, your account will be referred to an outside collections agency. There will be a $50 fee for each account that goes to the agency. A $35.00 fee will be assessed for all returned checks.

Scheduling an Appointment
To schedule an appointment please call the office at 561.741.0000 for Palm Beach Gardens and Jupiter or 561.393.8555 for Boca Raton. Our call center is open Monday through Thursday between 8 a.m. and 7 p.m. and on Friday 8 a.m. and 5 p.m. Our office hours vary by location with early morning, evening and weekend appointments available.

Cancellations and No-Shows
Your appointment is your reservation for our complete attention and care. Please honor this commitment by making it your top priority. In the event you are unable to keep your appointment or are going to be late, please call the office as soon as possible. This courtesy allows us to provide considerate and timely services to all of our patients. If you cancel less than 24 hours in advance or are a no-show for your appointment, you will be charged $25 after two such occurrences.

Urgent Care & Kids Express
If you have an urgent problem, please call the office for instructions. In a true life threatening emergency, call 911 or go to the nearest emergency room. Early morning walk-in times are available during Kids Express, which is held at our Jupiter (7:30-8:30 a.m.) and Boca Raton (8:00-8:30 a.m.) offices Monday through Friday. All other same day visits for your sick child require a scheduled appointment.

Behavioral Health Consulting Services
Pediatric Partners offers an in house creative art therapist & psychotherapist for our families. This service is a tremendous support for our families and provides a complement to our physicians' care. The therapists specialize in age appropriate developmental evaluations, parenting concerns, behavioral and psychological issues, adolescent support, ADHD and other school related concerns. Individual and group sessions are offered. Please refer to the "Psychotherapy Appointment and Consent to Treatment" form for additional information. At this time we are unable to accept insurance assignment for these services.

Non-Covered Services
We are happy to provide Flu, travel vaccines and other routine vaccinations for our parents and other family members. Pediatric Partners has available for sale numerous items and equipment including battery operated Nebulizers and acne products and treatments. We cannot bill your insurance company for these courtesy services nor accept payments from them. Payment and supplies are non-refundable.

Referrals
Please allow seven working days to coordinate referrals to other providers. If your child is enrolled in a managed care plan, you must receive authorization for a referral before making an appointment with a specialist. We are unable to provide any retroactive referrals.

Refills & Prescriptions
Please allow three working days for the coordination of refills and prescriptions with your pharmacy. Always contact your pharmacist first when refilling a prescription. The pharmacy will contact us for authorization, if necessary. If you require a "stat-same day" refill for a written prescription, there will be a $10 fee.

Medical & School Forms
We will be glad to fill out any school, college, athletic or cap physical forms and/or immunization records at the time of your child's PE at no charge. Please make sure you bring the appropriate forms with you at the time of your visit; if other than a routine school PE or immunization form. Request for completion of any of the aforementioned forms or any other form requiring medical assessment (e.g., FMLA) not done at the time of exam will require five working days and a $10 fee. Same day form completions will be charged an additional $10 fee. Patients with outstanding balances greater than 30 days will not be able to receive their forms until balances are current.

Medical Records
A completed and signed record Release must be done before any records are released. Please allow five working days for records to be copied if being picked up and additional time if being mailed. If records are not being directly released to another physician's office, there will be a fee of $1.00 per page up to 25 pages and $.25 per page thereafter applied and must be paid prior to release of any records.

Your Privacy
Your medical records are strictly private. No information will be given to others without your written permission, except as required by law. Please see HIPAA notice for further details.

PEDIATRIC PARTNERS
CONSENT TO TREAT/AUTHORIZATIONS/ATTESTATIONS

_____ (Please initial)

1. I am the parent/guardian of _____ (Name of Patient). I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to medical care, treatment, and diagnostic tests that the pediatricians and nurse practitioners at Pediatric Partners believe are necessary for this child.

_____ (Please initial)

2. In my absence and in case of emergency, I give my permission to any provider at Pediatric Partners to treat my child.

_____ (Please initial)

3. I hereby assign all medical benefits including Medicaid, Private Insurance and other health plans to Pediatric Partners. I hereby authorize Pediatric Partners to apply for benefits on my behalf for covered services rendered or ordered and release any medical or other information necessary to process claims. I request that payment from my insurance company be made directly to Pediatric Partners.

_____ (Please initial)

4. I authorize Pediatric Partners to use e-prescribing (electronic prescribing) to transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and dispensed medication history. I understand that a complete and accurate medication list is essential to effective and safe medical care.

_____ (Please initial)

5. I have received a copy of Pediatric Partners' Financial and Office Policies.

_____ (Please initial)

6.I have received a copy of Pediatric Partners' Notice of Privacy Health Information Policy.

_____ (Please initial)

7. A copy of this authorization may be used in place of the original. The authorizations/attestations and consent to treat will remain in effect as long as my child (or myself) remains a patient at this practice oruntil I withdraw my consent

_____ (Please initial)

8. Although I recognize that information left on telephone voicemail/answering machines and sent via electronic mail (e-mail) may not be secure, I give Pediatric Partners permission to relay test results via one or both of these methods as indicated below:

☐ Telephone: _____ and/or

☐ E-mail: _____

_____ Signature of Patient

_____ Date

_____ Signature of Parent/Guardian

_____ Date

_____ Relationship to Patient

Thank you for choosing Pediatric Partners

1025 Military Trail, Suite 109
Jupiter, FL 33458
561-741-0000

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Palm Beach Gardens, FL 33410
561-741-0000

5458 Town Center Road, Suite 101
Med Plex Building
Boca Raton, FL 33486
561-741-0000

Patient Registration Date:

Patient's Full Legal Name: (Last, First, Middle)	Date of Birth:	Nickname:

Social Security #: __ __ __- __ __ __- __ __ __ __	Gender : *Please Circle* : Male Female		
Address:	City:	State:	Zip:
Telephone Home #:	Telephone Work#:	Cell #:	

Mother's Information	Father's Information	Guardian's Information
Name:	Name:	Name:
If different than above Address:	*If different than above* Address:	*If different than above* Address:
City:	City:	City:
State: Zip Code:	State: Zip Code:	State: Zip Code:
DOB:	DOB:	DOB:
Mother's Telephone Information: Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __	Father's Telephone Information: Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __	Guardian's Telephone Information: Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Preferred Email: _____ **Relationship to patient:** *Please Circle :* Mother Father Guardian Other : _____

Primary Language: *Please Circle :* English Spanish Other: _____

Child's Race: *Please Circle All That Apply:*	Child's Ethnicity: *Please Circle :*
White Black/African American Asian American Indian /Alaska Native Native Hawaiian /Other Pacific Islander *Decline to answer*	Are you Hispanic or Latino? Yes No *Decline to answer*

Guarantor Information

Name:	Relationship: *Please Circle:* Self Mother Father Guardian
Home address if different than above:	DOB: SS# : ___ ___ ___-___ ___-___ ___ ___ ___

Insurance Information

Insurance Name:	Policy Holder 's Name:
Policy Holder's DOB:	ID #:
Group #:	Policy Holder's SS#: ___ ___ ___-___ ___-___ ___ ___ ___
Relationship: *Please Circle:* Self Mother Father Guardian	

Thank you for choosing Pediatric Partners

Patient's Full Legal Name: (Last, First, Middle)

_____ DOB: _____

Patient Medical History **Today's Date:**

Current Status

Are your child's vaccines up to date? **Yes** **No**

Does your child have any significant allergies to: **Medication** Yes No **Food** Yes No **Environmental** Yes No

List allergies	Reaction	List allergies	Reaction
1)		3)	
2)		4)	

Does your child have any significant/major current health problems? Yes No **Please List Below:**

1)	4)
2)	5)
3)	6)

Do you have any concerns about your child's: **Development?** Yes No **Behavior?** Yes No **Social Skills?** Yes No **Schooling?** Yes N o

Birth History

Prematurity: **Yes** **No** **Weeks?** _____ **Birth Weight** _____**Lbs.** _____**Ounces** **Discharge Weight :** _____**Lbs.** _____**Ounces**

Problems during Pregnancy or Delivery?	**Yes** **No** **List:**	**Infant Feeding:**	**Breast** **Bottle** **Both**
Any use of alcohol, tobacco, drugs or medications during pregnancy	**Yes** **No** **List:**	**Newborn hearing screening passed?**	**Yes** **No**
Was the baby in the NICU?	**Yes** **No** **List:**	**Metabolic screening (heel stick) Done**	**Yes** **No**

Patient's Medical History

Check appropriate boxes	*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
ADHD			Cancer			Hearing Problems		
Allergies			Chickenpox Year: _____			Heart Disease/Murmur		
Anemia			Congenital Anomalies			Mental Health Issues		
Asthma (recurring wheezing)			Constipation			Mononucleosis		
Autism			Developmental Delay			Pneumonia		
Bedwetting			Diabetes			Seizures		
Bladder/Kidney Disease (UTI's)			Eye Problems			Skin Issues (eczema, acne)		
Blood Disease			Failure to Thrive			Sleep Issues		
Blood Pressure, High			G. I. Problems			Thyroid Disease		
Blood Transfusions			GERD (reflux)			Other Medical History:		
Broken Bones			Headaches/Migraines					

Patient's Hospitalization & Surgical History

Has your child even been hospitalized (overnight?) **Yes** **N o** **Has your child ever had surgery?** **Yes** **N o**

Reason	*Date*	*Reason*	*Date*
1.		3.	
2.		4.	

Thank you for choosing Pediatric Partner

Patient's Full Legal Name: (Last, First, Middle)

_____ DOB: _____

Family History

Today's Date:

Family Social History

Fill in and Check appropriate boxes:	Occupation	Employer	Daycare	Year in School	GED	HS Diploma	Trade/Vocational	Associate Degree	Bachelor's Degree	Post Graduate
Patient			Yes No							
Mother										
Father										
Guardian										

Home and Family Environment

Parental Marital Status:. *Circle* : Married Divorced Separated Single Widowed Other: _____

Household Members. *Circle all that apply:* **Mother Father Stepmother Stepfather Grandparents Guardian Siblings Others: _____**

Siblings	DOB (MM/YY)	Gender	Siblings	DOB(MM/YY)	Gender
1.		Male Female	**4.**		Male Female
2.		Male Female	**5.**		Male Female
3.		Male Female	**6.**		Male Female

Are there pets in the home?	Yes	No	**Does your pool have a fence?**	Yes	No
Is a seatbelt/carseat used consistently?	Yes	No	**Is there smoking in the home?**	Yes	No
Is sunscreen used consistently?	Yes	No	**Are there guns in the home?**	Yes	No

Family Medical History

Check the appropriate boxes:	Alive	Deceased	ADHD	Anemia	Asthma	Bleeding/ Clotting issues	Blood Pressure	Cancer	Deafness	Diabetes	GI Problems	Headaches	Heart Disease	High Cholesterol	Immune/ Infectious Diseases	Kidney Problems	Mental Health	Seizures	Thyroid Disease	**Other Medical History**
Mother	A	D																		
Father	A	D																		
Sister(s)	A	D																		
Brother(s)	A	D																		
Maternal Grandparent	A	D																		
Paternal Grandparent	A	D																		
Maternal Aunt/Uncle	A	D																		
Paternal/Aun/Uncle	A	D																		
Cousin(s)	A	D																		

Thank you for choosing Pediatric Partners