Kids' Medical Care
Diana McLaughlin, MD
10661 Airport-Pulling Road
Suite 9
Naples, FL 34109
239-591-8481
239-596-0212 (FAX)

Name: _____
MR#: _____
DOB: _____
Date: _____

PATIENT INFORMATION

PLEASE FILL IN ALL BOXES AND PROMPTS

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SS #: _____ Gender: M or F_____

Full Address, City, Zip Code: _____

Cell Phone #1: _____ Cell Phone #2: _____ Email Address: _____

Pursuant to Federal Law please provide the following information. You may refuse by answering "No."

Race:
White Native American Indian
Black Asian
Other_____

Ethnicity:
Hispanic
Non-Hispanic
Other: _____

Language:

Mother or Legal Guardian

Mother's Name: _____

SS#: _____ D.O.B. _____

Driver's License #: _____

Address: _____

Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Father or Legal Guardian

Father's Name: _____

SS#: _____ D.O.B. _____

Driver's License #: _____

Address: _____

Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Please provide the name of someone not living in your household that we may contact in the event of an emergency.

Name: _____ Relation: _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____
Address: _____

I certify that the above information is correct at this time. I will promptly notify Kids' Medical Care of any changes in the above information.

Date: _____ Relationship _____ Parent/Legal Guardian Print: _____

Sign: _____

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PATIENT INFORMED CONSENT

Consent for Treatment:

I hereby agree and consent to authorize Diana McLaughlin, M.D., P.A., D/B/A Kids' Medical Care, physicians and staff to provide medical evaluation, treatments and services which may include but not limited to lab work, immunizations, medications and health screenings. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Consent for Payment and Assignment of Benefits:

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in cash and VISA and MasterCard. However, Kids' Medical Care agrees to accept assignment of benefits for patients in participating insurance networks.

- I hereby authorize and direct payment to Diana McLaughlin, M.D., PA, D/B/A Kids' Medical Care for the surgical and/or medical benefits, if any otherwise payable to me under terms of insurance.
- I understand that I am responsible for any amount not covered by insurance including but not limited to Co-pays, Co-Insurance, Deductibles, and/or non-covered services.
- I hereby authorize Kids' Medical Care to furnish and/or release any information to insurance carriers concerning illnesses and treatments, acquired in the course of my examination and/or treatment, in order to process my insurance claim. This order will remain in effect until revoked by me in writing.
- I understand that Kids' Medical Care has the right to pursue legal action against myself, guarantor and/or the insurance in the recovery of all payments owed including but not limited to fees, charges administrative fees, pre-judgment interest, post-judgment interest, court costs and attorney's fees.
- I hereby authorize photocopies of this form to be as valid as the original.

Notice of Privacy Practice Receipt:

I acknowledge that I was provided with the Notice of Privacy Practices for Kids' Medical Care.

Print Parent's Or
Legal Guardian's Name: _____ **Date: _____**

Signature: _____ **Relationship: _____**

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OFFICE POLICIES

ALL OFFICE VISITS ARE BY APPOINTMENT ONLY.
ALL WALK-IN PATIENTS MAY BE SEEN AT KMC'S SOLE DISCRETION.
ALL CANCELLATIONS MUST HAVE AT LEAST ONE BUSINESS DAY'S NOTICE.
PLEASE BE ON NOTICE THAT SAME DAY CANCELLATIONS OR NO SHOWS ARE SUBJECT TO FEES AT THE DISCRETION OF THE OFFICE MANAGER IN ORDER TO RESCHEDULE OR MAKE A NEW APPOINTMENT.
CANCELLATIONS WITHIN 5 HOURS OF APPOINTMENT TIME IS A NO SHOW

ARRIVING MORE THAN 15 MINUTES LATE MAY RESULT IN NO SHOW APPT FEE.
PATIENTS WITH 3 MISSED APPTS MAY BE DISCHARGED FROM THE PRACTICE.

ALL PAYMENTS INCLUDING BALANCES, CO-PAYS AND DEDUCTIBLES ARE DUE PRIOR TO OFFICE VISIT.

PATIENTS MAY RECEIVE ONE DH 3040 SCHOOL PHYSICAL FORM ANNUALLY.

ADDITIONAL DH 3040 SCHOOL PHYSICAL FORMS = $10.00 FEE EACH
ALL OTHER FORMS (except DH 680) = $10.00 FEE EACH AND UP
ALL LETTERS = $40.00 FEE AND UP
PATIENT REQUESTS FOR MAILING WILL INCUR A $1.00 FEE and up.

NO PATIENT INFORMATION WILL BE FAXED WITHOUT PROPER WRITTEN CONSENT.

REQUESTS FOR RX REFILLS; IMMUNIZATION FORMS; SCHOOL PHYSICAL FORMS; OR SCHOOL EXCUSES WILL REQUIRE A MINIMUM OF 24 HOURS NOTICE.

ANY PATIENT WHO DEFACES OR DISRUPTS THE OFFICE WILL BE DISMISSED.

THE OFFICE MAY BE UNDER VIDEO AND AUDIO SURVEILLANCE.

I certify that I have received notice of the above information. I agree to abide by the above policies. Kids' Medical Care policies are subject to change without notice.

Print Parent's or
Legal Guardian's Name: _____ Date: _____

Signature: _____ Relationship: _____

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CONSENT TO RECEIVE TEXT AND EMAIL COMMUNICATION

Kids' Medical Care wishes to provide the best quality service. We now have the ability to text and you for various healthcare related communications. We will **ONLY** text any health information on your child with express written consent. We will **not** receive any texts concerning any medical questions. You have a duty to notify the office if your phone number or email has changed. We will only send communications to the latest phone number we have on file. We may use text for:

- appointment reminders;
- annual physical reminders;
- immunization reminders;
- important general healthcare information;
- feedback on your experience;
- and to contact you to call us.

Please initial your consent:

Yes ___ No ___ I consent to receive text messages on any cell phone provided.

Yes ___ No ___ I understand that I may rescind this consent in writing only.

Yes ___ No ____ I understand that I may **not** communicate any information or medical questions using text or Emails. Any medical questions must be communicated by ***phone only***.

Yes ___ No ____ I understand that this service is provided at no cost but your wireless plan may charge for text messaging. Please contact your carrier for more information.

Cell Phone #1: _____ Cell Phone #2: _____

I certify that I have received notice of the above information. I agree to abide by the above policies. Kids' Medical Care policies are subject to change without notice.

Print Parent's or
Legal Guardian's Name: _____ Date: _____

Signature: _____ Relationship: _____

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IMPORTANCE OF HAVING A PRIMARY CARE PHYSICIAN

Having a Primary Care Physician (PCP) is beneficial for your child's health. Researchers found that PCPs provide better management of health issues and a higher level of satisfaction with their care.

Kids' Medical Care can help you choose a PCP. Your KMC PCP wants to become your partner to optimize your child's health care needs. Your KMC PCP will help coordinate your child's overall care including preventive care and acute care for illnesses. Over time, your PCP will get to know your child and be more adept at detecting health care issues sooner and more accurately.

KMC has a "health care team" that will assist in providing quality health care. KMC PCP will ensure that other physicians and members of the team also know your medical history. All KMC PCPs are board-certified Pediatricians. KMC's health care team can provide care in both English and Spanish.

KMC makes an effort to accommodate preventative care appointment requests within a few days. KMC makes an effort to accommodate all acute care appointment requests within 24 hours. KMC seldom has a long wait time in the waiting room. KMC provides routine office hours as well as extended office hours. Therefore, there are many reasons to avail yourself of KMC for all your pediatric needs.

KMC PCP's and heath care team will be able to provide personalized care for your child. KMC discourages the use of alternative venues such as urgent cares or emergency rooms for your child's care. Your child's insurance likely requires annual physicals. Regularly visiting KMC PCPs helps you to look out for your child's health and well-being—not just for today—but also for your child's future.

I choose the following PCP:
Place a check mark below
_____ Diana McLaughlin, M.D.

Print Parent's or
Legal Guardian's Name: _____ Date: _____

Signature: _____ Relationship: _____

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PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

IF FOR ANY REASON YOU WANT TO GIVE PERMISSION FOR ANY OTHER PERSON WHO IS NOT THE PARENT OR LEGAL GUARDIAN (I.E. GRANDPARENTS OR OTHER FAMILY MEMBERS) TO BRING YOUR CHILD TO THEIR OFFICE VISIT, PLEASE INDICATE IT IN THE BELOW BOX.

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

AUTHORIZATION

- I have the legal right to preauthorize this facility to deliver medical treatment to my child.
- I request and authorize this facility and staff to deliver medical care to my child listed below.
- I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated.
- Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.
- This form should not be considered without the advice of a lawyer.
- I appoint the following persons as my proxy decision maker for consenting to urgent or non-urgent medical care for my child.

PLEASE DO NOT WRITE THE PATIENT'S PARENTS' NAME. THE BELOW LINES ARE TO GIVE PERMISSION FOR SOMEONE OTHER THAN THE PARENT IN THE CASE THE PARENT DOES NOT ATTEND THE OFFICE VISIT.

Name: _____
Address: _____
_____
Tel. #: _____
Relation: _____

Name: _____
Address: _____
_____
Tel. #: _____
Relation: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given.

_____

Identify any limitations on the time frame for which this authorization is given.

_____

If the limitations above are left blank, it is assume there are **NO** limitations.

Print Parent's or
Legal Guardian's Name: _____ Date: _____

Signature: _____ Relationship: _____

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Authorization for Disclosure of Protected Health Information
Patient Request for Access to Protected Health Information

I authorize Kids' Medical Care the use and disclosure of the health information listed below. I authorize Kids' Medical Care to share and receive the health information listed below:

*_____ Any and all medical records (including billing records, alcohol/chemical dependency, mental health information, genetic testing and HIV/AIDS, and sexual transmitted disease related information),

or

*_____ Only Specific Medical Records, including_____

***Reason for Disclosure:** ___ **Transferring** ___ **Moving Away** ___ **Litigation** ___ **Self** ___ **Other** _____

***Information Released From:**

_____
_____
_____
_____
_____

***Information Released To:**

_____
_____
_____
_____
_____

Authorization expiration date: _____ (If left blank, this authorization will expire one year from the signature date.)

I understand that I may inspect or request copies of any information disclosed by this authorization of request for disclosure within 30 days of the receipt of this request.
I understand that production of copies of medical records requires extensive use of resources and you may be charged a fee according to Florida Law.
I understand that Kids' Medical Care is required to maintain records for specified periods of time according to Florida Law. If your request exceeds the required time period the medical records may no longer be available.
I understand that my medical and or billing information could be re-disclosed and are no longer protected by federal health information privacy regulations if the recipient(s) on this form are not required by law to protect the privacy of the information.
I understand that Kids' Medical Care may have the right to deny access to medical information according to Florida Law.
I understand that all medical/ billing records containing information related to **ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH and HIV/AIDS/STD RELATED INFORMATION** will be released unless otherwise indicated above.
I understand that I may revoke this authorization by notifying Kids' Medical Care in writing with the understanding that previously disclosed information would not be subject to my revocation request.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.
I understand that I have a right to request a copy of this form upon signing.

***Signature of Patient:** _____ ***Date:** _____

<u>If parent or legal guardian, sign below and state your relationship to the patient. All legal representatives other than the parents must provide identification and a document of authority.</u>

***Print Name of Parent/Legal Guardian:** _____ ***Date:** _____
Address: _____
_____
Tel. #: _____

***Signature of Parent/ Legal Guardian:** _____ **Relationship:** _____

***MUST BE COMPLETELY FILLED OUT!!**