SOMA
MEDICAL CENTER, P.A.

PATIENT INFORMATION

Date: _____

Child's Name: _____ SEX: Male Female
(Last Name) (First Name) (M.I.)

Date of Birth ____/____/____ Age_____ Child's SSN#: _____
Month Day Year (To be used for immunization registry)

Address _____ City _____

State____ Zip Code_____ Home Phone #_____ Cell Phone # _____

Previous records may be obtained from _____ Phone # _____

Other siblings (names & ages) _____

Email address _____

How did you hear about us? ___Insurance ___School ___Relative ___Friend___Other_____
(Please specify)

Pharmacy Name_____ Phone # _____

Address_____ City_____

State____ Zip Code _____

INSURANCE INFORMATION *Does the patient have medical insurance?____Yes____No

If yes, Insurance Name_____ I.D. # _____

Policy Holder _____

In Case of Emergency (Not living with you)

Name_____ Relationship_____ Phone # _____

Name_____ Relationship_____ Phone # _____

PARENT INFORMATION

Mother's Name_____ Father's Name _____

SSN #_____ SSN #_____

Driver's License #_____ Driver's License #_____

Date of Birth_____ Date of Birth_____

Address_____ Address_____

City/State/Zip_____ City/State/Zip_____

Phone #_____ Phone #_____

Employer_____ Employer_____

Employer Phone #_____ Employer Phone #_____

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Patient_____ **DOB**_____ **Today's Date**_____

PATIENT'S PERTINENT MEDICAL HISTORY (check all those that apply)

□ ADHD	□ Diabetes	□ Heart Murmur	□ Pneumonia
□ Allergies	□ Ear Infections	□ Hernia	□ RSV
□ Anemia	□ Eczema	□ Influenza	□ Speech Delay
□ Asthma	□ Epilepsy	□ Intestinal Parasites	□ Thyroid Disorder
□ Autism	□ Febrile Seizures	□ Kidney Problems	□ Tonsilar Hypertrophy
□ Bronchitis	□Fracture _____	□ Lacrimal Disorders	□ UTI
□ Cholesterol	□ GERD (reflux)	□ Otitis Media/Serous	□ Other _____

HOSPITALIZATIONS

Hospital	Dates	Reason(s)

MEDICATION HISTORY (list any current medications be taken by patient)

ALLERGIES

DRUG: □ Acetaminophen □ Ibuprofen □ Penicillin □ Macrolides □ Sulfas □ Other: _____

FOOD: □ Eggs □ Chocolate □ Milk □ Shellfish □ Strawberries □ Other: _____

ENVIRONMENT: □ Animal Dander □ Dust □ Grasses □ Latex □ Pollen □ Other: _____

SOCIAL HISTORY

Smoker in the home: Yes / No	# of Adults in Household:	Patient lives with:
Pets in the home: Yes / No	# of Children in Household:	Patient Attends: □Daycare □School □Babysitter □Stays home

SURGICAL HISTORY

Date	Reason

OTHER PERTINENT PATIENT HISTORY

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Patient._____**DOB**_____**Today's Date**_____

FAMILY HISTORY

Anemia :	□ Yes □ No	**Heart Disease/Stroke**	□ Yes □ No	**Asthma:**	□ Yes □ No
Disabled:	□ Yes □ No	**Emotional Disease**	□ Yes □ No	**Social Problems:**	□ Yes □ No
Cancer:	□ Yes □ No	**Seizures:**	□ Yes □ No	**Tuberculosis:**	□ Yes □ No
Epilepsy:	□ Yes □ No	**Diabetes:**	□ Yes □ No	**Mental Retardation:**	□ Yes □ No
Lung Diseases:	□ Yes □ No	**Smoker:**	□ Yes □ No	**Bloody Dyscrasias:**	□ Yes □ No
Birth Defects:	□ Yes □ No	**Alcoholism:**	□ Yes □ No	**Kidney/Urinary Disease**	□ Yes □ No
Child Abuse Situation:	□ Yes □ No	**Drug Addiction:**	□ Yes □ No	**Allergies:**	□ Yes □ No

Other problems:_____**Type of Allergy:** _____

MOTHER'S PRENATAL HISTORY

High B/P:	□ Yes □ No	**Alcohol**	□ Yes □ No	**Rubella:**	□ Yes □ No
STD (specify_____):	□ Yes □ No	**OTC Drugs:**	□ Yes □ No	**Hubs Ag:**	□ Yes □ No
Tobacco:	□ Yes □ No	**Diabetes:**	□ Yes □ No	**Street Drugs:**	□ Yes □ No
X-ray:	□ Yes □ No	**Prescriptions:**_____		**Mother's Blood Type:** _____	

Any problems/complications during pregnancy:_____

Trimester /Date Prenatal care began:_____

DELIVERY AND NEONATAL PROBLEMS & CONDITIONS

□**Spontaneous Vaginal Delivery**	□ **Prolonged labor**	□ **Breech**	□ **PROM**
□ **Precipitous Delivery**	□ **Forceps**	□ **Caesarean Delivery**	□ **Tremor**
□ **Deformities**	□ **Injuries**	□ **Respiratory**	□ **Cardiac**
□ **Jaundice**	□ **Oxygen**	□ **Irritability**	□ **Feeding**
□ **Incubator____days**	**PKU done? □ Yes □ No**	**Apgar Score:** _____	**Birth Weight:**_____

Any delivery problems/complications?_____Length of stay in hospital? _____

Any significant illness including hospitalization, emergency room visits, specialist consults since birth? □ Yes □ No

If yes, please explain:_____

Any speech therapy, special education, physical therapy, use of Ritalin, seizure disorder, etc? o Yes o No

If yes, please explain:_____

Signature:_____Date:_____Relationship with patient:_____

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Consent for Purposes of Treatment, Privacy, Payment and Healthcare Operations

I,_____consent to the use of _____
PARENT/GUARDIAN NAME PATIENT'S NAME

protected health information by Soma Medical Center P.A #4, for the purposes of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Soma Medical Center P.A #4. I understand that diagnosis or treatment of me by Soma Medical Center P.A #4 may be conditioned upon my consent as evidence by my signature on this document.

I, understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Soma Medical Center P.A #4, is not required to agree to the restrictions that I may request. However, if Soma Medical Center P.A #4 agrees to the restrictions that I may request; the restriction is binding in Soma Medical Center P.A #4. I have the right to revoke this consent in writing at any time, except to the extent that Soma Medical Center P.A #4 or Soma Medical Center P.A #4 has taken action in reliance on this consent.

My, "protected health information" means health information, including my demographic information, collected from me and created by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis top believe the information may identify me.

I understand I have a right to review Soma Medical Center P.A #4' s NOTICE OF PRIVACY PRACTICES prior to signing this document. The Soma Medical Center P.A #4's Notice of privacy practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in performance of health care operations of the Soma Medical Center P.A #4. The notice of Privacy Practices for Soma Medical Center P.A #4 is also posted at front desk office. This Notice of Privacy Practices also describes my rights and the Soma Medical Center P.A #4, with respect to my protected health information.

Soma Medical Center P.A #4, reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Soma Medical Center P.A #4, and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Patient Name Patient DOB

_____ _____
Signature of Patient or Representative Description of Personal Representative

_____
Date

SOMA
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NO SHOW/MISSED APPOINTMENT POLICY

Soma Medical Center, PA #4 Florida Mango understands that sometimes patients need to cancel or reschedule appointments and that there are emergencies. If a patient is unable to keep an appointment, we ask patients to please call us as soon as possible (with at least a 24-hour notice). Appointments can be rescheduled by calling the following number: (561) 964-1181. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Soma Medical Center, PA #4 Florida Mango reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

To ensure each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder is sent via automated phone call, text and/or email several business days prior to the scheduled appointment and up to the day of the scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Thank you for the understanding and cooperation as we strive to best serve the needs of all of our patients.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please reschedule appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Soma Medical Center PA #4-Florida Mango's and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

3. After the first "No-Show/Missed" appointment, you will receive a phone call or letter advising that you have broken our "No-Show" policy. Soma Medical Center PA #4-Florida Mango's will assist you to reschedule this appointment if needed. You will be assessed a $25.00 No-Show fee. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

4. If you have multiple "No-Show/Missed" appointments within a 12-month period time, you will receive a warning letter for non-compliance. Dismissal from the practice will be considered.
   ***You will be notified by certified mail if the dismissal was approved.**

I have read and understand Soma Medical Center PA #4-Florida Mango's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Soma Medical Center PA #4-Florida Mango's appropriately if I have difficulty keeping my scheduled appointments.

Patient Name _____ Date of Birth _____ Date _____

Patient Signature or Parent/Guardian if minor _____ Relationship to Patient _____

Staff Signature _____ Date _____

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CONSENT BY PROXY

I (we) appoint _____
(Full Name) (Address)

who is my (our) child(ren)'s _____ as my (our) proxy decision maker
(specify nature of proxy's relationship to child(ren)

for consenting to nonurgent medical care for my (our) children listed below. I (we) 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.

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____

_____

_____

Identify any limitation on the time frame for which this consent by proxy is given. If none, state "none."

_____

_____

_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

_____
Parent or Legal Guardian

_____
Parent or legal Guardian

_____
Proxy Decision Maker

Parent's Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

_____
Parent or legal Guardian Signature

_____
Parent or legal Guardian Signature

_____
Driver's license Number of Proxy Decision Maker

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HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME)_____**(DOB)**_____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RECORDS MAILED FROM: _____

_____

_____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS MAILED TO:

Specific description of information to be released (must include date(s) of service):

_____

The information to be released will be used for the purpose described below:

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying **Soma Medical Center P.A #4.** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____	_____	_____
Signature of Individual	Date of Signature	Date of Birth or SS Number

- ***OR, if applicable-***

_____	_____	_____
Signature of Guardian	Date of Signature	Description of Guardian's Personal Representative's Authority to Act for the Individual

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Consent for Non-Face-to-face "Virtual" Visits

Patient Name:_____Date of Birth:_____

Social Security No.:_____Today's Date:_____Time:_____am /pm

I,_____hereby voluntarily consent to receive "virtual" care. Examples of the virtual services offered here are:

Virtual check-ins – You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment is needed.

E-visits – You may communicate with your treating provider through our patient portal or secure email.

Telehealth visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication – like FaceTime, Skype or WhatsApp – to conduct a visit while you are home.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at____.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider._____(initials)
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording._____(initials)
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation._____(initials)
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care._____(initials)
- I understand that standard deductible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment _____(initials)

This form has been explained to me and I fully understand this *Consent for* **Non-Face-to-face "Virtual" Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

_____ _____

Name Date