South Lake Pediatrics

Welcome to South Lake Pediatrics and thank you so much for giving us the opportunity to participate in your child's care. We are excited to be a part of the Clermont community. To better serve you, please read thoroughly and fill out our welcome packet.

We have 2 main providers: Dr. Adi Nallamshetty and Dr. Norma Guzman. Both are board certified and Dr. Guzman can see newborns and patients who are hospitalized at South Lake Hospital. More seriously ill children will be handled by the pediatric hospitalist service at Arnold Palmer, Florida Hospital and Nemours Children's Hospital. South Lake Pediatrics is affiliated with A Plus Pediatrics. The doctors and management from both locations collaborate and have access to your medical record.

We will be able to see your children from birth and up until their 21st birthday although we do not accept new patients over 18 years old. All patients are required to have an annual well visit and have all vaccines as recommended by the CDC and the American Academy of Pediatrics.

Office visits are by appointment only. In order to minimize waiting room time, it is difficult to accommodate walk- in visits to our schedule, however, we do want to emphasize that our goal is to provide you with the timeliest service possible. We will always try to schedule our urgently sick patients within the same or, at the latest, by the next business day. We do have evening hours until 6 pm to help those whose jobs may pose some scheduling challenges. We kindly ask you give us a 24-hour notice if you're not able to keep your appointment. Multiple No Shows will be subject to discharge. Our office hours are the following:

Monday – Thursday 8:00am - 6:00pm
Friday 8:00am - 5:00pm
Closed Saturday and Sunday (sick patients can be seen at A Plus Pediatrics on Saturday from 9am -1pm by appointment only, please call A Plus Pediatrics that morning to schedule 352-557-4965)

For telephone calls, our office policy is to answer all messages within the same business day. After hours phone calls that are of an urgent nature will be handled by a doctor from our office or a doctor from A Plus Pediatrics. For these urgent matters you can reach an on-call doctor at (352) 235-5132. For appointments, refills, billing matters or non-urgent medical questions please call during regular office hours. Please note that it is our office policy not to call in prescriptions for illnesses that the patient has not recently been seen for, such as antibiotics.

Stay up-to-date by following us on Facebook, visiting your child's patient portal account and our website at www.southlakepeds.com

Again, thank you for choosing South Lake Pediatrics.

South Lake Pediatrics

WELCOME Today's Date __ / __ / _____

Please Print

Patient Name: _____ Patient DOB: ____ / _____ / _____

Patients Preferred first name:_____ **M**ale _____ **F**emale _____

Patient social security number ____-___-____ Siblings who are also patients here _____

Address of Patient: _____

Race/Ethnicity _____ Language spoken at home _____

Mother/Legal Guardian:_____ Father/Legal Guardian_____

DOB ___ /___ /_____ SS#_____-____-_____ DOB___ /___ /_____ SS#_____/___/_____

Home Phone (_____)_____-_____ Home Phone (_____)_____-_____

Cell Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Work Phone (_____)_____-_____ Work Phone (_____)_____-_____

Email _____ Email _____

Which phone number and email would you like as your primary contact (email will be for the secure patient portal for you to access patient's health information)? _____

If parents are Divorced, who has legal custody? _____

Please give names and Relationship of anyone besides the above-named legal guardian who has permission to bring your child in for medical treatment (the below mentioned person(s) you authorize to have access to the patient medical records).

Name: _____Relationship: _____ Name: _____Relationship: _____

Name: _____Relationship: _____ Name: _____Relationship: _____

Is it okay to leave messages and lab results on your primary number? ☐ Yes ☐ No

Medical Insurance Information

Primary Insurance

Insurance Company Name_____ Insurance phone number_____

Name of POLICY HOLDER_____ Policy Holder's : SS#_____

Policy Holder's: DOB_____ **Policy #**_____**Group #**_____

Employer:_____

Secondary Insurance (if applicable)

Insurance Company Name_____ Insurance phone number_____

Name of POLICY HOLDER_____ Policy Holder's : SS#_____

Policy Holder's: DOB_____ **Policy #**_____**Group #**_____

Employer:_____

I confirm the above information is correct: _____

Parent Signature

South Lake Pediatrics

Patient History

Patient Name: _____ Nickname(if any): _____

Date of Birth ___/____/_____ Gender: ____Male _____Female Race/ethnicity _____

Please circle : Is patient adopted Yes/ No Allergies to Medication_____

Birth History

Name and Location of Delivery Hospital:_____ ____Was it a vaginal delivery? _____

Where there any problems during pregnancy/delivery (please state)? _____

Did the mother smoke/drink alcohol/ use drugs or medications during pregnancy? _____

Was the baby more than 2 weeks premature or late(if so how many weeks)? _____

What was baby's weight at birth?_____ Any problems during nursery stay? _____

Development

Did baby sit by 7 months? ____ Did baby walk by 14 months? ____ Did baby say 3 words by 15 months? _____

Any school/developmental/discipline problems?_____

Please check off if patient has any of the following problems:

__bedwetting __sleep problems __ speech problems __problems with friends/peers

Social History

Name and age of mother _____ Name and age of Father_____

Name/age and sex of all siblings_____

_____

Who lives with patient?_____

Please circle: Are parents married/ divorced/ separated Are there any smokers in the home? _____

Is patient on any medications (OTC or prescription) or supplements?_____ If "Yes"please list _____

_____

Are there any home/domestic problems?_____

South Lake Pediatrics

Medical/ Family History

Please check off whatever medical condition patient or family member has had (please state what relationship to patient example: sister, maternal grandmother etc...)

Wheezing/Asthma	__ patient	__ family _____
Eye/Vision problems	__patient	__family _____
Hearing Loss	__ patient	__ family _____
Frequent Ear infections	__ patient	__ family _____
Eczema/skin problems	__ patient	__ family _____
Allergies/ Hay Fever	__ patient	__ family _____
Anemia/Bleeding disorder	__ patient	__ family _____
Diabetes	__ patient	__ family _____
Seizures	__ patient	__ family _____
Kidney/Bladder problems	__ patient	__ family _____
High Blood Pressure	__ patient	__ family _____
ADD/ADHD	__ patient	__ family _____
Liver problems	__ patient	__ family _____
Mental/ Psychiatric Illness	__ patient	__ family _____
Alcohol/Drug Abuse	__ patient	__ family _____
Thyroid disease	__ patient	__ family _____
High Cholesterol	__ patient	__ family _____
Sudden/Unexplained Death	__ patient	__ family _____
Heart Disease	__ patient	__ family _____
genetic/inherited diseases	__ patient	__ family _____
cancer	__ patient	__ family _____
autism/aspergers	__ patient	__ family _____
Other_____	__ patient	__ family _____

Has your child ever been prescribed a nebulizer machine?_____

Has anyone in the family had a heart attack/heart disease under the age of 50(who)? _____

Has Patient ever been hospitalized (please give date and illness)?_____

Has Patient had any surgeries (please give date and type of surgery)?_____

Has the patient had any serious illness or accidents?_____

South Lake Pediatrics

Financial Policy

1) New patient welcome packets must be completed prior to your being seen by the doctor. Verification of information will be updated on a yearly basis for established patients. Please thoroughly read our financial policy.

2) Please provide us with a current insurance card. You must notify us of any changes to your insurance prior to being seen by the doctor. If we cannot verify your insurance benefits you will be required to pay at the time of service or we will need to reschedule your visit.

3) We are required by our insurance contracts to collect co-pay or deductible (if applicable) on the day of visit. Fees for tests and vaccines not covered under your insurance plan will also be collected on the day of service. Any shots that are in a series (i.e. Antibiotic or Allergy shots), may require a co-pay for each shot visit.

4) It is your responsibility to make sure you understand the terms and limitations of your insurance policy; and what tests, vaccines, or procedures they cover.

5) For new babies most insurance companies require that you add the baby to the policy within 30 days of his/her birth. Please call your insurance company to verify that the baby has been added to the policy prior to the visit to prevent any delays in medical care.

6) If your insurance carrier requires you to select a PCP, you must ensure that you have chosen us as your PCP prior to being seen. Please obtain a confirmation number when changing your PCP. If a claim is denied because you failed to select us as your PCP, you will be responsible for the claim.

7) Your insurance carrier is required to remit payment or provide a written response within (30) days of receipt of the claim. If a problem occurs with your claim, you will be asked to assist in resolving the issue.

8) If there are extenuating circumstances and you are unable to pay at the time of service, you may speak with the office manager and set up payment arrangements. All Balances are due in full 90 days from the date of service or will be subject to collections.

9) If for some reason your account becomes past due/delinquent, we will take the necessary steps to collect this debt. This may include referral to a collection agency or attorney; you will be expected to pay all collection and legal fees incurred. This may lead to discharge from the practice and you will be given 30 days' notice to establish medical care and during that time South Lake Pediatrics will only provide emergency care.

Print Name and Sign _____ / _____

Date _____

3155 Citrus Tower Blvd., Clermont, FL 34711 phone: 352-242-1500 fax: 352-242-0053

South Lake Pediatrics

Consent and Authorizations

Patient Name:_____ DOB_____ Today's Date_____

Parent/Legal Guardian Name_____ Signature_____

I the undersigned, hereby authorize South Lake Pediatrics to render medical care to my child (self if over age 18). I authorize payment of medical benefits directly to South Lake Pediatrics, A Plus Pediatrics and/or the attending physician for services rendered.

_____ Signature of Parent/Legal Guardian/Person responsible for account

I the undersigned, have received South Lake Pediatrics "**HIPAA** _Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I authorize use/disclosure of information to coordinate and /or manage my child's (my if over 18) healthcare and any related services. I authorize South Lake Pediatrics to call my home or mail to my home any items that assist in the practice of carrying out treatment, payment and healthcare operations. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that South Lake Pediatrics is not required to agree to these requested restrictions but if they do, the office is bound by this agreement.

_____Signature of Parent/Legal Guardian/Person responsible for account

I the undersigned have received South Lake Pediatrics "Financial Policy" and agree to abide by the terms set forth. It is my responsibility to provide South Lake Pediatrics with all necessary information to file insurance claims and to notify the office of any changes in coverage prior to any visits. I understand that my insurance policy is a contract between myself and my insurance company and that I am ultimately financially responsible for charges not covered by the policy. I understand it is my responsibility to know my insurance coverage and benefits including contracted laboratories/hospitals where my child may receive care . I understand that all co-pays, deductibles or patient percentages are due at the time of services rendered. I will assist in the collection of my insurance benefit should there be a delay in payment. In the event that my account becomes delinquent and must be turned over to a collection agency, I agree to pay any and all costs of collection including attorney fees.

_____Signature of Parent/Legal Guardian/Person responsible for account

South Lake Pediatrics

Notice of Privacy Policies

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you or your child (as a patient of South Lake Pediatrics) may be used and disclosed. We are dedicated to maintaining the privacy of your and/or your child's protected health information. At each visit to our office, an encounter form with all the necessary information that is used to diagnose and treat you/your child will be added to the patient's medical record. Also, a bill will be created that will be sent to your insurance company for reimbursement of services rendered. Phone calls are also added to your medical records.

We may disclose you/your child's Health Information in the Following Ways

1) For Treatment: including labs, prescriptions, consultations with other health care providers, communication with health professionals that contribute to your care, appointment reminders, review of other treatment options/alternatives, available health benefits/services, business associates (such as radiology, ER or labs who are also required to safeguard your information), evaluation and improvement of care and quality of care. We may release your information to family and friends whom you have indicated in writing as directly involved in your child's care.

2)For Payment: Eligibility status, insurance billing (includes disclosure of diagnosis, procedures and supplies used), other third parties documented as responsible for costs.

3)For Legally Authorized Entities: Public Health institutions, Health Oversight Agencies (investigations/audits), FDA, Organ procurement organizations, Law Enforcement agencies, legally approved and authorized research institutions, court orders lawsuits and subpoenas.

4)Other: Funeral directors, workers compensation, obtaining interpreters when necessary, education of health professionals.

South Lake Pediatrics is required by law to maintain your privacy and we will not use your protected health information, without your authorization, in ways not covered under this notice. We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. We will post a copy of your current notice in our office and you may request a copy of our most current Notice of Privacy Policies at any time.

We do request that you keep us updated to any change to your contact information to ensure delivery to the correct address, phone number and email.

You have the right to: 1) Inspect and receive a copy of your health records. 2)Amend your/your child's health records if you believe it is incorrect or incomplete (in keeping with HIPAA policy). 3) Obtain an accounting of disclosures of the health records. 4)Request a restriction or revocation of health information records.

Please make requests in writing to our Privacy Officer, if you have any questions the privacy officer may be contacted by calling our office at (352) 242-1500.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer and/or with the Office for Civil Rights/ US dept of Health and Human Services at:

200 Independence Ave, S.W.
Room 509f, HHH Building
Washington D.C. 20201

South Lake Pediatrics

Late Arrival Policy

Our doctors, medical assistants, and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy. If a patient is more than 15 minutes late for their appointment, you will be given the option to wait for the next appointment with the available provider or you may be rescheduled to another day. This is to ensure that the patients who arrive on time for their appointment do not wait longer than necessary. If you are late, we will try to accommodate you as best as possible, but we cannot compromise on the quality and timely care provided to our other patients.

Making and Keeping Appointments

When you make your appointment, please be sure to let our receptionist know the nature of your visit (ear pain, rash, complete physical, etc.). Also, please let us know at the time you schedule your appointment if you have multiple questions/concerns so we can allow enough time for your visit.

No Show Policy

Please kindly give us notice by 8 am to reschedule or cancel your appointment for the same day. Cancellations may be left on our voicemail overnight. **Multiple ''No Shows'' may result in termination** of physician-patient relationship; this will be determined by the doctor.

The doctors and staff at South Lake Pediatrics truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Patient(s) Name_____

Parent Signature_____ Date _____

South Lake Pediatrics

Authorization for Release of Patient Health Information

Date___/___/_____

Medical facility Information requested from:		Information to be sent/given to:	
Physician Name	_____	Name:	South Lake Pediatrics_____
Address	_____	Address:	3155 Citrus Tower Blvd.
	_____		Clermont, FL. 34711_
Phone No.	_____	Phone No:	(352)242-1500_____
Fax No.	_____	Fax No:	(352)242-0053_____

I _____ do hereby Authorize the release to South Lake Pediatrics of the following information from the medical records of:

Name_____ DOB_____

Information Requested: (Please note this authorization Expires 90 days after it is signed).

__**Complete Medical Records**
__Immunization record and any Pertinent Medical Record/ Problem list/ Growth Chart
__Hospital Records including labs and tests results
__Labs/ X-ray Reports
__Specialist Consultation
__Last visit and vaccination only
__Other/Please Specify _____

Parent Authorization

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as signed below. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection. **AS PART OF THE MEDICAL RECORDS CHECKED BELOW, THE FOLLOWING INFORMATIONWILL BE RELEASED ONLY BY MAIL OR PICK-UP UNLESS STRICKEN**: HIV/AIDS related information and/or records; sexually transmitted diseases; mental health information and/or records and drug/alcohol diagnosis, treatment or referral information.

*Initial by the following information you wish to be excluded from the records that are released.

____ Drug/ Alcohol abuse/treatment & Diagnosis
____ HIV/AIDS diagnosis/treatment/testing
____ Sexually transmitted disease/treatment
____ Mental illness or psychiatric diagnosis/treatment

My Rights

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view this process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Parent or Guardian Signature _____ Date: _____