DOLPHIN PEDIATRICS, LLC
9850 STIRLING ROAD, SUITE 103
COOPER CITY, FL 33024
TEL (954) 362-3200 - FAX (954) 362-3205

PATIENT INFORMATION

PLEASE WRITE **LEGIBLY** AND FILL THIS SECTION OUT **COMPLETELY**.

LAST NAME: _____ **FIRST NAME**: _____

MALE / FEMALE **BIRTHDATE**: _____**PHONE NUMBER**_____

SIBLINGS: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHARMACY: _____ PHARMACY PHONE NUMBER: _____

GESTATIONAL AGE: HOW LONG WAS THE PREGNANCY FOR THIS CHILD? _____ WEEKS

FOR ELECTRONIC MEDICAL RECORDS DEMOGRAPHICS

RACE: AMERICAN INDIAN OR ALASKA NATIVE ASIAN WHITE BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER HISPANIC OTHER REFUSE TO ANSWER

ETHNICITY: _____

***PLEASE* READ CAREFULLY**

GENERAL OFFICE POLICIES

MISSED APPOINTMENT POLICY---Unless there are extenuating circumstances, a 24-hour notice of cancellation is required for all scheduled appointments. Failure to give a 24-hour notice may result in a **$35.00 fee**. The missed appointment fee cannot be billed to the insurance. A patient may be asked to re-schedule their appointment if they are more than 15 minutes late for that appointment. A call to verify availability is appreciated.

INSURANCE: It is your responsibility to notify us of any changes in your insurance well before the time of your appointment. If you arrive for your appointment and there is a problem with your insurance coverage, our staff may or may not have the time to address it properly and we may ask you to pay for the visit privately or reschedule your appointment. It is also your responsibility to understand your insurance policy. If your insurance requires you to select a PCP, for example, and you are assigned to someone other than our doctors at the time of your visit, your insurance will not cover the visit until you contact your insurance to change your PCP and you will have to reschedule or pay for the visit privately.

CALLS: When you call our office, please be prepared. If you want to make an appointment, have your calendar out. If you need your doctor to sign forms for school, know which forms they are and what exactly that school is asking of you. If you call for directions, be able to describe where you're coming from. We have a service that directs your call to the area that can help you the fastest. Please respect the phone service and dial the appropriate number, so we can best serve everyone that calls our office.

***LABS / IMAGING RESULTS*:** We do our best to call you with results as soon as we receive them, if you do not hear from us after 5-7 days of your test, please call us to ensure we received them.

REFILLS: will be completed within 24-72 hours of receipt of the request. REFILLS ARE NOT CONSIDERED EMERGENCIES.

FMLA PAPERWORK: can take anywhere from 10-12 business days to be completed.

OFFICE HOURS: are from 8:00am- 5:00pm, Monday through Thursday and 8:00am -4pm on Friday. We close for Lunch from 12:30 to 1:45. We are closed for all major holidays.

PHONE MESSAGES: we will do our best to return phone calls in a timely manner. Phone messages will be returned within 24-48 hours in order of medical priority. **If you have an emergency please call 911 or go to the nearest emergency room.**

SCHOOL/CAMP LETTERS/FORMS: will be completed from 3-5 business days of receipt of request.

I M P O R T A N T : SINCE OUR PRACTICE FOLLOWS THE AMERICAN ACADEMY OF PEDIATRICS IMMUNIZATION SCHEDULE, WE CAN NOT SEE PATIENTS WHO WISH TO OPT OUT OR SPLIT VACCINES. BY SIGNING THIS FORM YOU ACKLOWEDGE AND ACCEPT OUR GENERAL OFFICE POLICIES.

_____ _____

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ **DATE**

REV 11/15/2019

DOLPHIN PEDIATRICS, LLC
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COOPER CITY, FL 33024
TEL (954) 362-3200 - FAX (954) 362-3205

PARENT/GUARDIAN INFORMATION

PLEASE WRITE **LEGIBLY** AND FILL THIS SECTION OUT **AS COMPLETELY AS YOU CAN**.

*PATIENT'S NAME*_____ *& DATE OF BIRTH*_____

	MOTHER/GUARDIAN 1	**FATHER/GUARDIAN 2**
NAME:		
DATE OF BIRTH:		
CEL #:		
E-MAIL:		
EMPLOYER:		
WORK #:		
LANGUAGES:		
MARITAL STATUS:		

If divorced, please let us know who has custody and who is responsible for the child's bills. We may ask for court papers to respect the State's decision about the child's well-being.

As long as we are able, we extend you the courtesy of calling the day before an appointment to confirm. Whose cell phone should we call? _____and do we have your permission to leave a voicemail? **Yes / No**
Who referred you to us? _____

If there is an emergency and **you or another parent/guardian cannot be reached**, is there anyone else you trust to **authorize emergency treatment** on your behalf?

NAME	**PHONE #**	**RELATIONSHIP TO CHILD**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you or another parent/guardian is unable to bring your child(ren) into the office for an appointment, is there anyone else you authorize to bring them in?

NAME	**RELATIONSHIP TO CHILD**
_____	_____
_____	_____

_____

SIGNATURE OF A PARENT/GUARDIAN **DATE**

CONSENT TO TREAT

I authorize the medical professionals at Dolphin Pediatrics LLC. to examine, treat, immunize, and give emergency care to my child(ren) at this facility.

_____

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ **DATE**

DOLPHIN PEDIATRICS, LLC
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FINANCIAL POLICY

Thank you for choosing Dolphin Pediatrics as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. COPAYMENTS ARE DUE PRIOR TO THE VISIT AND DEDUCTIBLES WILL BE COLLECTED THE SAME DAY AFTER THE VISIT. We accept: Cash, Check, Visa, MasterCard, Discover and American Express (Credit card payments must be over $10.00)

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance information. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. We are In Network with most major insurance carriers. However, it is the patient's responsibility to verify that we are participating providers of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurance, and deductibles must be paid at the time of service. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from us, your primary care physician if your insurance carrier requires it for your visits. Please allow 2-5 days for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $35.00 fee for missed appointments (no show). Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some, and/or perhaps all, of the services you receive may not be covered, or not considered reasonable or necessary by Medicaid or other insurers. You will be responsible for payment of these services, in full, at the time of visit.

RETURNED CHECKS: Any checks returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice), along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collecting agency fees, court cost, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

SCHOOL FORMS: There is a flat fee of $10.00 for each set of school and sports clearance forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patients Name: _____ Date: _____

_____

NAME AND SIGNATURE OF PARENT/GUARDIAN/GUARANTOR OR PATIENT IF 18+

DOLPHIN PEDIATRICS, LLC
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REQUEST TO RELEASE OR COPY MEDICAL RECORDS

PATIENT NAME(S):_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

ADDRESS: _____ PHONE: _____

_____

FOR RECORD RELEASE: By signing this authorization, I authorize the entity or physician listed below to use and/or disclose certain protected health information about me and/or my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released.

FOR COPIES: I understand and agree that I am financially responsible for the cost associated with my request. I understand that the charge for a fax request is $10.00. I understand that the charge for a paper copy is $10.00 + $0.15 per page.

THIS AUTHORIZATION PERMITS PHYSICIAN THAT HOLDS YOUR RECORDS NOW

NAME: _____
ADDRESS: _____
_____
TEL: _____
FAX: _____

TO DISCLOSE TO

NAME: **DOLPHIN PEDIATRICS LLC.**
ADDRESS: **9850 STIRLING RD SUITE 103**
COOPER CITY, FL 33024
TEL: (954)362-3200
FAX: (954)362-3205

The following information
- ☐ OFFICE NOTES for these dates: _____
- ☐ LAB/RADIOLOGY RECORDS for these dates: _____
- ☐ IMMUNIZATIONS AND GROWTH CHARTS
- ☐ ALL OF THE ABOVE
- ☐ OTHER _____

REASON FOR RECORD RELEASE OR COPY:

☐ Personal copy ☐ Over age 21 ☐ Referral for a specialist
☐ Moving ☐ Transferring to another practice ☐ Other: _____

This authorization shall not be valid for more than 12 months after date of signature. I understand that after the custodian of records discloses my health information, federal privacy laws may no longer protect it. I further understand that this authorization is voluntary and that I may refuse to sign it. My refusal will not affect my ability to obtain treatment or be eligible for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use of this information.

_____
PRINTED NAME OF PARENT/GUARDIAN or PATIENT IF 18+

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ **DATE**

DOLPHIN PEDIATRICS, LLC
9850 STIRLING ROAD, SUITE 103
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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA), **this notice describes how health information about your children may be used and disclosed**, and how you can get access to your individually identifiable health information (IIHI). Please review this notice carefully.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In running our pediatric practice, we will create records regarding you and your child(ren) and the services we provide to you. We are required by law to maintain the confidentiality of your IIHI and to provide you with this notice of our legal duties and the privacy practices concerning your IIHI.

The terms of this notice apply to all records containing your children's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. A copy of our current Notice is always available to you as a PDF on our website, dolphinpediatrics.com, and as a hard copy in our office. You may request a copy of our most current Notice at any time.

If you have questions about this notice, please contact our privacy officer, Jesus Troccoli, by calling our office at (954) 362-3200 or e-mailing him at information@dolphinpediatrics.com.

Use and Disclosure of a Patient's IIHI

1. Treatment. We may use your child's IIHI to treat your child. For example, we may ask your child to have laboratory tests (such as blood or urine tests), and we may use the results to reach a diagnosis. We might also use your child's IIHI in order to write a prescription for them. All of the permanent employees at Dolphin Pediatrics may use or disclose your child's IIHI to treat your child or assist other health care providers in their treatment. Additionally, we may disclose your child's IIHI to others who may assist in your child's care, such as your spouse or parents, as instructed by you. We may also use and disclose your child's IIHI to inform you of potential treatment options or alternatives. An example would be to refer you to a home healthcare agency.

2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your child's treatment. We may use and disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your child's IIHI to bill you directly for services and items. We may disclose your child's IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your child's IIHI to operate our business. As an example, our practice may use your child's IIHI for the state and regulatory agencies to evaluate the quality of care you received from us.

4. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. Examples are free formula or pharmaceutical supply houses to procure expensive drugs.

5. Release of Information to Family/Friends. Our practice may release your child's IIHI to a friend or family member who is involved in your child's care, or who assists in taking care of your child, as authorized by you. For example, a parent or guardian may authorize a babysitter or nanny to bring their child into the office for a sick visit. In this case, we may disclose your child's IIHI to the babysitter or nanny.

6. Organ and Tissue Donation. Our practice may release IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if your child is an organ donor.

7. Disclosures Required by Law. Our practice will use and disclose your child's IIHI when we are required to do so by federal, state, or local law.

(a). Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

1. Maintaining vital records, such as births and deaths
2. Reporting child abuse or neglect
3. Preventing or controlling disease, injury, or disability
4. Notifying a person regarding potential exposure to a communicable disease
5. Notifying a person regarding a potential risk for spreading or contracting a disease or condition
6. Reporting reactions to drugs or problems with products or devices
7. Notifying individuals if a product or device they may be using has been recalled

(b). Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Examples are: investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

(c). Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding and in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

(d). Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

1. Regarding a crime victim in certain situations, if we are unable to obtain your agreement
2. Concerning a death, we believe has resulted from criminal conduct
3. Regarding criminal conduct at our offices
4. In response to a warrant, summons, court order, subpoena or similar legal process
5. To identify/locate a suspect, material witness, fugitive or missing person

6. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator) deceased patients. Our practice may release IIHI to a medical examiner or coroner to
7. Identify a deceased individual or to identify the cause of death. If necessary, we may also release information for funeral directors to perform their jobs.

(e) Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to their health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your Rights Regarding Your Child(ren)'s IIHI

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to our Privacy Officer, Jesus Troccoli, specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Personal Representatives. A "personal representative" is a person legally authorized to make health care decisions on the patient's behalf, and such person has access to the respective medical records. In this case, as the parent or guardian of a minor, you are the personal representative, and we are required to treat your personal information the same way we would your child(ren's) IIHI. Under certain circumstances, such as divorce or a change in custody, we must defer to the State and other laws to determine who can act as the minor's personal representative(s). If the state or the law is silent concerning this matter, our doctors will use their professional judgment to provide or deny access to a minor's IIHI, always with the child's best interest in mind.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in our use or disclosure of your child's IIHI, you must make a request in writing to our Privacy Officer, Jesus Troccoli. Your request must describe in a clear and concise fashion: (1) the information you wish restricted, (2) whether you are requesting to limit our practice's use, disclosure or both; and (3) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit a signed to our Privacy Officer, Jesus Troccoli, to inspect and/or obtain a copy of your child's IIHI. Our practice will charge a fee for the costs of copying, mailing, and labor/supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer, Jesus Troccoli. You must provide us with a reason that supports your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete, (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for nontreatment, non-payment or non-operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your child's information to file your insurance claim. To obtain an accounting of disclosures, you must submit your request in writing Privacy Officer, Jesus Troccoli. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice will charge you for an additional list within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, call our office or contact Privacy Officer, Jesus Troccoli. A copy of this notice is also located on our web site at www.dolphinpediatrics.com.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services or the Illinois Attorney General. To file a complaint with our practice, contact Privacy Officer, Jesus Troccoli. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You may revoke any authorization you provide to us regarding the use and disclosure of your child's IIHI at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your child's healthcare. Again, if you have any questions regarding this notice or our health information privacy policies, please contact, Privacy Officer, Jesus Troccoli.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to make a copy of our Notice of Privacy Practices available to you. There's a PDF available on our website and hard copies in our office that you may ask for at any time that our office is open. Our privacy practices describe how we may use and/or disclose a patient's protected health information according to HIPAA (the Health Insurance Portability and Accountability Act of 1996).

I, _____ (PRINT NAME), acknowledge that I have received a Notice of Privacy Practices.

_____ _____

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ DATE

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our privacy practices from this patient, a parent, or a guardian, but it could not be obtained because:

- The patient/guardian refused to sign.
- Due to an emergency, it was not possible.
- We weren't able to communicate with the patient/guardian.
- other_____

_____ _____

SIGNATURE OF AN EMPLOYEE DATE

DOLPHIN PEDIATRICS, LLC
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Mission Statement

At Dolphin Pediatrics we believe in creating a partnership with parents to help them raise healthy children physically and emotionally, promote prevention and a healthy lifestyle based on scientific evidence. The physicians and staff strive to provide professional, compassionate, quality, up to date care while maintaining high ethical standards in a respectful and friendly environment. We enjoy caring for children from birth to young adults, we value the relationship with our families and aim to be accessible to them. We appreciate the trust that parents and grandparents place in us, and feel privileged to be part of their lives. Dolphin Pediatrics is committed to helping make a difference in the overall health and well-being of children and thus impact the global diverse community we live in.

About Vaccines…..

We live in a multicultural world where travel is accessible to all and there are people from all over the world around you, so we are not isolated. We recognize that there have always been, and always will be, questions about vaccinations but these mainly come from the fact that because vaccines have been so successful at eradicating disease, many parents don't have the experience of having a relative or loved one that has had polio, diphtheria, bacterial meningitis, whooping cough, tetanus, or even chicken pox and thus do not believe they exist. This can lead to many people thinking they do not need to vaccinate their kids. When parents choose not to vaccinate their child they are taking advantage of millions of others who do vaccinate their children. The immunity provided by the large population of vaccinated children decreases the likelihood that the un-vaccinated child will contract these diseases. This sort of "herd immunity" only works as long as the majority of children are vaccinated. If immunization rates decrease there is greater chance for our children to become ill from vaccine preventable diseases.

We want to make our parents aware of these facts not to scare or coerce, but to emphasize the importance of vaccinating all of our children. We recognize that the decision may be a very emotional one for some parents. We will do everything we can to convince the parents, who trust us with their child's health, that vaccinating according to the routine schedule is the right thing to do. We cannot provide everyone with a different vaccination schedule as there is no evidence that alternate vaccination schedules offer any advantage over the traditional AAP approved schedule and because our office, which is small in order to provide a closer relationship with your family, becomes chaotic with everyone getting vaccines at different times. So, without exception, our office does not offer alternative vaccination schedules.