Perez-Grossman, LLC
Pediatric and Adolescent Medicine
1235 SW 87 Avenue
Miami, FL 33174

Patient Name (Last name, First Name): ______________________________

Sex: __________ (M/F) DOB: ____________________ (mm/dd/yy)

Race: ☐ White ☐ Asian ☐ Black or African American ☐ Hispanic ☐ American Indian ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic or Latin American ☐ Non Hispanic or Latin American ☐ Other ☐ Declined

Home Address: ______________________________

City: ______________________________ State: __________________ Zip: ______________________

Child Resides With: ☐ Both Parents ☐ Mother ☐ Father ☐ Relative ☐ Other: __________________________

Mother's Name: ______________________________ Contact Phone Number (____) ____________

Father's Name: ______________________________ Contact Phone Number (____) ____________

Emergency Contact (other than parents): ______________________________

Relationship to Patient: ______________________________ Contact Phone Number (____) ____________

Pharmacy Name: ______________________________ Pharmacy Phone Number (____) ____________

Person(s) authorized to bring your child to medical appointments:

____

How did you hear about Dr. Lisa Perez-Grossman?

- ☐ Your insurance company
- ☐ A current patient of Dr. Perez-Grossman, if so: ______________________________
- ☐ Another physician, if so: ______________________________
- ☐ Internet / Social Media

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Insurance Company Name: ________________________________ Policy ID: _____________________________

Insured Name: ____ DOB: ____________________ (mm/dd/yy)

Insured Address: ____ City: _________ State: _______ Zip: _____

Insured Phone Number: (____) _____________________ Insured Social Security Number: _________________

Insured Relation to Patient: ________________________

Insured Occupation: ______________________________ Insured Employer: _____________________________

Guarantor **(person financially responsible for patient's account if different from above):**

Guarantor Name: ____ DOB: __________________ (mm/dd/yy)

Guarantor Address: ____ City: _________ State: _______ Zip: _____

Guarantor Phone Number: (____) _____________________

Guarantor Relationship to Patient: ____

PAST MEDICAL HISTORY

Has your child ever been hospitalized? **NO** **YES** **(please list)**	Has your child had any surgeries? **NO** **YES** **(please list)**
Does your child have any allergies? **NO** **YES** **(please list)**	Does your child have any chronic illnesses? **NO** **YES** **(please list)**

REVIEW OF SYSTEMS

Does your child have any of the following

Lung problems	**NONE**	**YES (please list)**
Heart problems	**NONE**	**YES (please list)**
Kidney/Urinary problems	**NONE**	**YES (please list)**
Bone / Muscle problems	**NONE**	**YES (please list)**
Gastro-intestinal problems	**NONE**	**YES (please list)**
Brain / Nervous System problems	**NONE**	**YES (please list)**
Genital Problems	**NONE**	**YES (please list)**
Skin Problems	**NONE**	**YES (please list)**
Eyes / Ears / Nose / Throat problems	**NONE**	**YES (please list)**
Developmental or Learning problems	**NONE**	**YES (please list)**
Behavioral / Psychiatric problems	**NONE**	**YES (please list)**

Does your child take any regular medications (over the counter or prescription): **NO** **YES (please list)**

COMMUNICATION NEEDS

Preferred Language, if other than English: Child______________________ Parent ______________________

Does your child have any special communication needs: **NO** **YES (please list)**

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ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICES, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

Patient Information Form – Financial Agreement

- You are responsible for co-pays, deductibles, non-covered services, co-insurance, and items considered "not medically necessary" by your insurance company.
- For unpaid claims over 45 days, it is your responsibility to follow up with our insurance company and the balance may be considered due and payable.
- It is your responsibility to notify our front desk of any insurance or address changes.
- You will be responsible for any charges that occur if changes to your current insurance are not communicated at time of services.

Patient Authorization and Consent

I, ______________________________________ (if minor, for _________________________________) hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services by Lisa Perez-Grossman, MD or her authorized designees, as they may in their professional judgment deem necessary to provide appropriate medical care.

I authorize Lisa Perez-Grossman, MD to submit claims to my insurance company for services rendered by medical providers.

I authorize release of any medical information necessary in order to process this assignment on the claim.

I authorize payment be made to Lisa Perez-Grossman, MD for services provided by her.

____ ______________________________
Patient Signature (or authorized representative) Date

____ _________________________________
Patient printed name (or authorized representative) Date

Relationship to Patient: ____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

Last Updated April 23, 2014

I, (name of patient) ____, acknowledge and agree that I have received a copy of Lisa Perez-Grossman, MD, PA Notice of Privacy Practices.

____ _____________________________

Patient Signature (or authorized representative) Date

____ _____________________________

Patient printed name (or authorized representative) Date

Relationship to Patient: ____

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION.

The Health Insurance Portability Act of 1996 (HIPAA) provides you the right to request that PEREZ-GROSSMAN, LLC communicate with you about your health information at an alternative address or phone number, or by an alternative means (for example, by email) that is more confidential for you. LPGMD must accommodate your request if it is reasonable. LPGMD may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, the Medical Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.

To request confidential communications, please complete the form below and send to:
Lisa Perez-Grossman, MD 1235 SW 87 Avenue, Miami, FL 33174

Patient Name: ______________________________ **Telepone Number: (____)** ____________________

Address: ______________________________ **City:** __________ **State:** ____________ **Zip:** ___________

Describe the alternative means of communication you are requesting:

____

____

I am requesting that LISA PEREZ-GROSSMAN, MD, communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me. I understand that the Medical Center will not accommodate unreasonable requests.

______________________________ ______________________________

SIGNATURE OF PATIENT (or authorized representative) **DATE**

EMAIL CONSENT FORM

LISA PEREZ-GROSSMAN, MD offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. LPGMD will use reasonable means to protect the security and confidentiality of email information sent and received. However, LPGMD cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between LPGMD and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that LPGMD may communicate with me regarding my protected health information by email.
My consented email address is: ____

______________________________ ______________________________

SIGNATURE OF PATIENT (or authorized representative) **DATE**

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **LISA PEREZ-GROSSMAN M.D., P.A.,** **"**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

CONCENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD y CONFIRMACIÓN DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de **LISA PEREZ-GROSSMAN M.D., P.A.,** y doy mi consentimiento para usar y compartir Informacion Personal De Salud como lo permitad y/o requiera la ley.

Patient's Name: X ____

Nombre del Paciente: (please print) (nombre en letra de molde por favor)

Patient's Signature: **X** ____ **Date:** ______________

Firma Del Paciente: (Patient or legal representative*)(Paciente o Representante Legal*) **Fecha:**

*May be requested to show proof of representative status *Puede pedirse prueba de la representación

E-Mail / Text Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by email / text regarding your Protected Health Information.

Perez-Grossman, LLC offers patients the opportunity to communicate by e-mail / text. Transmitting patient information by e-mail / text has a number of risks that patients should consider before granting consent to use e-mail/ text for these purposes. **LPGMDPA** will use reasonable means to protect the security and confidentiality of e-mail/ text information sent and received. However, **LPGMDPA** cannot guarantee the security and confidentiality of email/ text communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail/ text between **LPGMDPA** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

PROPÓSITO: Esta forma es usada como consentimiento de usted para comunicarnos vía e-mail/ texto en referencia a su Información de Salud Protegida .

Perez-Grossman, LLC ofrece a sus pacientes la oportunidad de comunicación vía e-mail/ texto. Trasmitir información vía e-mail/ texto tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **LPGMDPA** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía e-mail/ texto. De todas formas,**LPGMDPA** no podrá garantizarle proteger confidencial y seguro la comunicación vía e-mail/ texto y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía e-mail/ texto entre **LPGMDPA** y yo y consentimiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient's Acknowledgment and Agreement /Paciente Recibió y Acordó

Yo estoy de acuerdo y consiento que **LPGMDPA** se pueda comunicar en referencia a mi Información de Salud Protegida vía e-mail / texto.

I agree and consent that **LPGMDPA** may communicate with me regarding my protected health information by e-mail/ text.

My Consented E-Mail Address is: ____

Mi direccion de E-Mail consentida es

Text to : ____

Texto a:

Signature of Patient or Legal Representative X_________________________________ **Date Signed:** ______________

Firma Paciente o Representante Legal **Fecha Firmada**