pediatric center
OF EXCELLENCE

4425 Ponce de Leon Blvd., Suite 115
Coral Gables, FL 33146
Tel: 305-667-3152
Fax: 305-667-6702
Email: info@pediatricexcellence.com
pediatricexcellence.com

Dr. Liat Corcia, *Pediatric Endocrinologist*
Miami Pediatric Endocrinology, LLC

PATIENT INFORMATION:

Patient's Name: _____
Date of Birth: _____/_____/_____ Sex: ☐ Male / ☐ Female
Address: _____ Zip Code: _____
Home Phone: (_____) _____-_____ E-mail Address: _____
Preferred Phone: (_____)_____-_____
Preferred Language: (Spanish) or (English)
Referring Physician: _____
How did you hear about our Practice? _____

PARENT / LEGAL GUARDIAN INFORMATION:

Name: _____ Address:_____
Home Phone: (_____) _____ - _____ Work Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Relationship: _____

INSURANCE INFORMATION:

Plan Name: _____ *I.D. Number: _____
Group Number: _____ *Policy Holder: _____
Effective Date: _____ Policy Holder's Social Security Number: _____ - _____ -_____
*Policy Holder's Date of Birth: _____/_____/_____ Sex: ☐ Male / ☐ Female

SECONDARY INSURANCE INFORMATION:

Plan Name: _____ I.D. Number: _____
Group Number: _____Policy Holder: _____
Effective Date: _____ Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

***If your insurance requires a referral for you to see Dr. Liat Corcia, it is your responsibility to provide our office with the referral. If your insurance company denies payment (due to no referral) you, the patient, agree to pay the Pediatric Center of Excellence / Miami Pediatric Endocrinology in full for any charges incurred during your visit.**

Patient/Parent (if minor) Signature: _____ Date: _____

INSURANCE RELEASE INFORMATION:

I hereby authorize the office, Pediatric Center of Excellence / Miami Pediatric Endocrinology, to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Pediatric Center of Excellence. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Parent (if minor) Signature: _____ Date: _____

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Notice to All Patients

Your health plan has specific regulations you must follow in order for you to avoid liability from full payment on service rendered by our physicians.

Referrals: We participate with many health plans. It is your responsibility as a patient to provide us with an updated referral on the day of you scheduled appointment. Our office cannot be held responsible for obtaining referrals. If we do not have a referral on file on the date of your scheduled appointment, we will reschedule you for a later date. To avoid this problem, we suggest you contact your primary care physician in advance.

Payment Policy:
Please be prepared to present your insurance card and Identification card at every visit to ensure that our doctor actively participates with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to pay in full at the time of the visit. All insurance co-payments and deductibles must be paid the time of service. We accept cash, Visa, MasterCard, Discover, and personal checks.

Patients may receive and are responsible for bills for services sent to another facility such as laboratory or diagnostic center which may not be covered by your insurance. Patients will be responsible for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. Balances must be paid in 30 days. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan.

Non-Cancellation Policy: Please be courteous and call us if you cannot make your scheduled appointment 24 hours in advance. This allows us to see other patients who may be in need of our services.

Forms: There is a $20 fee to resubmit school forms.

Test Results: Pediatric Center of Excellence may require a follow-up visit to review and discuss any diagnostic testing or pathology results.

Finally, this is your information plan. Please familiarize yourself with every rule of the health plan you are enrolled in. Your insurance company will mail a summary of charges, payments, denials, or requests for your further information. Please review all insurance correspondence.

Please sign and return to the front desk after reading. If you have any questions, feel free to speak to one our office personnel.

I have read and understand the above information.

Patient Name: _____

Signature: _____ Date: _____

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COMMUNICATION AUTHORIZATION

Miami Pediatric Endocrinology / Pediatric Center of Excellence (Practice) would like to communicate with you in the ways you prefer. By signing below, you allow us to disclose your Protected Health Information (PH) as described on this form. PHI includes all information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

Patient Name: _____

Date of Birth: _____ **Today's Date**: _____

			Initials
1	**Telephone messages:** Telephone messages: We may leave messages on answering machines or with individuals answering the phone at numbers written in this section, including referral information, prescription refill reminders, appointment reminders, test results, and other information the Practice determines to be appropriate to leave on voicemail.	Phone numbers:	
2	**Email Communications:** We may send email messages to your listed email address including referral information, test results, and other information.	Email:	

PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN:

_____ Yes, my child may be treated when accompanied by:

Name	Relationship

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

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Notice of Privacy Acknowledgement

Miami Pediatric Endocrinology, LLC
Pediatric Center of Excellence

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name (print) Patient Date of Birth

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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MEDICAL RECORD RELEASE FORM

Telephone: 305-667-3152
Fax: 305-667-6702

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to **Miami Pediatric Endocrinology at the Pediatric Center of Excellence**:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films (X-ray, Ultrasound, CT, MRI, etc.)

_____ _____
Signature of Patient or Parent/Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type 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, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance of the consent

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New Patient Medical History Form

Please complete the following questionnaire prior to your appointment with the physician. This information is very important to us for your care so please answer all the sections as accurately as possible.

General Information

Patient Name: _____
Date of Birth: _____ Age: _____ Today's Date: _____
Name of Person Completing Form: _____ Relationship: _____

Why is the patient seeing us today? _____

_____

When did this problem start? _____

Any labs/x-rays for this problem? ☐ No ☐ Yes _____
Has your child been seen by an endocrinologist before? ☐ No ☐ Yes Doctor's Name: _____

Birth History:

Birth Weight: _____ Birth Length: _____
☐ Vaginal Delivery ☐ C-Section if yes, why: _____
☐ Full-Term ☐ Born early/late – how many weeks? _____

Any problems during pregnancy? ☐ No ☐ Yes Explain: _____

Any problems during delivery? ☐ No ☐ Yes Explain: _____

Did the child need help breathing at birth? ☐ No ☐ Yes

Did the child go to ICU following birth? ☐ No ☐ Yes Explain: _____

Medical History:

Hospitalizations or ER visits? ☐ No ☐ Yes List: _____

Surgeries? ☐ No ☐ Yes List: _____

Major/Chronic medical problems? ☐ No ☐ Yes Explain: _____

Developmental History:

Any developmental problems? ☐ No ☐ Yes Explain: _____

Diet History:

☐ Breast Milk ☐ Formula Special formula: _____

Diet/weight concerns: _____

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24-Hour Diet Recall:

Breakfast: _____

Snack (if any): _____

Lunch: _____

Snack (if any): _____

Dinner: _____

Snack (if any): _____

Number of cups per week:

Juice: _____ Soda: _____ Milk: _____

Sports Drink: _____ Sweetened Beverage: _____

Exercise History:

On average, how much physical activity does your child get per day? _____ minutes _____ days per week
Comments: _____

Social Information:

Grade in School: _____ School performance: _____
Parents Names: Ages:
Mother: _____ _____
Father: _____ _____
Number of siblings: _____ Ages: _____
Does child live with family? ☐ Yes ☐ No Explain: _____

Family History:

Mother's Height: _____ Weight: _____ Mother's age at first menstrual period: _____
Father's Height: _____ Weight: _____ Father's puberty early or late? ☐ Yes ☐ No

Check all that apply:

Condition	Mother	Father	Sibling	Relative
Diabetes				
Thyroid				
Heart Disease				
High Blood Pressure				
Cholesterol Problems				
Overweight/obesity				
Early/late puberty				
Short stature				
Blood disorders				
Cancer (type)				
Other				

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Review of Systems – please check if your child has a history of any of the following:

General:
☐ Excess / poor weight gain
☐ Recent weight loss
☐ Frequent fevers
☐ Fatigue (tiredness)
☐ Paleness

Endocrine:
☐ Heat or cold sensitivity
☐ Frequent nausea or vomiting
☐ Excessive sweating
☐ Nighttime sweats
☐ Diabetes / High blood sugar
☐ Low blood sugar
☐ Excessive thirst for _____
☐ Excessive hunger
☐ Urinating at night _____ times
☐ Salt craving
☐ Rapid / slow growth
☐ Maturing too quickly / slowly
☐ Breast changes _____

Eyes
☐ Glasses / contact lenses
☐ More trouble seeing than usual
☐ Eye pain
☐ Eye redness / Dry eyes
☐ Double vision

Ear / Nose / Throat:
☐ Ear problems _____
☐ Hearing loss
☐ Sinus trouble
☐ Snoring – regular / irregular rhythm
☐ Inability to smell
☐ Nosebleeds
☐ Trouble swallowing
☐ Unusual cry: _____

Respiratory:
☐ Wheezing
☐ Coughing
☐ Chest Pain
☐ Difficulty catching breathing
☐ Fast breathing

Heart / Blood Vessels
☐ Problems with heart
☐ High blood pressure
☐ Heart Murmur
☐ Blue spells
☐ Dizziness
☐ Swelling of hands/feet
☐ Palpitations

Digestive:
☐ Coughing / choking / gagging with eating
☐ Frequent vomiting
☐ Constipation
☐ Frequent heartburn / stomachache
☐ Frequent diarrhea / loose stools

Genitourinary:
☐ Frequent urination
☐ Pain/burning on urination
Girls:
First menstrual period: _____
Last menstrual period: _____
☐ Issues with menstruation: _____

Allergy / Immune System:
☐ Seasonal or chronic runny nose
☐ Watery eyes
☐ Nasal congestions
☐ Sneezing
☐ Frequent infections

Skin:
☐ Acne
☐ Infections
☐ Darkening and/or thickening of sin
☐ Hair changes / unusual hair growth
☐ Stretch marks
☐ Birthmarks: _____

Blood / Lymph:
☐ Anemia
☐ Easy bruising / bleeding
☐ Enlarged lymph nodes

Muscles / Bones / Joints:
☐ Muscle weakness
☐ Joint problems
☐ Limp
☐ Bone pain
☐ Fractures: _____

Neurologic
☐ Headaches
☐ Seizures
☐ Weakness
☐ Paralysis
☐ Tremors
☐ Speech problems

Psychiatric / Behavioral:
☐ Mood swings
☐ Nervousness
☐ Trouble sleeping
☐ Depressions
☐ Temper outbursts

Other: _____

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Medication Information:

List child's current medications in detail or attach list; if not applicable write N/A:

Name	Dose	How many times a day?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Any herbal/natural supplements including skin/hair products? ☐ No ☐ Yes List: _____

Any medication allergies? ☐ No ☐ Yes List: _____

Other allergies/intolerances: _____

Preferred Pharmacy:

Name: _____ Phone: _____

Address: _____

I acknowledge the above information is true to the best of my knowledge.

Patient Name (print): _____ DOB: _____

Parent / Guardian (print): _____

Signature: _____ Med. Asst.: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.