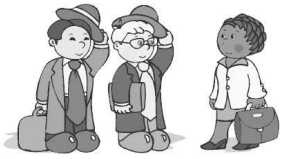


Silver Lake Pediatrics, P.A

33017 Professional Drive
Leesburg, FL 34788
(P) 352-314-2275
(F) 352-314-2279

Date of Birth_____**HOW DID YOU HEAR ABOUT OUR OFFICE?**_____

Last Name:_____ First Name_____M or F_____DOB_____SS#_____

Siblings (Name, DOB, M/F, SS#)_____

Siblings (Name, DOB, M/F, SS#)_____

Home Phone:_____ Work Phone:_____Cell_____Email_____

PREFERRED METHOD OF CONTACT __ Cell/text __Email or __ BOTH

Address:_____City:_____State:_____ Zip:_____

Father's Name_____SS#_____DOB:_____Occupation_____

Mother's Name_____SS#_____DOB:_____Occupation_____

Child resides with ?_____

Pharmacy/Location_____ Pharmacy's Phone#_____

Primary Insurance:_____ HMO / PPO/ Standard
Circle One

Primary Insured's Name:_____ Relation to Patient:_____

Member's Social Security#:_____ Member's D.O.B._____

Insurance ID#:_____ Group #:_____

Mailing Address:_____City:_____State:_____Zip:_____

Employer:_____ Work Phone/ext:_____

I hereby give authorization to Silver Lake Pediatrics, P.A., to provide medical care for the above-mentioned patient.

Insurance Assignment & Release Form: I hereby assign to Silver Lake Pediatrics, P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Silver Lake Pediatrics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Silver Lake Pediatrics, I agree to forward to the practice all health insurance or other third party payments that I receive for services rendered to me immediately upon receipt I recognize that I am financially responsible for all services rendered to the above-name patient regardless of insurance coverage. By signing this form, I agree to assign all health insurance benefits to Silver Lake Pediatrics and to be financially responsible for any co-payments, deductibles, and non-covered fees.

Office Policy: I realize all fees are due at the time services are rendered. I know that there is a $25 charge on all returned checks and a $25 charge for confirmed sick appointments and a $50.00 charge for physicals, consultations or extended visits cancelled without 24 hours prior notice or failure to show up for a scheduled appointment. **I understand Silver Lake Pediatrics, P.A. will file claims to the insurance company as a courtesy, and that I am responsible for any services the insurance company does not cover. Additional charges may apply for same day emergent visits.**

Acknowledgement of Receipt of Privacy Notice: I have been presented with a copy of Silver Lake Pediatrics, P.A. **NOTICE OF PRIVACY POLICIES,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions(s) if any concerning the use of my personal medical information:

_____

Signature:_____**Print Name:**_____ Date:_____
(Parent, Guardian, or Legal Representative of Patient) CIRCLE ONE PLEASE

Silver Lakes Pediatrics, P.A.
Rafael A. Cheas, M.D., F.A.A.P.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. As part of this commitment, we provide several services as a courtesy to you, the patient, as outlined below:

If you have:	**You are responsible for:**	**Our staff will, as a courtesy to you:**
An HMO with which we are contracted	Payment of co- pays and deductibles at the time of service.	File an insurance claim on your behalf.
An HMO with which we are not contracted	**Payment in full is due at the time of service.**	
Point of Service (POS), PPO Plan, or Indemnity (commercial plans) with which we are contracted	Payment of the patient responsibility is due at the time of service.	File an insurance claim on your behalf.
Commercial Plans, PPO Plans, POS plans or any other type of plan with which we are **not** contracted such as:	Payment of the patient responsibility is due at the time of service based on out of network benefits. Many insurance companies base their payment on "usual and customary charges." The patient is responsible for any amount above "usual and customary."	File an insurance claim on your behalf.
Medicaid	Payment of the patient responsibility is due at the time of service.	File an insurance claim on your behalf.
No Insurance	**Payment in full is due at the time of service.**	

As a courtesy, we will attempt to call your insurance company ahead of time to determine eligibility, deductibles, coinsurance, and obtain approval. This does not guarantee reimbursement. As the parent/guardian, you remain fully responsible for the entire amount of the bill.

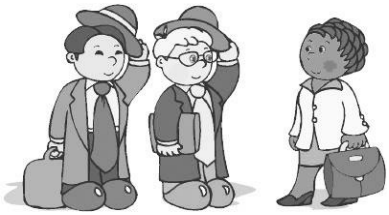
Divorce
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I understand that failure to pay my account may result in my account being forwarded to a collection agency as well as restrictions to scheduling appointments.

I authorize my insurance benefits to be paid directly the provider. I also authorize the provider to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
PATIENT NAME

_____ _____ _____
PARENT/GUARDIAN SIGNATURE PRINTED NAME DATE



Release Form for individuals involved in the care of the patient

I, _____, give Silver Lake Pediatrics, P.A.**,** permission to speak with the following individuals regarding my child(ren) health status, including diagnosis, treatment options/plans and payment for health services my child(ren) receive from Silver Lake Pediatrics, P.A.

This consent is valid until such time as I provide Silver Lake Pediatrics, P.A. written revocation of it.

Silver Lake Pediatrics, P.A. may speak with:

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Parent/Guardian Signature:_____ Date:_____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Silver Lake Pediatrics, P.A.** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records. **IF THE PATIENT DOES NOT WISH TO HAVE ANY OF THE FOLLOWING INFORMATION RELEASED, PLEASE INDICATE BY INITIALING THE APPROPRIATE SPACES BELOW:**

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is:

_____.

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already acted in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time _____ AM/PM

_____
Signature of Patient (or Authorized Representative*)

_____
Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

_____

_____

_____

VACCINATION POLICY

After careful thought and consideration, and in response to the recommendations of both The American Academy of Pediatrics (AAP) and The Centers for Disease Control (CDC), Silver Lake Pediatrics, P.A. **requires all new patients of the practice to immunize their children following the recommended CDC schedule**. Not only does this protect your child from preventable illnesses but lessens the risk to newborn infants and other children in our waiting room.

Established patients who have selected one of our three schedules previously offered, this will not affect your child. Vaccines will be administered as indicated on your selection.

Established families with Newborns will now be required to follow the AAP/CDC schedule.

Established or patients transferring into our office that are unimmunized or under immunized we will follow the **CDC CATCH UP SCHEDULE** to begin the process of appropriately vaccinating your child.

We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that childhood vaccines are critical to maintaining healthy children and communities. As medical professionals, we feel that vaccinating children following the recommended schedule with currently available vaccines is the absolute best choice for all children and young adults.

- We firmly believe in the effectiveness of vaccines too prevent serious illness and save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all the recommended vaccines according to the AAP/CDC.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines are not associated with autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can provide as parents/caregivers for your child's well-being.

In Summary:

- We adhere to the American Academy of Pediatrics (AAP) and the Center for Disease Control (CDC) Immunization Guidelines.
- Because we are committed to protecting the health of your children, we require all our patients to be vaccinated.
- Effective Jan. 1, 2019 we will not allow any "alternative schedules". **For any established family who refuses to adhere to the CDC/AAP recommended vaccine schedules must sign a refusal to vaccinate and your family may be discharged from our practice.**
- **Please visit: https://www.cdc.gov/vaccines or https://www.aap.org for any additional questions you may have regarding any vaccines.**

For parents who are choosing not to vaccinate we urge you to reconsider.

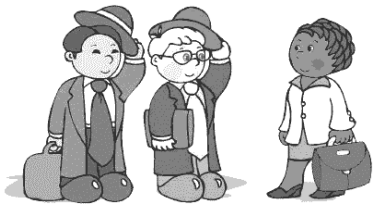
I acknowledge that I have read this document in its entirety and fully understand it.

Child's name_____**DOB**_____

Parent/Guardian Signature_____**Date**_____

Witness_____**Date**_____

1/19



Silver Lake Pediatrics, P.A.

33017 Professional Drive, Leesburg, FL
Phone: (352)314-2275 Fax: (352) 314-2279

Request for Protected Health Information/Medical Records

This is an authorization to:
Release clinical/medical information to another healthcare provider/facility for treatment purposes.

Patient Name: _____ DOB: ____/____/____
Address: _____
Phone: (____)_____-_____ Insurance:_____ ID #: _____

I _____, hereby authorize information to be released from:
(Please print name)
Practice Name: _____
Address: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____

FAXED
/ /

Send information to:

33017 Professional Drive
Leesburg, FL 34788 or Fax : (352) 314-2279

The type of information to be released is as follows: (check the appropriate boxes)

- ☐ Last Well Child Exam
- ☐ Last Encounter/Sick
- ☐ Immunization Record
- ☐ Newborn screening
- ☐ Labs
- ☐ Diagnostic Testing
- ☐ Problem List

Purpose of release:

- ☐ My personal Records
- ☐ Other: _____
- ☐ Use by another health care provider

This authorization for the release of medical records and information including diagnosis, treatment and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted disease.

As required by state and federal law, your healthcare provider may not use or disclose your health information except as provided by its Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed on this form without my further authorization, but that my healthcare provider cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the healthcare provider releasing the information. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend, in any way, on whether I sign this authorization. I understand that I have the right to inspect and to obtain a copy of any information disclosed.

I hereby release Silver Lake Pediatrics, P.A., and its employees from any/all liability that may arise from the release of information as I have directed.

I hereby authorize Silver Lake Pediatrics, P.A. to obtain the medical records described above.

_____ _____
Parent / Guardian / Patient (once 18 yrs of age) Signature Date

Relationship to Patient: _____

Initials _____
Date ___/___/____
Hx attached _____

NAME :_____ **DOB:** _____

Initials _____ Date ___/___/____

PAST MEDICAL HISTORY - (PATIENT ONLY)

***Any chronic, ongoing or recurrent medical conditions (i.e. ADHD, Behavioral Problems, Cerebral Palsy, Down Syndrome, Diabetes, etc.)**
_____
_____

- Full Term Pregnancy **NO YES IF NO HOW MANY WEEKS _____Planned Pregnancy?_____**
- Jaundice at Birth **NO/YES IF YES TREATMENT_____**
- Vision Problems: N/A NO YES - If YES, please explain: _____
- Natural Chickenpox: N/A NO YES - If YES, please give the Date: _____
- GER or Gastro Problems: N/A NO YES - - If YES, please explain: _____
- Surgeries: N/A NO YES - If YES, please explain: _____
- Hospitalizations: N/A NO YES - If YES, please explain: _____
- Problems with Ears or Hearing: N/A NO YES - If YES, please explain: _____
- Asthma, Bronchitis, Bronchiolitis, or Pneumonia: N/A NO YES - If YES, please explain: _____
- Heart Problems or Heart Murmur: N/A NO YES - If YES, please explain: _____
- Blood Transfusions: N/A NO YES - If YES, please explain: _____
- Constipation requiring Doctor Visits: N/A NO YES - If YES, please explain: _____
- Thyroid or Endocrine Problems: N/A NO YES - If YES, please explain: _____
- Use of Alcohol or Drugs: N/A NO YES - If YES, please explain: _____
- If Female have Menstrual Periods Started?: N/A NO YES - If YES, please give the Date: _____
- Any Problems with menstrual cycle? N/A NO YES - If YES, please explain: _____
- Chronic or Recurrent Skin Problems (Acne, Eczema, Etc.): N/A NO YES - If YES, please explain: _____
- Convulsions or Other Neurological Problems: N/A NO YES - If YES, please explain: _____
- Ringworm or Fungal Infections: N/A NO YES - If YES, please explain: _____
- Sore throats/Recurrent Strep: N/A NO YES - If YES, please explain: _____
- Serious Injuries or Accidents: N/A NO YES - If YES, please explain: _____
- Frequent Ear Infections: N/A NO YES - If YES, please explain: _____
- Frequent Headaches: N/A NO YES - If YES, please explain: _____
- Diabetes: N/A NO YES - If YES, please explain: _____
- Anemia or Bleeding Problems: N/A NO YES - If YES, please explain: _____
- Frequent Abdominal Pain: N/A NO YES - If YES, please explain: _____
- Bladder or Kidney Infections: N/A NO YES - If YES, please explain: _____
- Bed Wetting: (After age 5): N/A NO YES - If YES, please explain: _____

Nurse: Initials _____ Date ___/___/____

RSE SIDE >>>>>>>>>

SOCIAL HISTORY

*Lives with both parents: NO YES

If NO, then has visitation with other parent: NO YES
If NO, then who has custody of child:_____

*Parents Age (DAD): _____ Height: _____ Education Level: _____ Occupation: _____

*Parents Age (MOM): _____ Height: _____ Education Level: _____ Occupation: _____

*Siblings: NO YES
If YES, then how many_____

*Pets: NO YES
If YES, then what kind, how many, & inside or outside_____

*Frequent travel outside the United States: NO YES *Missionary Work: NO YES

*Does child live on a farm: NO YES

*Does the child participate in hunting activities: NO YES

*Smokers in the home: NO YES

FAMILY HISTORY
ONLY AS FAR BACK AS PATIENT'S GRANDPARENTS.
M=Mother, F=Father, S=Siblings, MGM=Maternal (Mother's) Grandmother, MGF=Maternal (Mother's) Grandfather, PGM=Paternal (Father's) Grandmother, PGF=Paternal (Father's) Grandfather, A=Aunt, U=Uncle, C=Cousin

*Deafness or Hearing Impaired :_____ *Kidney Disease: _____

*Nasal Allergies or Hay Fever: _____ * Bed Wetting (after age 10): _____

*Drug Allergies: _____*Epilepsy or Convulsions: _____

*Asthma/Chronic Bronchitis/COPD: _____ *Mental Illness/Retardation: _____

*Tuberculosis: _____ *Immune Problems, HIV, AIDS: _____

*Heart Disease: _____ *Cancer (What Kind): _____

*High Blood Pressure :_____*Sudden Death <30 yars old: _____

*High Cholesterol :_____*Blindness/Vision Problems: _____

*Anemia: _____ *Autism: _____

*Bleeding Disorders:_____ * Liver Disease: _____

*Alcohol Abuse:_____ *Drug Abuse: _____

*Endocrine: Diabetes, Thyroid, Pancreas, Parathyroid, others(please specify) :_____

*Gastrointestinal Problems: _____

Lactose, galactose, fructose, celiac disease (gluten): _____

ALLERGIES (PATIENT ONLY)

*Medication Allergies:_____

*Food Allergies :_____

*Insect Allergies (Bees, Wasps, Ants):_____

*Indoor/Outdoor Allergies: _____

If allergies what type of a reaction (Hives, facial swelling, etc..)_____