PALM BEACH PEDIATRIC HEMATOLOGY ONCOLOGY

12957 Palms West Drive, Building 9 • Suite 103 • Loxahatchee, FL 33470
Phone: 561-798-9119 • Fax: 561-798-9193 • msinger@pedshemonc.com

PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____Your Name/Relation to Patient: _____

Date of Birth: _____Sex: M ___ F ___ Race_____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( ) _____

Email: _____Caringbridge Web Address (if applicable): _____

School/Daycare: _____

Referred By: _____ Phone Number: _____

Pediatrician (PCP): _____Phone Number: _____

Pharmacy: _____ Location: _____Phone: ( ) _____

How did you hear about us? _____

Child's Other Physician(s) (besides Pediatrician): _____

Father's Name: _____ Date of Birth: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____Work Phone: ( )_____ Cell Phone: ( )_____

Employer: _____ Employer Address: _____

Social Security Number: _____ Marital Status: _____

Mother's Name: _____ Date of Birth: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____Work Phone: ( )_____ Cell Phone: ( )_____

Employer: _____ Employer Address: _____

Social Security Number: _____ Marital Status: _____

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INSURANCE INFORMATION

Primary Insured

Guarantor's Name: _____Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth:_____ Sex: M____F____

Social Security #:_____Employer:_____

Primary Insurance Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policy Type: ____HMO ____PPO _____PPC Other: _____ Co-Pay Amount: _____

If you belong to an HMO, do you also have other Group Insurance Coverage? _____ Yes _____ No

Secondary Insured

Guarantor's Name: _____Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____Date of Birth:_____ Sex: M____F____

Social Security #:_____Employer:_____

Primary Insurance Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policy Type: ____HMO ____PPO _____PPC Other: _____ Co-Pay Amount: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: ( )_____

Name: _____ Relationship: _____ Phone: ( )_____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.
I hereby grant permission to Palm Beach Pediatric Hematology Oncology to release any pertinent information to my insurance company upon request, and I authorize payment directly to Palm Beach Pediatric Hematology Oncology. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____ Witness: _____

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PATIENT HISTORY

Date: _____

CHILD'S NAME: _____
What is the reason for your visit? _____
_____

PRENATAL HISTORY

Was the child pre-term or full-term?_____ Vaginal/C-Section?_____Birth Weight_____Length_____
Did mother have any infectious illnesses during the pregnancy?_____
Did mother take any medications during pregnancy? _____
Were there any complications of the pregnancy (pre-eclampsia, excessive bleeding)? _____
_____
Were there any complications of the labor or delivery (fetal distress, forceps)? _____
_____
Did child have any medical problems after birth (bleeding, bruising, jaundice, anemia, low platelets) ?_____
_____
Did the infant stay in the hospital longer than the mother? _____If so, why? _____
_____
Hospital of Birth (Name, City, State)_____

PATIENT'S PAST ILLNESSES

Has the child been given a diagnosis previously? Yes____No_____Date:_____Explain:_____
_____
Have there been any hospitalizations? ___Yes ____No
Hospital/Date/Reasons: _____
Have there been any other major medical problems? ___Yes ____No
Medical Problems (if any):_____
Surgeries? Yes _____No _____Date(s):_____Surgery:_____
Any complications/excessive bleeding during surgery?_____
Any "childhood" illnesses (chickenpox, etc.)? ____Yes ____No Illness:_____
Fracture or other injury? ____Yes ____No Injury:_____
Bleeding or bruising?____Yes ____No Explain:_____
_____
Abnormal blood counts (white cells, hemoglobin, platelets)?____Yes ____No Explain:_____
_____
Other blood work abnormal?____Yes _____No Problem:_____
Immunizations up-to-date? _____Yes _____No Blood Type if known: _____
Please explain any of above:_____
Primary Language Spoken: English Spanish Creole Other
If your child is 18 years of age or older, do they have Advanced Directives? ___Yes____No

MEDICATIONS , VITAMINS

_____
_____
_____

ALLERGIES

_____
_____
_____

DIET

_____
_____

TRANSFUSIONS IN THE PAST

_____
_____

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FAMILY HISTORY

CHILD'S NAME: _____

Father (biological): _____ Age: _____
Medical problems: _____
Occupation: _____

Mother (biological): _____ Age: _____
Medical Problems: _____
Occupation: _____

Siblings (biological):

Name	Age	M/F	Full/Half	Medical Problem (if any)

MEDICAL CONDITIONS (in biological family)*:

Paternal Grandfather: _____

Paternal Grandmother: _____

Paternal Uncle(s): _____

Paternal Aunt(s): _____

Paternal Cousin(s): _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Maternal Uncle(s): _____

Maternal Aunt(s): _____

Maternal Cousin(s): _____

* Please include any blood diseases, bleeding problems (gum, nose, heavy menstrual periods), and cancers.

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PATIENT HISTORY cont'd

CHILD'S NAME: _____

Who lives at home? _____ _____
Who cares for child while parent(s) is/are at work? _____

SCHOOL PERFORMANCE

Preschool/Daycare/School?_____Grade_____
What are your child's average grades?_____
Have there been any concerns about learning or behavior issues?_____
_____

DEVELOPMENT

Does your child have any developmental problems? _____
_____

REVIEW OF SYSTEMS

Has she/he had frequent problems with (please mark yes/no and explain):

_____ Head: Headaches, dizziness, injury, other:_____
_____ Eyes: Vision problems, nystagmus, pain, other: _____
_____ Ears: Hearing problems, infections, pain, other: _____
_____ Nose: Frequent congestion, sinusitis, nosebleeds, other:_____
_____ Mouth: Gum bleeding, mouthsores, other:_____
_____ Throat: Frequent sore throat, trouble with swallowing, other:_____
_____ Neck: Stiffness, swollen lymph nodes, other:_____
_____ Lungs: Pneumonia, cough, asthma, other:_____
_____ Heart: Chest pain, shortness of breath, murmur, other:_____
_____ Abdomen: Vomiting, frequent pain, diarrhea, constipation, other:_____
_____ Genitourinary: Heavy periods, yeast infections, other:_____
_____ Skin: Rash, bruising, other:_____
_____ Neurologic: Development problems, seizures, other:_____
_____ Endocrine: Diabetes,thyroid problems, other:_____
_____ Limbs/Musculoskeletal: Joint pain/swelling, difficulty walking, other:_____
_____ Hematologic: Anemia, bleeding, other:_____
_____ Nutrition: Change in weight or diet: _____
_____ Pain: Sites of pain and description: _____
_____ Psychosocial: Depression, anxiety, other: _____

If yes to any of the above, please explain: _____
_____
_____

Are there specific problems you wish to discuss today? If so, please explain:_____
_____
_____

Do you have any specific concerns about your child? If so, please explain:_____
_____
_____

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PALM BEACH PEDIATRIC HEMATOLOGY ONCOLOGY

I (We) _____ authorize Melissa S. Singer, M.D., P.A. dba Palm Beach Pediatric Hematology Oncology and its personnel to deliver medical services to my child,

_____
CHILD'S NAME DATE OF BIRTH

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

_____ _____
Signature of Parent/Legal Guardian Date

_____
Printed Name of Parent/Legal Guardian

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Physician/Facility Name: _____

Address: _____

City: _____State: _____Zip: _____

Child's Name: _____ Date of Birth: _____
(Please Print)

I hereby authorize and request the complete Medical Record of the child listed above to be released to:

Palm Beach Pediatric Hematology Oncology
Melissa S. Singer, M.D., P.A.
12957 Palms West Drive, Suite 103
Loxahatchee, FL 33470-4989
(561) 798-9119 (office)
(561) 798-9193 (fax)

This consent for disclosure of medical information will be honored for the request only and will not be transferable for any additional information without the express written consent of the patient. It expires immediately upon completion of this action. I understand I may revoke this consent at any time except to the extent that the action has been taken in reliance on my consent. No other disclosure to other parties by release is permitted without the express written consent of the parent/legal guardian/patient. I have read and fully understand the above information and hereby give my permission

_____ _____
Signature of Parent / Legal Guardian Date

PBPHO
06/25/06
Revised 02/01/10

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Effective Date of this Notice: April 2003

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD (AS A OUR PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS O YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Melissa S. Singer, M.D., P.A. dba Palm Beach Pediatric Hematology Oncology is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to him/her. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child's IIHI
- Your child's privacy rights in their IIHI
- Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child'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 child's 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. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Office Manager at (561) 798-9119.

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

The following categories describe the different ways in which we may use and disclose your child's IIHI:

1. Treatment. Our practice may use your child's IIHI to treat your child. For example, we may disclose your child's IIHI as follows:

- To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.

- To write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for you.
- To treat or to assist others in the treatment of your child.
- To inform you of potential treatment options or alternatives or programs.
- To others who you have given permission to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- To other health care providers for purposes related to their treatment.

2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items provided by us for your child. For example, we may disclose your child's IIHI as follows:

- To contact your child's health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your child's insurer with details regarding your child's treatment to determine if the insurer will cover, or pay for, your child's treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- 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 examples of the ways in which we may use and disclose your child's information for our operations include, but are not limited to the following:

- To evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.
- To other health care providers and entities to assist in their health care operations under certain circumstances.
- To contact you and remind you of your child's appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- When we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

1. 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:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, 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.

3. 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. We also may disclose your child's IIHI 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.

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

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

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. 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 your child's 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.

8. Workers' Compensation. Our practice may release your child's IIHI for workers' compensation and similar programs.

9. Compliance. We are required to disclose your child's IIHI to the Secretary of the Department of Health and Human Services or his designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to section E.3. below.

E. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI

You have the following rights regarding the IIHI that we maintain about your child:

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 instance, you may ask us not to contact you work. In order to request a type of confidential communication, you must make a written request to the Office Manager, specifying the requested method of contact, 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. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or health care 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 child's care or the payment for 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 IIHI, you must make your request in writing to the Site Manager. Your request must describe in a clear and concise fashion:

- the information you wish restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- 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 your request in writing to the Office Manager in order to inspect and/or obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and 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 the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting 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 child's IIHI for non-treatment, 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. We also will not provide an accounting of disclosures made to you about your child, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Site Manager. 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 may charge you for additional lists 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, contact the Office Manager.

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. To file a complaint with our practice, contact our Office Privacy Officer, 12957 Palms West Drive, Suite 103, Loxahatchee, FL 33470. 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. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

Privacy Officer
Palm Beach Pediatric Hematology Oncology
12957 Palms West Drive, Suite 103, Loxahatchee, FL 33470

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of the Notice of Privacy Practices
Parent/Guardian Name (please print)

from Melissa S. Singer, M.D., P.A. dba Palm Beach Pediatric Hematology Oncology.

_____ _____
Parent/Legal Guardian Signature Date

_____
Printed Name of Parent/Legal Guardian