Palm Beach Pediatric Hematology Oncology

PATIENT HISTORY

Date: _____

CHILD'S NAME: _____

DATE OF BIRTH: _____

What is the reason for your visit: _____

PRENATAL HISTORY

☐Full term ☐Preterm/Weeks Gestation_____ ☐Vaginal ☐C Section Birth Weight: _____Length: _____

Did the child have any medical problems after birth (bleeding, bruising, Jaundice, anemia, low platelets)?

_____

_____

PATIENT'S PAST ILLNESSES

Has the child been given a diagnosis previously? Yes_____ No _____ Date: _ _____ Explain: _____

_____

Have there been any hospitalizations? _____

Medical problems: _____

Surgeries: Yes_____ No_____ Date: _____Surgery: _____

Abnormal blood work counts (white cells, hemoglobin, platelets, coagulation?) Yes_____ No_____

_____

Primary language spoken: English_____ Spanish_____ Creole_____

LIST DAILY MEDICATIONS AND DOSES

_____

_____

_____

Check if No Daily Medications ☐

LIST ALL DRUG ALLERGIES

_____

Check if No Drug Allergies ☐

FAMILY HISTORY

Father (biological): _____Age: _____

Medical problems: _____

Mother (biological): _____Age: _____

Medical Problems: _____

PLEASE LIST ANY HEMATOLOGIC (blood/cancer) DISORDER IN BLOOD RELATIVES:

_____

_____

REVIEW OF SYSTEMS/LIST RECENT COMPLAINTS: _____

_____

Do you have any specific concerns about your child or specific problems you wish to discuss today? If so, please explain: _____

_____

Pharmacy Name: _____ Pharmacy phone number: (_____)_____

Address: _____

Palm Beach Pediatric Hematology Oncology

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: _____

Pediatrician (PCP): _____Phone Number: ( ) _____

Pharmacy: _____ Location: _____Phone: ( ) _____-_____

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: ( ) _____

Mother's Name: _____ Date of Birth: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Insurance: _____ Policy Number: _____

Guarantor's Name: _____Date of Birth: _____Relation to Patient: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____ Witness: _____

I understand that payment for all medical care is due at the time of service. In the 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 photo static copy of this authorization shall be considered as effective and valid as the original.

Palm Beach Pediatric Hematology Oncology

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., PA
12957 Palms West Drive, Suite 103
Loxahatchee Fl, 33470-4989
561-798-9119 (office)
561-798-9193 (fax)

_____ _____

Signature of Parent / Legal Guardian **Date**

****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****

Palm Beach Pediatric Hematology Oncology

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: _____

Okay to leave a message on Voice mail (_____) _____-_____

☐ **don't Want Voice Mails For Results**

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name of Parent/Legal Guardian

Palm Beach Pediatric Hematology Oncology

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY
    a. I understand that I am financially responsible for my (child's) health insurance deductible, coinsurance or non-covered services. Payments must be made within 30 days of receipt of the billing statement. Failure to make payments may result in delay of my (child's) treatment or follow-up appointment.
    b. Co-payments are due at the time of service.
        1. If my (child's) health insurance requires a referral from the primary pediatrician, I must obtain it prior to the visit.
    c. In the event that my (child's) health insurance plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided within 30 days of the billing statement.
    d. If I (my child) is uninsured, I agree to pay for the medical services rendered to me at the time of the service.
    e. If I do not call to cancel my office appointment within 24 hrs prior to the appointment, I (my child) may be charged $25 for the no-show.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
    I hereby authorize and direct payment of my (child's) medical benefits to Palm Beach Pediatric Hematology Oncology on my (child's) behalf for any services furnished to me by the providers.

3. APPOINTMENT CANCELLATION PROCEDURE
    I agree to call 24 hours prior to my scheduled appointment to cancel an appointment for myself (my child).

_____ _____

Patient Name Patient DOB

_____ _____

Signature of Parent, Authorized Representative or Responsible Party Date

_____

Relationship to Patient

PALM BEACH PEDIATRIC HEMATOLOGY ONCOLOGY

Written Acknowledgements

Please initial each statement and sign below.

_____ **Receipt of notice of privacy practices:** I have received a copy of the Notice of Privacy Practices from Melissa S. Singer, M.D., P.A. dba Palm Beach Pediatric Hematology Oncology.

_____ **Email consent:** By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion. You also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. You agree to hold PBPHO harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

_____ **APRN:** Please acknowledge that you have been informed of the Advance Practice Registered Nurse and their role at **Palm Beach Pediatric Hematology Oncology.**

During your visits with Doctor Singer, you may also be seen by our ADVANCE REGISTERED NURSE PRACTITIONER, April Roemer who joined our practice in January 2022.

April works very closely every day with Doctor Singer and she is an integral part of our practice. April has vast experience as a pediatric oncology RN prior to joining the practice.

As an Advance Practice Registered Nurse, her practice includes, but is not limited to, assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their parents and/or authorized representatives.

_____ _____

Patient Name Patient DOB

_____ _____

Signature of Parent/Legal Guardian/Patient Printed name of Parent/Legal Guardian/Patient

_____ _____

Relationship to Patient Date