



# VIERA PEDIATRICS

Dr. Preeti Bimbrahw, Nicole Horn, APRN, Lindsay Piwinski, APRN  
 8095 Spyglass Hill Road – Suite 104 • Melbourne, FL 32940  
 Ph (321) 241-6400 • Fax (321) 428-3945

PATIENT INFORMATION		
Patient's Full Name (Last, First):		Nickname/Preferred Name:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined to specify	Social Security #:
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined to specify		
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Declined to specify		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Street Address:		
City:	State:	Zip Code:
Home Phone #:	Cell Phone #:	Work Phone #:
Siblings (Names and Birthdates): #1: _____ #2: _____ #3: _____		

PHARMACY		
Pharmacy Name:	Address:	Phone #:

MOTHER/LEGAL GUARDIAN	FATHER/LEGAL GUARDIAN
Name:	Name:
Relationship: <input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian <input type="checkbox"/> Foster <input type="checkbox"/> Step-Mom	Relationship: <input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian <input type="checkbox"/> Foster <input type="checkbox"/> Step-Dad
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
E-mail Address:	E-mail Address:
Mailing Address: <input type="checkbox"/> Same as Patient	Mailing Address: <input type="checkbox"/> Same as Patient
Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:
Work Phone #:	Work Phone #:
Employer:	Employer:
Occupation:	Occupation:



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## EMERGENCY CONTACT

Name:	Relationship:
Address:	Phone #:

## PRIMARY INSURANCE INFORMATION

Insurance Company:	Policy #:	
Policy Holder's Name:	DOB:	S.S. #:

## SECONDARY INSURANCE INFORMATION

Insurance Company:	Policy #:	
Policy Holder's Name:	DOB:	S.S. #:



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## FINANCIAL POLICY

- It is the parent/guardian’s responsibility to **bring and keep updated the following at every visit:**
  - Current health insurance card
  - Photo ID
  - Updated demographics
  - Payment in the form of cash or credit card

\_\_\_\_\_  
Initial

### INSURANCE:

- Health insurance is a contract between patient/parent, employer, and insurance company. It is the patient’s responsibility to be familiar with the insurance policy, including, but not limited to: vaccine and visit coverage, referral/authorization requirements for specialty care, radiology, lab tests, and emergency and/or hospital care.
- Full payment, including co-payments, coinsurance, and deductibles are required at the time of service.
- It is the responsibility of parent/guardian to contact their human resources department or insurance plan to add their newborn to their insurance plan. This is not done automatically. *Newborns not added to insurance policies within 30 days may be subject to self-payment.*
- Failure to disclose all insurance plans child is covered under may result in insurance plan rejecting claims and payment for services rendered will be charged to parent/guardian.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Initial

### PAYMENTS:

Co-pays and coinsurance payments are due at the time of service. In the case of domestic separation or divorce, the parent accompanying child is responsible for payment of copays, or other fees related to services rendered.

\_\_\_\_\_  
Initial

### RETURNED CHECKS:

There will be a fee of \$25 for any returned checks or payments.

\_\_\_\_\_  
Initial

### NO SHOW POLICY:

Missed, no showed, or cancelled appointments with less than 24-hour notice may be subjected to a \$25 fee. Multiple missed appointments or late cancellations may result in discharge from the practice.

\_\_\_\_\_  
Initial

### PAST DUE ACCOUNTS:

We will attempt to work out a payment schedule with you, however seriously delinquent accounts will be referred to a collection agency. Any legal fees that we pay to secure past due balances will be added to your account.

\_\_\_\_\_  
Initial

I understand that I am financially responsible for all charges for services to me, including co-payments, coinsurance, out of pocket, deductibles and non-covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Viera Pediatrics/Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney’s fee. I authorize the disclosure of my medical information to all of Viera Pediatrics/Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

Patient Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## AUTHORIZATION TO TREAT/HIPAA RELEASE OF INFORMATION

I, \_\_\_\_\_ parent/legal guardian of: \_\_\_\_\_  
authorize Viera Pediatrics to provide medical treatment to said child. I authorize the following adult(s), acting as my agent to accompany and consent for treatment, testing, and immunizations for my child.

I authorize Viera Pediatrics/Medical Associates of Brevard to release medical information regarding my child to the following person(s):

**\*I understand that this person may be required present proper ID when bringing my child for Treatment.**

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

I authorize Viera Pediatrics to leave a detailed message on voicemail.

\_\_\_\_\_  
Parent/Guardian signature DATE \_\_\_/\_\_\_/\_\_\_

### NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been received a copy of the Provider Notice of Privacy Practices for Viera Pediatrics/ Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the duties of Viera Pediatrics/Medical Associates of Brevard with respect to my protected health information.

Patient Name \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



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## MEDICAL HISTORY

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Relationship: \_\_\_\_\_

### CURRENT MEDICATIONS:

Medication Name		Dose	How many times a day?

### CHILD'S MEDICAL HISTORY: *(please mark all that apply)*

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> ADD/ADHD                   | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Dental Decay          |
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> High Blood pressure      | <input type="checkbox"/> Disability               | <input type="checkbox"/> Eczema                |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Vesicoureteral reflux |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Hearing Problems         | <input type="checkbox"/> Other:                |
| <input type="checkbox"/> Bleeding/clotting disorder | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Vision Problems          |  |
| <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Recurrent ear infections |  |

### HOSPITALIZATIONS AND SURGICAL HISTORY:

Hospitalization/Surgery/Procedure:	Year:

### FAMILY HISTORY:

Please indicate if there is a family history of any of the following:

Medical Condition	Family Member	Medical Condition	Family Member
ADD/ADHD		Hearing Disability	
Alcohol/Drug Abuse		High Cholesterol	
Allergies		High Blood Pressure	
Asthma		HIV/AIDS	
Birth Defects		Learning Disability	
Blood Disorder		Mental Illness	
Cancer	<i>(please include what type)</i>	Migraines	
Heart Disease		Scoliosis	
Seizure Disorders		Speech Problems	
Developmental Delay		TB/Lung Disease	
Diabetes		Stroke	
Genetic Disorder		Thyroid Disease	
Hepatitis/Liver Disease		Other:	



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## VACCINE POLICY

- We at Viera Pediatrics firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians. It is our belief that by not vaccinating your child, you are putting them at unnecessary risk for life-threatening illness, disability or even death.

Please be advised that refusing, delaying, or breaking up vaccines to give one or two at a time goes against expert recommendation as well as our medical advice as providers at Viera Pediatrics.

*If you decide not to continue to vaccinate your child, we request that you seek another provider who shares your views.*

## VACCINE POLICY ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read Viera Pediatrics Vaccine Policy and I agree to vaccinate my child with immunizations as recommended by the AAP and CDC (this includes vaccines required for entry into school). I understand that all vaccines will be discussed prior to administration and that a separate consent form will be signed before any vaccine is given to my child.

Patient Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## NO SHOW/MISSED APPOINTMENT POLICY

We at Viera Pediatrics understand that sometimes you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please call us as soon as possible (at least 24 hours in advance). To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call and text message are made/sent one business day prior to your scheduled appointment. It is the responsibility of the patient to arrive for their appointment on time.

### **PLEASE REVIEW THE FOLLOWING:**

1. Please cancel your appointment with at least 24 hours' notice. There is a waiting list to see the providers at Viera Pediatrics and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than 24-hour cancellation is given the appointment will be documented as a "No Show" appointment.
3. If you do not present to the office for your appointment, it will be documented as a "No Show" appointment.
4. After the first "No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Show" policy. Viera Pediatrics will assist you to reschedule this appointment if needed.
5. If you have two "No Show" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a \$25 no show fee.
6. If you have three "No Show" appointments within a one-year time period, you will receive a second \$25 no show fee assessment. Dismissal from the practice will be considered.

*I have read and understand the Viera Pediatrics No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Viera Pediatrics appropriately if I have difficulty keeping my scheduled appointments.*

Patient Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



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## MEDICAL RECORDS RELEASE AUTHORIZATION

### \*NO DISK RECORDS PLEASE\*

I, \_\_\_\_\_ (PRINT PARENT/GUARDIAN NAME), authorize the release of  
medical records of  
\_\_\_\_\_ (PRINT NAME OF PATIENT), \_\_\_\_\_ (PATIENT'S DOB)

Obtaining Records From: **OR**  Releasing Records To:

Recipient Name	Street Address	City, State, ZIP code
Phone Number	Fax Number	

#### INFORMATION TO RELEASE (CHECK ALL THAT APPLY):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Immunization               | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Imaging                  | <input type="checkbox"/> Consultation Documentation | <input type="checkbox"/> Hospital Records   |
| <input type="checkbox"/> Prescription Data        | <input type="checkbox"/> Other (Specify):<br>_____  |   |

#### If my record contains the following, it will be released if box is checked:

- Substance Abuse     Mental Health     HIV/STD Testing/Treatment     Pregnancy Testing

#### PURPOSE OF DISCLOSURE:

- Transfer of Care     Continuing Care     Personal Copy     Other \_\_\_\_\_

This authorization is valid for 1 (one) year from date of signature unless otherwise specified. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released. I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**NOTICE: There may be costs associated with this request in compliance with State and Federal laws.**