

DIVAKER PEDIATRICS
Patient Information (Please Print)

DATE: _____

Patient's Last Name _____		First Name _____		Middle name _____	
Suffix _____		Gender <input type="checkbox"/> M <input type="checkbox"/> F Other <input type="checkbox"/>		DOB _____	
Race _____		Ethnic Group <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			
Preferred Language _____					
Mailing Address _____		City _____		State _____ Zip _____	
Home Address _____		City _____		State _____ Zip _____	
(Disregard if same address)					
Home Ph#: _____		Cell Ph# _____		Work Ph# _____	
Email Address _____		Emergency Ph # _____			

WHO IS FINANCIALLY RESPONSIBLE FOR THIS PATIENT					
Self <input type="checkbox"/>		Spouse <input type="checkbox"/>		Parent <input type="checkbox"/> Other <input type="checkbox"/>	
Last Name _____		First Name _____		Mid Initial _____	
SSN _____		DOB _____		Home Ph#: _____	
Cell Ph#: _____		Work Ph# _____			
Street Address _____		City _____		State _____ Zip Code _____	
Employment Status (check one) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Retired Date _____					

POLICY HOLDER INFORMATION (if different from Patient). If same as responsible, please check here

Self <input type="checkbox"/>		Spouse <input type="checkbox"/>		Parent <input type="checkbox"/> Other <input type="checkbox"/>	
Last Name _____		First Name _____		Mid Initial _____	
SSN _____		DOB _____		Home Ph#: _____	
Cell Ph#: _____		Work Ph# _____			
Street Address _____		City _____		State _____ Zip Code _____	
Employment Status (check one) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Retired Date _____					

Emergency Contact (Parent/Guardian if patient is a minor)

Name _____ Relationship _____

Home Ph# _____ Cell Ph# _____ Work Ph# _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

Patient, Parent, Legal Guardian or Authorized Representative

Date

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Divaker Pediatrics. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account balance for any professional services rendered.

Patient Signature

Date

ADVANCED DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

I have executed an Advance Directive (Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate)

I HAVE NOT executed an Advance Directive

Patient Signature

Date

Divaker Pediatrics
Rezia Divaker, M.D.
Diplomate, American Board of Pediatrics

Vaccine Administration Consent

The doctor will keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number and the signature and title of the person who gave the vaccine.

"I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Material(s) and have read, or have had explained to me, information about the diseases and the vaccines listed below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or the person named below (for whom I am authorized to make this request)."

Information about Person to Receive Vaccine (please print)

Name: _____

Signature of Person to Receive Vaccine or Authorized to Make the Request (Parent or Guardian)

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

DIVAKER PEDIATRICS

COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Please complete the following information for all requests

1. Today's date: _____

2. Patient name: _____

3. Date of Birth: _____

4. Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

You may leave the following messages on voicemail:

- Referral Information
- Prescription refill information
- Test results
- Other: _____

You may discuss and/or give access to information regarding my treatment and care with the following family members and /or friends (name and phone number please):

You may contact me regarding my treatment and care at the following numbers:

Signature of Patient or Guardian _____ Date _____

Signature of Staff Person _____ Printed Name of Employee _____

DIVAKER PEDIATRICS

“Serving with a Spirit of Compassion”

6551 N. Orange Blossom Trail #229, Mount Dora, FL 32757

352-383-8384 (P) 678-553-0329 (F)

Notice of Patient Privacy Practices

Written acknowledgement of receipt of Divaker Pediatrics Notice of Privacy Practices.

By Signing this written acknowledgement, I hereby acknowledge my receipt of Divaker Pediatrics Notice of Privacy Practices.

Patient Name: _____

Printed Parent/Legal Guardian Name: _____

Parent/Legal Guardian or Patient (Ages 18-21) Signature:

Acknowledgement not obtained because:

Patient/Parent/Legal Guardian declined to accept Notice of Patient Privacy Practices.

Patient/Parent/Legal Guardian receive Notice of Patient Privacy Practices but refused to sign acknowledgement.

Other

NO SHOW FEES/BAD CHECK FEES

Divaker Pediatrics charges a \$50 No Show/No Call Fee. Divaker Pediatrics charges a \$20 bad check fee, for any checks returned and charging NSF fees.

Printed Patient/Parent/Legal Guardian
Name: _____

Signature (Parent/Legal Guardian/Patient (Ages 18-21):

Date: _____

DIVAKER PEDIATRICS

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)

Part A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purposes, and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will and I have the right to revoke this authorization.

Patient-Name: _____

Home-Address: _____

DOB: _____

Previous physician providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)

Divaker Pediatrics
6551 N Orange Blossom Trail, Ste 229, Mount Dora, FL 32757
352-383-8384 (Phone) 678-553-0329 (Fax)
Dr. Rezia Divaker

The following items must be initialed to be included in the use or disclosure of other health information:

- HIV/AIDS related health information and/or records.
- Mental health information and/or records
- Genetic testing information and/or records
- Domestic violence information and/or records
- Drug/alcohol diagnosis, treatment and /or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.

Part B: Must be completed only if Divaker Pediatrics has requested the Authorization

1. Divaker Pediatrics must complete the following:
- a. What is the purpose of the use or disclosure? (Check one.)
 At the patient's (or the patient's representative's) request or direction.
 For marketing For fundraising Other
 - b. Will Divaker Pediatrics requesting the Authorization, receive financial compensation of any kind, directly or indirectly in exchange for using or disclosing the health information? Yes No
2. The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form. * Initial: _____

b. I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it. * Initial: _____

Part C: Must be completed for ALL Authorizations

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

I understand that this authorization will expire (Please choose 1 of the 3 options below):

a. No expiration (permitted only for Authorizations used to create or maintain research databases or repositories.) Initial _____

b. On _____ Initial _____

c. When the following event occurs: _____
Initial: _____

*Signature: _____ Date: _____

Of Patient or Patient's Representative
(Form MUST be completed before signing)

*Print Name of Patients Representative: _____

*Relationship to Patient: _____

*Reason Authorization is signed by the Patient's Representative: (check one)

Minor

Incompetent

Other (Explain) _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION