SUN 'N LAKE MEDICAL GROUP

MEDICAL RECORDS REQUEST

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____

_____ **Phone #:** _____

(City, State Zip)

For Record Release or copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

_____ To use or disclose to **Sun 'N Lake Medical Group Pediatrics**

(Provider's Name)

_____ 4958 Sun 'N Lake Blvd Suite B

(Street Address)

_____ Sebring, FL 33872

(City, State, Zip)

_____ **Phone: (863) 386-4711 Fax: (863)3864301**

(Phone Number)

Information to be released/copied:

( ) All pertinent medical records including immunizations and lab tests

( ) Day sheets- Dates: _____ ( ) Lab Information- Dates: _____

( ) Other: _____

Information to be excluded/not released:

( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing

( ) Sexual Assault/Victimization records ( ) other: _____

Be sure to review any restrictions prior to copying/releasing

Reason for Record Release or Copy: _____

_____

(Please see below, charges could apply.)

For patient or Guardian Inspection/Copy Requests: ( ) Check Here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: $1.00 per page for the first 25 pages, then $0.25 for each page thereafter.

_____ _____

(Parent/Legal Guardian Signature) **(Date)**

_____ *Inspection requests are valid on the date of signature only

(Parent/Legal Guardian Name Printed) *Release/Copy requests expire 30 days from signature date

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentially is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent from subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).

For Internal Purposes Only: Name and Title of Person Releasing Records: _____

Method of transfer: ( ) Mailed on: _____ **( ) Certified? (Certification #)** _____

( ) Picked up by: _____**/ (Date)** _____ **Form of ID:** _____

( ) Faxed: _____**/ (Date)** _____**Verification of ID Performed: ( ) Yes ( ) No**

SUN 'N LAKE MEDICAL GROUP

Date: _____ Email: _____

Who is responsible for patient: ( ) Self ( ) Parent ( ) Grandparent ( ) Other

Patient's Last Name: _____ First Name: _____ MI: ____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone # _____ ( ) Home ( ) Cell /Alternate Phone #: _____

Patient's SSN: _____- _____- _____ Date of Birth: _____ ( ) Male ( ) Female

Do you have an alternate address? ( ) Yes ( ) No/ If yes, please print here: _____

Mother's Information:

Last Name: _____ First Name: _____

SSN: _____-_____- _____ Date of Birth: _____

Address: _____ Phone #: _____

Employed By: _____

Father's Information:

Last Name: _____ First Name: _____

SSN: _____- _____-_____Date of Birth: _____

Address: _____Phone #: _____

Employed By: _____

Please have your insurance card and driver's license ready for the receptionist. Payment for professional services is due and payable when services are rendered.

Emergency Contact:
Name of close relative not living with you: _____

Relationship to patient: _____Phone #: _____

Address: _____

Release of Medical Records
I hereby authorized the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for the insurance carriers or for continuing patient care. Any of the classifications above may be crossed off if that information is not to be released.

Parent/Guardian Signature: _____Date: _____

Consent for Evaluation or Treatment
The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient named above.
Parent/Guardian Signature: _____Date: _____

SUN 'N LAKE MEDICAL GROUP

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, and Discover.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor- in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. We will collect the copayment when you arrive for your appointment.
- If you have insurance coverage with a plan with whom we do not have a prior agreement, we will prepare and sent the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- All health plans are not the same and don not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
- *I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.*

Signature of Patient or Responsible Party, if a Minor **Date**

Please Print the Name of the Patient

SUN 'N LAKE MEDICAL GROUP

PERMISSION TO BRING

Raisa D. Camilo, M.D. & Associates
4958 Sun 'N Lake Blvd.
Sebring, FL 33872
(863) 386-4711 (Office)
(863) 386-4301 (Fax)

I, _____ the parent/legal guardian of _____, give the following person(s) permission to seek medical care for the above mentioned child in my absence. This is to be effective on date signed and to remain in effect until further notice is given.

The listed person (s) should also considered as "emergency contacts" in the event that you (the parent/legal guardian) are unable to be reached.

Name (Nombre)	Relationship to Patient (Relación con el paciente)	Phone Number (Numbero De Telefono)

Signature of parent (Firma del padre/guardián legal): _____

Date (Fecha): _____

FOR OFFICE USE ONLY

Witness (Testigo): _____

Identification verified (Identificación verificada): _____Yes (Si) _____No

Employee Initals (Iniciales del empleado): _____

Sebring Office:
4958 Sun 'N Lake Blvd., Suite B
Sebring, FL 33872
(863) 386-4711(Phone)
(863) 386-4301 (Fax)

Lake Placid Office:
511 West Interlake Blvd
Lake Placid, FL 33852
(863) 699-1220(Phone)
(863) 699-1811 (Fax)

SUN 'N LAKE MEDICAL GROUP

Lead Poisoning Risk Assessment Questionnaire Yes, No, or Don't Know

_____ 1. Does your child live in or regularly visit (once a week or more) any house or building built before 1978?

_____ 2. Does your child live in or regularly visit any house or building that has recently undergone renovation?

_____ 3. Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead?

Examples:

Occupation- building renovation, battery factory or recycling, auto or radiator repair; highway bridge sandblasting or painting, welding metal structures, or wire cable cutting

Hobbies – refinishing furniture home renovation; casting bullets: auto battery or radiator repair, making stained glass, ceramics, toy soldiers, dive weights, or fishing weights

_____ 4. Does your child have contact with cosmetics, kohl, candies, spices, jewelry, ceramic dishware and/or home (or folk) remedies not made in the United States; and/or leaded crystal, imported ceramic, or pewter dishes?

_____ 5. Does your child play in loose soil, near a busy road or near any industrial sites such as battery recycling plant, junk yard or lead smelter?

_____ 6. Have you ever seen your child eat dirt or put his/her mouth on painted surfaces, paint chips, toys, jewelry or vinyl mini blinds?

_____ 7. Has your child recently visited or lived in another country for an extended period of time?

PARENT SIGNATURE: _____ DATE: _____

Sebring Office:
4958 Sun 'N Lake Blvd., Suite B
Sebring, FL 33872
(863) 386-4711(Phone)
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SUN 'N LAKE MEDICAL GROUP

HIPPA- CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

ACKNOWLEDGE OF RECEIPT OF PRACTICE NOTICE OF PRIVACY PRACTICES:

Patient Name: _____ Patient DOB: _____

Consent to disclose my general health information:

By my signature below, I hereby authorize Sun 'N Lake Medical Group to disclose my medical information so that the practice may treat me, seek payment from third parties for such treatment and generally carry on the practice's health care operations (e.g., quality assurance). I also authorize Sun 'N Lake Medical Group to disclose my medical information to insurers and providers outside of the practice when necessary so that these providers may treat me; seek payment for that treatment, and for the purpose of their health care operations.

- May we phone, email, or send a text to you to confirm appointments? **YES NO**
- May we leave a message on your answering machine at home or on your cell phone? **YES NO**
- May we discuss your medical condition with any member of your family? **YES NO**
  If **YES**, please name the members allowed

Name of individual:	**Phone Number:**
1.	
2.	
3.	
4.	
5.	
6.	

My highly confidential information:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside of the practice for the purpose of obtaining treatment for me, payment for the treatment proved to me, and so that these entities can carry out their health care operations:

- Information about HIV/AIDS status
- Information about genetic testing
- Information related to confidential communications with a psychotherapist, psychiatrist, psychologist, social worker, mental health professional, or human services professional
- Information about diagnosis and treatment for substance abuse (alcohol or drug)
- Information about venereal diseases
- Mammography results
- Information about family planning services
- If I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- Information about treatment with controlled substances
- Abortion consent forms

Note to patient: please strike any of the above –listed bullet points, to the extent you do not want the information disclosed.

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

FOR OFFICE USE ONLY

_____ _____

(Witness Signature) **(Date)**

SUN 'N LAKE MEDICAL GROUP

Mother's Name: _____ Age:_____Patient's Name: _____

Occupation: _____ Patient's DOB: _____

Father's Name: _____ Age: _____ Reason for Today's Visit:_____

Occupation: _____
If adults in the household work outside the home, what childcare arrangements are made for this child?
_____

Pregnancy and Birth:
1. Hospital Child was born at: _____
2. Did mother have illness during pregnancy? **Yes or No**
3. Did she take any other medications other than vitamins and iron? **Yes or No If so what?**
4. Mother's age when giving birth: _____
5. Was the baby born on time? **Yes or No**
6. What was the baby birth weight? _____
7. Did the baby have any trouble while in the hospital? (Jaundice, infection, other) If so, what kind? _____
8. What time was the baby born? _____

Safety/Environment: (***Please Circle)***
1. Do you live in a private home, apartment, mobile home or other?
2. Do you know the hottest temperature of the water in your pipes? **Yes or No**
3. Is there a working smoke alarm on each floor in the house? **Yes or No**
4. Does your child always use a car seat/seatbelt when riding in the car? **Yes or No**
5. Are there any smokers in the household? **Yes or No**
6. Are there any problems with the condition of your home? (Peeling paint, insects, rats, or mice?) **Yes or No**
7. Does your child always wear a helmet when riding their bicycle? **Yes or No**

Past Medical History:
1. Child's previous medical doctor: _____
2. Date of last physical examination: _____
3. Date of last dental examination: _____
4. Has your child had any allergic reaction to foods? **Yes or No**
5. Has your child had any allergic reactions to immunizations? **Yes or No**
6. Any hospitalizations/surgeries other than birth? **Yes or No**
What for? _____
7. Any serious injuries? **Yes or No**
What kind? _____
8. Are any medications taken regularly? **Yes or No**
9. Has your child had chickenpox? **Yes or No**
If so, when? _____

Review of systems:
1. Has your child had frequent ear infections? **Yes or No**
2. Has your child had any eye infections? **Yes or No**
3. Has he/she had any problems with teeth? **Yes or No**
4. Does he/she have frequent colds or sore throats? **Yes or No**
5. Is there asthma, pneumonia or recurrent cough? **Yes or No**
6. Does he/she have a heart murmur or any heart problems? **Yes or No**
7. Any problems with urination? **Yes or No**
8. Any problems with diarrhea or constipation? **Yes or No**
9. Have there been convulsions or nervous problems? **Yes or No**
10. Any eczema, hive, or other skin problems? **Yes or No**
11. Has your child ever been anemic? **Yes or No**
Please list any other medical problems: _____

Family History:
1. Are the child's parents both in good health? **Yes or No**
2. Circle any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:
Anemia Asthma Allergies Diabetes High Blood Pressure Heart Trouble Tuberculosis Mental Illness Drug Problems Alcohol Problems Inherited Disease Venereal Disease Cancer AIDS others:
3. Are any of your children deceased? **Yes or No**

Developmental/Behavior:
1. At what age did your child sit alone? _____
2. At what age did your child walk? _____
3. Did he/she say any words by the time he/she was 1 – ½ years old? **Yes or No**
4. How does your child compare to others his/her age? **Advanced Normal or Behind** *(Please circle)*
5. Does he/she have trouble sleeping? **Yes or No**
6. Does he/she had trouble in school? **Yes or No**
7. What grade is he/she in? _____
8. Does he/she get along with other children? **Yes or No**
9. Circle if your child has had any of the following? ***Nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactive, nightmares, speech problems, problems with discipline, others:***
_____

Feeding and Nutrition
1. Is your child's appetite usually good? **Yes or No**
2. Is it good now? **Yes or No**
3. Was there any severe colic or any unusual feeding problems during the first 3 months? **Yes or No**
4. Does any food disagree with him/her? **Yes or No**
5. For the first six months, was he/she **Bottle fed/Breast fed?** *(please circle)*
6. If still on formula, which do you use? _____
7. Does he/she take vitamins? **Yes or No**

SUN 'N LAKE MEDICAL GROUP

Your Patient-Centered Medical Home

Welcome to Your Medical Home

A Medical Home is all about you. Caring about you is the most important job of your Patient Centered Medical Home. In this personal model of health care, your primary provider leads the team of health care professionals that collectively take responsibility for your care. They make sure you get the care you need in wellness and illness to heal your body, mind and spirit.

Your personal provider and an extended team of health professionals build a relationship in which they know you, your family situation, and your medical history and health issues. In turn, you come to trust and rely on them for expert, evidence-based health care answers that are suited entirely to you or to your family.

The Medical Home advantage

There are many benefits to being in a Medical Home:

- Comprehensive care means your medical home helps you address any health issue at any given stage of your life.
- Coordination of care occurs when any combination of services you and your provider decide you need are connected and ordered in a rational way, including the use of resources in your community.
- Continuous care occurs over time and you can expect continuity in accurate, effective and timely communication from any member of your health care team.
- Accessible care allows you to initiate the interaction you need for any health issue with a physician or other team member through your desired method (office visit, phone call, or electronically) and you can expect elimination of barriers to the access of care and instructions on obtaining care during and after hours.
- Proactive care ensures you and your provider will build a care plan to address your health care goals to keep you well, plus be available for you when you get sick.

Who is your Medical Home team?

Your team may include a doctor, nurse practitioner, and medical assistant, as well as other health professionals. These professionals work together to help you get healthy, stay healthy, and get the care and services that are right for you. When needed, your personal doctor arranges for appropriate care with qualified specialists. On-site behavioral health appointments are available if necessary to your care.

We want to learn about you:

- We want to get to know you, your family, your life situation, and preferences, and suggest treatments that make sense for you.
- We want to treat you as a full partner in your care
- We want to communicate effectively with you
- We want to give you time to ask questions and we want to answer them in a way you understand
- We want to make sure you know and understand all of your options for care
- We want to help you decide what care is best for you. Sometimes more care is not better care. We want to ask you for feedback about your care experience.

We want to support you in caring for yourself:

- We want to make sure you develop a clear idea of how to care for yourself.
- We want to help you set goals for your care and help you meet your goals one step at a time
- We want to encourage you to fully participate in recommended preventive screenings and services
- We want to give you information about classes, support groups, or other types of services to help you learn more about your condition and stay health

We are available for clinical matters 24/7 by telephone!

You are the most important member of the medical home team.

Here is what you can do to actively participate in your care:

• Understand that you are a full partner in your own health care

• Learn about your condition and what you can do to stay as healthy as possible

• As best you can, follow the care plan that you and your medical team have agreed is important for your health

Communicate with your Medical Home team:

• Bring a list of questions to each appointment. Also, bring a list of any medicines, vitamins, or remedies you use as well as a complete medical history

• If you don't understand something your doctor or other member of your medical home team says, ask them to explain it in a different way

• If you get care from other health professionals, always tell your medical home team so they can help coordinate for the best care possible

• Talk openly with your care team about your experience in getting care from the medical home so they can keep making your care better

Office Hours:
Monday – Friday 8AM to 5PM
Saturday (Sebring office only): 8AM-12PM

Sebring: 4958 Sun N Lake Blvd
P: 863-386-4711 F: 863-386-4301

Lake Placid: 511 W Interlake Blvd
P; 863-699-1220 F: 863-699-1811

Sunnlakemedicalgroup.com

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