CHILDREN'S MEDICAL GROUP
HUMERAA QAMAR, M.D., M.P.H., F.A.A.P.
JUAN DEL RIO, M.D.
1749 SE 28TH LOOP
OCALA, FL 34471

PATIENT INFORMATION

Please print clearly

Today's Date:______________________

Patient Name:____
(first) (mi) (last)

DOB:_____________________________

Address:____

E-mail address:____

Home Phone:_______________________Social Security #:________________

Father's Name:____

Employer:____

Work Phone:_________________Cell Phone:_____________________

Mother's Name:____

Employer:____

Work Phone:_________________Cell Phone:_____________________

How would you prefer we contact you? Home #, Cell #, Work #, e-mail (circle one)

Patient's school or daycare:____

Person who does not live with you to contact in an emergency:

___________________________________Phone:_______________________

___________________________________Phone:_______________________

Referral source:____

Patient lives with: (circle) Both parents, Mother, Father, Grandparents, Other

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PATIENT QUESTIONAIRE

Patient Name:____

DOB:_________________________

Allergies:____

Immunizations: (please circle) **Up to Date** **Behind**

Father's DOB:__________________ **Mother's DOB:**__________________

Father's SS#__________________ **Mother's SS#**__________________

Brother's names and ages:____

____

Sister's names and ages:____

____

Smokers: (please circle) **in home** **outside home**

Pets: (please circle) **in home** **outside home**

Individuals to whom information may be released or who can authorize treatment:

Name:_________________________ **Relationship:**___________________

Name:_________________________ **Relationship:**___________________

Name:_________________________ **Relationship:**___________________

Parent or Guardian Signature:____________________________________

Date:__________________________

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JUAN DEL RIO, M.D.

OFFICE POLICIES

Please keep all scheduled appointments. We maintain a schedule so that all patient's can be seen in a timely manner. At times we may run slightly behind due to emergencies that arise. We ask for your patience and understanding when these situations arise. In turn, we ask that you arrive for your scheduled appointment on time. If you are unable to be here within 10 minutes of your appointment, please call to let us know. Our policy is to charge $20.00 late fee for late arrival or you have the option of rescheduling. Also, if you NO SHOW for your appointment there will be a charge of $20.00, (not billed to insurance).

Co-pays and deductibles must be paid at the time of service. It is your responsibility to update insurance information as well as current addresses and phone numbers.

All patients and family members are expected to be dressed accordingly while in our office. (Shirt and Shoes).

NO SMOKING EITHER INSIDE OR IN AREAS WHERE THERE ARE PATIENTS ENTERING AND LEAVING OUR OFFICE. MANY OF OUR CHILDREN EXPERIENCE SEVERE REACTIONS TO SMOKE AND IN SOME SITUATIONS THIS COULD BE LIFE THREATENING.

If there is a question regarding custodial parents we must have access to the legal papers assigning custody. We have the right to refuse release of information to any parent or other family member who cannot prove custody.

Signature:____

CHILDREN'S MEDICAL GROUP
Humeraa Qamar, M.D., M.P.H., F.A.A.P.
Juan Del Rio, M.D.
1749 SE 28th Loop
Ocala, FL 34471
Phone (352)369-8690
Fax (352)369-8693

Authorization for Use or Disclosure of Health Information

Patient Name:____

Patient DOB:______________________

I authorize the disclosure of health information relating to me as described below:

____

Records released from:____

Records released to: Children's Medical Group
1749 SE 28th Loop
Ocala, FL 34471

I understand that if the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Children's Medical Group in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Children's Medical Group before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Date:_____________________ Authorization expires on:__________________

Signature of patient or representative:_________________________________

Print name of patient or representative:________________________________

Relationship to patient if representative:_______________________________

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1749 SE 28 LOOP
OCALA, FL 34471

NOTICY OF PRIVACY PRACTICES

I acknowledge that I was provided with the Notices of Privacy Practices of the Medical Practice named at the top of this page.

DATE ____

PATIENT NAME ____

DATE OF BIRTH____

PERSONAL REPRESENTATIVE____

RELATIONSHIP____

SIGNATURE____

NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES YOUR RIGHTS AS A PATIENT AND HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

PLEASE REVIEW THIS NOTICE CAREFULLY. YOU WILL BE ASKED TO SIGN A FORM TO ACKNOWLEDGE RECEIPT OF THIS INFORMATION. FOR FURTHER INFORMATION YOU MAY REQUEST TO SPEAK TO THE PRIVACY OFFICIAL.

EFFECTIVE DATE: APRIL 14, 2003

REVISED: OCTOBER 18, 2011

The terms of this Notice of Privacy Practices apply to Humeraa Qamar, M.D... This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This office is required by law to maintain the privacy of our patients' individual health information and to provide patients with notice of privacy practices with respect to your individual health information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in this office, upon your request.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Except as described below, this office will maintain the confidentiality of your individual health information. Your individual health information may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operation and pursuant to a signed authorization form permitting the use or disclosure. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment and Health Care Operations.

Except as otherwise provided, or with your signed consent, this office will use and disclosure your individual health information as necessary and permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc.

Family and Friends.

With your approval and using our best judgment, individual health information may be disclosed to designated family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited individual health information with such individuals without your approval.

Business Associates.

At times it may be necessary for us to provide your individual health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your information.

Appointment and Services.

This office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your individual health information from us by alternative means or at alternative location. You may request such confidential communication in writing and may send your request to:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

You also have the right to request that we not send you any future marketing material and we will use our best efforts to honor such request. You may make the request by sending your name and address to:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

Other uses and disclosures of your individual health information, permitted or required by law, may be made without your consent or authorization.

- The release of your individual health information for any purpose required by law;
- The release of your individual health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- The release of your individual health information as required by law if we suspect child abuse or neglect; we may also release your individual health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- The release of your individual health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- The release of y our individual health information to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- The release of your individual health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;

•The release of your individual health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;

•The release of your individual health information to law enforcement officials as required by law to report wounds and injuries and crimes;

•The release of your individual health information to coroners and/or funeral directors consistent with law;

•The release of your individual health information if necessary to arrange an organ or tissue donation from you or a transplant for you;

•The release of your individual health information if you are a member of the military as required by armed forces services; we may also release your individual health information if necessary for national security or intelligence activities; and

•The release of your individual health information to worker' compensation agencies if necessary for your workers' compensation benefit determination.

YOUR RIGHTS

1. Access to Individual Health Information.

You have the right to copy and/or inspect much of the individual health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you $1.00 per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form from:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

2. Amendments to Individual Health Information.

You have the right to request in writing that individual health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

3. Accounting for Disclosures of Individual Health Information.

You have the right to receive an accounting of certain disclosures made by us of your individual health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

The first accounting in any 12 month period is free; you will be charged a fee of $5.00 for each subsequent accounting you request within the same 12 month period.

4. Restriction on Use and Disclosure of Individual Health Information.

You have the right to request restriction on certain of our uses and disclosures of your individual health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. Your also have the right to terminate, in writing or orally, any agreed to restriction by sending such termination notice to:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

5. Complaints.

If you believe your privacy rights have been violated, you can file a complaint with:

Humeraa Qamar, M.D.
Privacy Official
1749 SE 28th Loop
Ocala, FL 34471

Your complaint must be in writing.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

ADDITIONAL INFORMATION

If you have questions or need additional assistance regarding this Notice, you may contact:
Humeraa Qamar, M.D., Privacy Official, 1749 SE 28th Loop, Ocala, FL 34471