DIVAKER PEDIATRICS
Patient Information (Please Print)

DATE: _____

Patient's Last Name_____ First Name_____ Middle name_____ Suffix_____ Gender ☐M ☐F Other ☐ DOB _____
Race_____ Ethnic Group☐ Hispanic ☐ Non-Hispanic ☐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☐ Spouse☐ Parent☐ Other☐
Last Name_____ First Name_____ Mid Initial____
SSN_____ DOB_____ Home Ph#:_____
Cell Ph#:_____ Work Ph#_____
Street Address _____ City_____ State____ Zip Code_____
Employment Status (check one) ☐ Full-Time ☐Part Time ☐Retired Retired Date_____

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

Self☐ Spouse☐ Parent☐ Other☐
Last Name_____ First Name_____ Mid Initial____
SSN_____ DOB_____ Home Ph#:_____
Cell Ph#:_____ Work Ph#_____
Street Address _____ City_____ State____ Zip Code_____
Employment Status (check one) ☐ Full-Time ☐Part Time ☐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 ASSGNMENT

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**

AVANCED 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

Written Acknowledgement of Receipt of Divaker Pediatrics Notice of Patient Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of Divaker Pediatrics Notice of Patient Privacy Practices.

Patient or Legal Representative Signature_____

Printed Patient or Legal Representative Name_____

Relationship to Patient_____

Date_____

Acknowledgement NOT obtained because:

____Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

____Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement

____Other_____
_____

Employee Signature_____

Printed Name of Employee_____

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.)

___x__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 ____x__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