Pediatric Gastroenterology Hepatology & Nutrition of Florida

Daniel T. McClenathan, M.D.
Michele P. Winesett, M.D.
Greg C. Kaiser, M.D.
Joseph Rene A. Ignacio, M.D.
Michael J. Wilsey, Jr., M.D.

Adria A. Condino, D.O.
Karina Irizarry, M.D.
Viraine S. Weerasooriya, M.D.
Tiffany Linville, M.D.

Michelle Schreck, A.R.N.P.
Shawn Beck-Sarnaik, P.A.
Beverly Gursky, A.R.N.P.
Andrea McCoy, A.R.N.P.
Cassidy Mann, A.R.N.P.
Alicia Tenn' A.R.N.P.
Michele Johnson, A.R.N.P.
Ranae Preseau, A.R.N.P.
Kristin Del Torro, A.R.N.P.
Shanna Sherman, A.R.N.P.

Your child, _____, has an appointment with Dr. McClenathan, Dr. Winesett, Dr. Kaiser, Dr. Ignacio, Dr. Wilsey, Dr. Condino, Dr. Irizarry, Dr. Weerasooriya, Dr. Linville on _____. Please arrive at: _____ at our St. Petersburg, Fletcher, St. Joseph's, Palm Harbor, Lakeland, Sarasota, New Port Richey, Brandon, Odessa or Ft. Myers office.

If you cannot keep your appointment, please call our office at least 24 hours in advance to allow another patient to utilize your appointment time. Our policy is to charge for "NO-SHOW" appointments. Please help us to serve you better by keeping your scheduled appointments. Please complete the enclosed patient information sheet and bring it with you. You will also need to bring any medical records that pertain to your visit (lab work or x-rays) and your child's insurance card. Please call your pediatrician's office to obtain any additional information as soon as possible.

We are committed to your child's successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our FINANCIAL POLICY of which we request you read and sign prior to treatment.

IF WE PARTICIPATE WITH YOUR INSURANCE PLAN: all copays and deductibles are due prior to treatment. If your insurance company requires a referral/authorization, ***IT IS YOUR RESPONSIBILITY TO OBTAIN IT PRIOR TO YOUR VISIT***. If you choose to see the physician without having prior authorization, you will be financially responsible for the visit. Please verify with your insurance company that we are a provider to your plan.

Our practice is committed to providing the highest quality treatment for our patients. Our charges reflect the extremely specialized services we provide. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this policy.

_____ / _____ / _____

SIGNATURE OF GUARDIAN | CHILD'S NAME | DATE

(727) 822-4300
601 5th Street South, Suite 605 – St. Petersburg, FL 33701
5881 Rand Blvd. – Sarasota, FL 34238
4443 Rowan Road – New Port Richey, FL 34653
9400 Gladiolus Dr., Suite 250 - Ft. Myers, FL 33908
1840 Mease Dr., Suite 204 – Safety Harbor, FL 34695

(813) 987-2911
5205 E. Fletcher Ave. – Temple Terrace, FL 33617
3310 Lakeland Hills Blvd. – Lakeland, FL 33805
3003 West M.L.K. Blvd. – Tampa, FL 33607
885 South Parsons Avenue – Brandon, FL 33511
1265 Creekside Pkwy, Ste. 203 - Naples, FL 34108
14111 State Rd. 54 – Odessa, FL 33556

www.tummydoctors.com

PEDIATRIC GASTROENTEROLOGY, HEPATOLOGY AND NUTRITION OF FL, P.A.

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CHILD'S LAST NAME _____ FIRST _____ M.I. _____ NICK NAME _____

SEX _____ AGE _____ BIRTHDATE _____ SOCIAL SECURITY # _____

ADDRESS _____ APT _____ CITY _____ ST _____ ZIP _____

PHONE (___) _____ EMERGENCY CONTACT _____ PH# _____

REFERRING PHYSICIAN _____ CITY _____ PHONE (___) _____

MOTHER/ GUARDIAN LAST NAME _____ FIRST _____ (MI) _____ DOB _____

SOCIAL SECURITY # _____ EMPLOYER _____ WORK PHONE (___) _____

FATHER/ GUARDIAN LAST NAME _____ FIRST _____ (MI) _____ DOB _____

SOCIAL SECURITY # _____ EMPLOYER _____ WORK PHONE (___) _____

PARENT NOT LIVING WITH CHILD NAME: _____ RELATION _____

ADDRESS _____ CITY _____ ST ____ ZIP _____ PHONE (___) _____

*** **PLEASE GIVE A COPY OF YOUR INSURANCE CARD TO THE RECEPTIONIST BEFORE YOUR VISIT*****

MEDICAID ID # _____ **DOES YOUR CHILD HAVE CMS?** Y/N LOCATION _____

INSURANCE CO _____ HMO/PPO/PRI-POLICY HOLDER _____

POLICY ID# _____ GROUP _____ GROUP NAME _____ INSURANCE PHONE # _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

****IF YOU HAVE AN HMO INSURANCE A REFERRAL NUMBER IS NEEDED FOR EACH VISIT. IF YOU CHOOSE TO SEE THE DOCTOR WITHOUT A REFERRAL YOU ARE ACCEPTING RESPONSIBILITY FOR THE CHARGES****

***** FINANCIAL POLICY*****

Payment is due when services are rendered. **IF WE PARTICIPATE WITH YOUR INSURANCE PLAN**; your co-pay or deductible needs to be paid at the time of the visit. **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE**; as a courtesy to you, our office will be happy to submit your claim to your insurance company for your reimbursement. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carrier to establish why they have not paid or why they paid less then originally indicated. If your insurance carrier pays in excess of the balance, we will promptly refund the credit amount to you. By signing below you are accepting all financial responsibility for the above named minor.

****RELEASE OF RECORDS/ASSIGNMENT OF BENEFITS*****

I, _____, herby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including medicare and other government sponsored programs, private insurance and any other health plans to : Daniel T. McClenathan, M.D., P.A. I also authorize said assignee to release or receive any and all information regarding medical treatment records for myself or my child of which I have legal responsiblity._____Initial. This authorization will remain in effect until revoked by me in writing.

SIGNATURE: _____ **DATE:** _____

NAME: _____

PLEASE DESCRIBE THE MAIN REASON FOR YOUR CHILD'S (OR YOUR) VISIT:

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY FOR THE PATIENT (CIRCLE YES/NO WHEN INDICATED)

Birth weight_____ prematurity: **YES / NO** If yes, how many weeks premature: _____

If patient is infant, did he/she pass stool (meconium) after birth? **YES / NO**

If patient is infant, did he/she have prolonged jaundice after birth? **YES / NO**

Any past medical problems? **YES / NO** If yes then list all problems:_____

_____

_____

Any past surgeries? **YES / NO** If yes then list all past surgeries: _____

_____

_____

Any allergies to medications or foods? **YES / NO** If yes then list all allergies:_____

_____

_____

Please list all prescriptions, over-the-counter (ex. tylenol), vitamin and herbal medications and doses:

MEDICATION NAME: **DOSE:**

_____

_____

_____

_____

SOCIAL HISTORY FOR THE PATIENT

Please list all members living in the household (Ex. Mother, Father, etc.):_____

_____

_____

Is your child in school/preschool/daycare? **YES / NO** What grade:_____

Any missed school days because of symptoms? **YES / NO**

Please list any family, social or school stressors:_____

_____

_____

_____

Please list patient's favorite activities/sports/ extra-curricular activities:_____

_____

_____

Any recent travel outside U.S.? **YES / NO** If so where?_____

NAME: _____

PLEASE MARK YES/NO IF THE PATIENT (YOU, IF YOU'RE THE PATIENT) HAS ANY OF THE FOLLOWING PROBLEMS:

	YES	NO
GENERAL		
Weight Loss		
Fever		
Lethargy/Fatigue		
HEAD AND NECK		
Eye Changes		
Wear Glasses		
Nasal Congestion		
Sinus Infection		
Frequent Colds/Flu		
Tooth Decay		
Mouth Sores		
SKIN		
Rashes		
Itching		
NEUROLOGIC		
Headaches/Migraines		
Seizures		
PSYCHIATRIC		
Anxiety		
Depression		
Developmental Delay		
Mood Changes		
HEMATOLOGY		
Bruising/Bleeding		
Anemia		
CARDIAC		
Murmur		
High Blood Pressure		
Fainting		
Heart Rhythm Changes		
GI		
Abdominal Pain		
Diarrhea		
Constipation		
Jaundice		
Vomiting		
Heartburn/ Reflux		
Appetite Loss		
Swallowing Problems		
GENITOURINARY		
Difficult Urination		
Blood in Urine		
Urinary Tract Infection		
Bed Wetting		
Abnormal Menstrual		
MUSCLE/JOINTS		
Joint Redness		
Joint Swelling		
Joint Pain		
Muscle Aches		

EXPLAIN FURTHER FOR ANY ANSWERS OF YES ABOVE:

Use the following symbols: M=mother, F=Father, S=Brother/Sister. MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM=Paternal Grandmother, PGF=Paternal Grandfather, MU=Maternal Uncle MA= Maternal Aunt, PU=Paternal Uncle, PA= Paternal Aunt, O=Other (ex. Cousin).

PLEASE MARK BELOW WITH ANY OF THE ABOVE SYMBOLS IF ANY FAMILY MEMBER HAS A PROBLEM/DISORDER LISTED BELOW.

_____ GERD (reflux disease)	_____ Anxiety	_____ Stomach Ulcers Depression
_____ Irritable Bowel Syndrome	_____ Migraines	_____ Crohn's Disease
_____ Food Allergies	_____ Ulcerative Colitis	_____ Lactose Intolerance
_____ Gallstones/Cirrhosis	_____ Bleeding Disorders	_____ Constipation
_____ High Cholesterol	_____ Colon Polyps	_____ Child/Infant Death
_____ Seizures		

OTHER FAMILY DISORDERS WE SHOULD KNOW ABOUT:

NAME: _____

RELEASE OF MEDICAL INFORMATION

I give my permission to release confidential health information to the following people:

These people can also bring patient to appointments

Name_____ Relationship_____ Date of Birth_____

Name_____ Relationship_____ Date of Birth_____

Name_____ Relationship_____ Date of Birth_____

Please specify if there is any personal health information you DO NOT want to be disclose to above named people_____

TELEPHONE CONTACT

Primary number (including area code)_____

Can we call you at this number? **YES / NO**
Can we leave a message on your voicemail to return our call? **YES / NO**
Can we leave a message on your voicemail stating negative lab results? **YES / NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES / NO**
Can we leave a message with the person answering the phone to return our call? **YES / NO**

Secondary number (including area code)_____

Can we call you at this number? **YES / NO**
Can we leave a message on your voicemail to return our call? **YES / NO**
Can we leave a message on your voicemail stating negative lab results? **YES / NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES / NO**
Can we leave a message with the person answering the phone to return our call? **YES / NO**

Alternate number (including area code)

Can we call you at this number? **YES / NO**
Can we leave a message on your voicemail to return our call? **YES / NO**
Can we leave a message on your voicemail stating negative lab results? **YES / NO**
Can we leave a message on your voicemail regarding appointments/prescriptions? **YES / NO**
Can we leave a message with the person answering the phone to return our call? **YES / NO**

Print Patient Name_____DOB:_____

_____

_____

Signature_____ Date_____

Notes_____

It is your responsibility to notify the office in writing of your request to change or update any of the above information

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Shanna Sherman, A.R.N.P.

Name of Patient_____ Patient's DOB:_____

Parent/Guardian:_____

Please Read, Initial and Sign

Procedures:

___ A follow up office visit must be scheduled with your physician and/or ARNP in order to receive the results from your child's procedure. This is necessary so that we can answer any questions you may have regarding the care of your child, and to discuss your child's future treatment. Please allow enough time for results to be completed before scheduling your follow up appointment.

Labs & X-Rays:

___ A follow up office visit must be scheduled with your physician and/or ARNP in order to receive the results of your child's labs or X-rays. This is necessary so that we can answer any questions you may have regarding the care of your child, and to discuss your child's future treatment. Please allow enough time for the results of the labs or X-rays to be completed before scheduling your follow up appointment.

No Show Policy:

___If you do not show for your scheduled procedure and do not call at least 24 hours prior to the procedure, you will be responsible for a $50.00 No Show Fee. This is not covered by your insurance and must be paid prior to your next appointment.

Returned Check Charge:

____If we receive a returned check from your bank due to non-sufficient funds, closed account, etc. you will be charged an administrative fee of $35.00. This fee and any balance due must to be paid prior to your next appointment.

Copay's:

____Copay's are due at the time of service. Patients will be asked to reschedule their appointment if the copay is not collected.

Completion of Forms:

____There is a $25.00 charge for completion of all paperwork, including FMLA, Homebound, short term and long term disability. Payment will be collected at the time the paperwork is received in our office. Paperwork will be completed as quickly as possible, and our office will contact you when it is completed.

I have read the above, and understand and agree to policies.

Signature of Parent or Guardian:_____ Date:_____