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Shannon McClenathan, A.P.R.N.
My Nguyen, A.P.R.N.
Jessica Koehler, A.P.R.N.

Your child, ____, has an appointment with Dr. McClenathan, Dr. Winesett, Dr. Kaiser, Dr. Ignacio, Dr. Wilsey, Dr. Condino, Dr. Irizarry, Dr. Karjoo, Dr. Beltroy, Dr. Marin, Dr. Sidhu, Dr. Rivera, Dr. Law on ________________.
Please arrive at: ______________ at our St. Petersburg, Fletcher, St. Joseph's, Palm Harbor, Lakeland, Sarasota, Brandon, Odessa, Ft. Myers or New Port Richey office.

Please help us to serve you better by keeping your scheduled appointments. 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 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

601 5th Street South, Suite 605 - St. Petersburg, FL 33701
1840 Mease Dr., Suite 204 - Safety Harbor, FL 34695
4040 Sawyer Road - Sarasota, FL 34233
15740 New Hampshire Court, Suite B - Ft. Myers, FL 33908
6331 State Road 54. - New Port Richey, FL 34653

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
14111 State Rd. 54 - Odessa, FL 33556
1305 SE 25th Loop, Suite 103 - Ocala, FL 34471

Main Line (727) 822-4300
www.tummydoctors.com

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

2022 UPDATE

CHILD'S
LAST NAME ______________ FIRST ______________ M.I. ______

NICK NAME ______________ SEX ______ AGE ______ BIRTHDATE ______

ADDRESS ______________ APT ______ CITY ______ ST ____ ZIP ______

PHONE (____) ______________ EMERGENCY CONTACT ______________ PH# ______________

TEXT CONFIRMATION **YES** ☐ (___) ______________

PEDIATRICIAN ______________ CITY ______________ PHONE (____) ______________

MOTHER/
GUARDIAN LAST NAME ______________ FIRST ______________ (MI) ______________ DOB ______

EMPLOYER ______________ WORK PHONE (____) ______________

FATHER/
GUARDIAN LAST NAME ______________ FIRST ______________ (MI) ______________ DOB ______

EMPLOYER ______________ WORK PHONE (____) ______________

PARENT NOT LIVING WITH CHILD NAME: ______________ RELATION ______

ADDRESS ______________ CITY ______________ ST ____ ZIP ______ PHONE (____) ______________

Effective January 1, 2022 all credit card payments are subject to a 3% convenience fee.

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

PREFFERED PHARMACY ______________ PHONE ______________ ADDRESS ______________

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 ______

HAS YOUR CHILD SEEN A GI IN THE PAST ☐ YES ☐ NO IF SO, PLEASE PROVIDE NAME & CITY ______________

****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 reimbursement. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact your carrier to establish why we 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. All past due balances will accrue interest at the rate 1.5 per cent per month, or 18 per cent per annum. In the event your account is sent to a collection attorney, you acknowledge that you will be responsible for all cost of collections, including a reasonable attorney's fee, whether or not suit is file.

****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 plan to : Pediatric Gastroenterology, Hepatology and Nutrition of FL, 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 responsibility. __________ Initial. This authorization will remain in effect until revoked by me in writing.

SIGNATURE: ______________________________ **DATE:** ______________

Patient Name ______________________ Date Of Birth ____________

Reason For The Clinic Visit (What Is The Chief Complaint?) ______________________

____

____

Birth History

Number Of Weeks Of Gestation	Vaginal Or Cesarean Section	Birth Weight

Please describe any complications after birth, NICU stay, etc. ______________________

____

Did your child pass stool (meconium) within 24 hours after birth? **YES** or **NO**

Did your child have prolonged jaundice after birth? **YES** or **NO**

Past Medical History - Diseases Or Conditions

Date Diagnosed (Year At Least)	Disease Or Condition

Comments regarding past medical history ______________________

____

Hospital Admissions

Date (Year At Least)	Facility Name	Reason For Admission

Comments regarding hospital admissions ______________________

____

Patient Name________________________________ Date Of Birth________________

Surgeries

Date (Year At Least)	Type Of Surgery	Hospital Or Outpatient	Surgeon's Name

Comments regarding surgeries____

____

Current Medications - Include Prescription, Over The Counter, Vitamin And Herbal

Date Started	Medication Name	Dosage	Taken How Often	Regularly Or As Needed

Comments regarding medications____

____

Allergies - Medications And Foods

Date Noted	Medication Or Food	Reaction That Occurred

Comments regarding allergies____

____

Patient Name________________________________ Date Of Birth_________________

Family History

Relationship To Patient	Disease Or Condition	Age	Living Or Deceased

(If "YES" To Any Below, Please Include In The Family History Chart Above)

Any family members have **Inflammatory Bowel Disease** (**Crohn's** or **Ulcerative Colitis**)? **YES** or **NO**

Any family members have **Celiac Disease**? **YES** or **NO**

Any family members have **Liver Disease**? **YES** or **NO**

Any family members have **Hirschsprung's Disease**? **YES** or **NO**

Any family members have **Cystic Fibrosis**? **YES** or **NO**

Any family members have **Thyroid Disease**? **YES** or **NO**

Comments regarding family history____

____

Social History

Please list all individuals living in the household with the patient______________________________

____

Does the patient attend daycare or school? **YES** or **NO** What grade?______________________

Has the patient missed days of school due to symptoms? **YES** or **NO** How many days?__________

Please list any family, social and/or school stressors____

____

Please list the patient's favorite activities, sports, extra-curricular interests________________________

____

Please list any pets or animals the patient has contact with____________________________________

____

What type of water does the patient drink? (Circle All That Apply) **City/Tap** **Bottled** **Well**

Any recent travel outside the United States? **YES** or **NO** If so, to where?_____________________

Patient Name________________________ Date Of Birth______________

Review Of Systems

Please indicate whether the patient has had any of the following using the "YES" or "NO" choices.

If a family member has / had any of these conditions, please indicate in the "Relatives" column using the abbreviations M = Mother, F = Father, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather, MU = Maternal Uncle, PU = Paternal Uncle, C = Cousin and O = Other

	YES	NO	Relatives
General			
Weight Loss			
Fever			
Fatigue			
Head and Neck			
Eye Changes			
Wears Glasses			
Nasal Congestion			
Sinus Infections			
Frequent Colds			
Tooth Decay			
Mouth Sores			
Skin			
Rashes			
Itching			
Neurologic			
Headache / Migraines			
Seizures			
Developmental Delay			
Psychiatric			
Anxiety			
Depression / Bipolar			
Mood Changes			
Hematology			
Bruising / Bleeding			
Anemia			
Sickle Cell Anemia			
Thalassemia			

	YES	NO	Relatives
Cardiac			
Murmurs			
High Blood Pressure			
Fainting			
Rhythm Changes			
Gastrointestinal			
Abdominal Pain			
Diarrhea			
Constipation			
Jaundice			
Liver Cirrhosis			
Pancreatitis			
Gallstones / Gallbladder Disease			
Vomiting			
Reflux / Heartburn			
Peptic Ulcer Disease			
Helicobacter pylori			
Irritable Bowel Syndrome			
Polyps			
Lactose Intolerance			
Loss Of Appetite			
Swallowing Problems			
Genitourinary			
Difficulty Urinating			
Blood In Urine			
Urinary Tract Infection			
Bed Wetting			
Abnormal Menstrual Cycles			
Muscles/Joints			
Joint Redness			
Joint Swelling			
Joint Pain			
Muscle Aches			

PATIENT NAME:_________________________________ **DATE OF BIRTH:** ____/____/____

RELEASE OF MEDICAL INFORMATION

I give my permission to release confidential health information to the following people:
These people can also bring this patient to appointments. Biological parents have rights unless proper documentation is presented.

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 disclosed to above named people____

TELEPHONE CONTACT

Primary number (including area code)____

Text confirmations can be sent to ( ) ___________________
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**

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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Jessica Koehler, A.P.R.N.

Name of Patient_______________________________ Patient's DOB:____________________

Parent/Guardian:____

Please Read, Initial and Sign

Procedures:

____ A follow up office visit must be scheduled with our office in order to receive the results form 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. Patients must be present at time of appointment.

Labs & X-Rays:

____ A follow up office visit must be scheduled with our office in order to receive the results form 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-ray to be completed before scheduling your follow up appointment. Patients must be present at time of 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 in not covered by your insurance and must be paid prior to your next appointment. If you No Show your scheduled appointment or call prior to the appointment time you may be responsible for a $25.00 No Show Fee. If you have 3 No Shows you may be discharged from our practice.

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 and Appointments:

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

____Patients must be present at all appointments.

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.

Medical records requested by another physician are free of charge. Medical records requested by a parent or attorney are available for a fee. This could take up to 30 days so please allow.

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

Signature of Parent or Guardian:____________________________ Date:____________________

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My Nguyen, A.P.R.N.
Jessica Koehler, A.P.R.N.

I guardian of: ________________________________ do consent to an examination of the perineum area with or without digital rectal exam with my presence and/or Medical staff as witness in the exam room.

Date:__________________

____

Print Name

____

Signature

____

Provider Signature

601 5th Street South, Suite 605 - St. Petersburg, FL 33701
1840 Mease Dr., Suite 204 - Safety Harbor, FL 34695
4040 Sawyer Road - Sarasota, FL 34233
15740 New Hampshire Court, Suite B - Ft. Myers, FL 33908
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