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

2025 UPDATE

PATIENT INFORMATION

Patient Name: Last ________________________ First_____________________ MI______ D.O.B____________________

Sex: M F Patient lives with: Mother______ Father______ Other______

Primary Doctor/Pediatrician: ____ Phone: ________________________

Referring Doctor: ____ Phone: ________________________

Emergency Contact (if other than parents): _______________________ Relation to Child: ___________ Phone: ___________

Pharmacy Name: ____ Pharmacy Phone: ________________________

Has your child seen a GI previously? Yes______ No______ If so, where: ____

PARENT/LEGAL GUARDIAN INFORMATION

Mother/Guardian: ____ D.O.B __________________

Phone: ____________________________ Email: ____

Address: ____ City: ______________ State: _______ Zip Code: __________

Employer: ___________________________________

Father/Guardian: ____ D.O.B __________________

Phone: ____________________________ Email: ____

Employer: _______________________________________

INSURANCE INFORMATION

Primary Insurance Co. Name: ____ Policy #: ________________________

Member ID#: __________________________ Group#: ________________ Group Name: ____________________

Primary Policy Holder: _____________________________________ Relationship to Patient: __________________________

Primary Policy Holder D.O.B ________________ SS#: _______________________ Phone: _____________________

Address (if different from above): ____

Secondary Insurance Co. Name: ____ Policy #: ________________________

Member ID#: __________________________ Group#: ________________ Group Name: ____________________

Primary Policy Holder: _____________________________________ Relationship to Patient: __________________________

Primary Policy Holder D.O.B ________________ SS#: _______________________ Phone: _____________________

Address (if different from above): ____

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

******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:** ____/____/____

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**

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

******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 been 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 percent per month, or 18 percent 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 filed.

SIGNATURE: ____ **DATE:** ______________________

Daniel T. McClenathan, M.D.
Michele P. Winesett, M.D.
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Shannon McClenathan, A.P.R.N.
Madison Baima, P.A.
Amanda Parker, A.P.R.N.
Samantha Hensley, A.P.R.N.
Amanda Smith, A.P.R.N.
Taylor Carral, 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 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. 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 from 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 is not covered by your insurance and must be paid prior to your next appointment. If you No Show your scheduled appointment or do not 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:____________________

Pediatric Gastroenterology History New Patient Form

Patient name: ________________________________ Date of birth: ____________ □ Male □ Female

Main symptom you would like to discuss today: ____

Symptom length:	□ _______days	□ ______weeks	□ _____months	□______years
Symptom frequency:	□ sometimes	□ daily	□ always	
Most frequent time of day:	□ upon waking □ at night	□ daytime □ random	□ evening	□ after eating
Symptoms interfere with:	□ eating	□ sleeping	□ school activities	
Other treatments:	□ Medications: ____________________ □ Food changes: ____________________ □ Other: ____________________			
Other testing: □ None	□ Blood work	□ Urine studies	□ Stool studies	□ Imaging

Other symptoms in the past year □ NONE

□ Poor appetite	□ Weight loss or lack of weight gain	□ Cough that won't go away
□ Nausea	□ Chronic or unexplained fevers	□ Wheezing
□ Vomiting	□ Low energy or feeling tired	□ Hoarse voice
□ Trouble swallowing	□ Headaches	□ Chest pain
□ Heartburn	□ Lightheadedness	□ Irregular heart beat
□ Abdominal pain	□ Chills or night sweats	□ Wetting or urine (pee) accidents
□ Burping more than usual	□ Red or painful eyes	□ Painful urination
□ Gas or bloating	□ Mouth sores	□ Back pain
□ Diarrhea	□ Achy joints	□ Feeling dizzy
□ Constipation	□ Red or swollen joints	□ Bleeding or a lot of bruising
□ Painful stools (poop)	□ Hair loss	□ Irregular periods
□ Soiling or stool accidents	□ Rash	□ Anxiety or stress
□ Blood in stool	□ Bigger lymph nodes	□ Depression or feeling mood

Tell us about your bowel movements

How often: _________times per day OR every_________days

How do they look: □ hard □ lumpy □ smooth and formed □ soft □ loose □ watery

Food and Nutrition

Food restrictions or allergies:	□ None
If child is under 1 year of age:	□ Breastmilk □ Formula: ____________________ How many ounces per feeding:______________ How many feedings per day: ________________

Current Medications □ NONE

Medication	Amount	How many times per day?

Pediatric Gastroenterology
History New Patient Form

Medication Allergies and Side Effects □ **None**	
Medication	Reaction

Birth History

How was the baby delivered: □ Vaginal □ Caesarean
When was the baby born: □ At term, 38-42 weeks □ Premature, before 37 weeks:__________
What was the baby's weight at birth: ______________
Were there any problems during or after mom gave birth?:___________________________________

Other known health problems □ **None**	

Past Surgeries □ **None**		
Surgery	Date	Hospital and Surgeon

Past Hospital Stays □ **None**		
Reason	Dates	Hospital

Social History

Who lives with the patient? ____
Who cares for the patient during the day? ____
School:__________________________________Grade in school: ________________
How does the patient do in school: □ Above average □ Average □ Below Average
Activities/Hobbies/Sports:____
Pets or animals at home: □ None ____
Do you suspect your child is involved with:
□ Tobacco □ Marijuana □ Sexual Activity
□ Other drugs: ____________________________
Other issues (stresses, divorce, custody, abuse, etc.): ____

Pediatric Gastroenterology
History New Patient Form

Family History

Patient's mother is: □ Alive □ Deceased □ Unknown Occupation: ____________________

Patient's father is: □ Alive □ Deceased □ Unknown Occupation: ____________________

How many brothers does the patient have? ____________

How many sisters does the patient have? ____________

Do any of your family members have any of these conditions?

M = Mother	**F** = Father
S = Sister	**B** = Brother
MGM = Maternal Grandmother	**PGM** = Paternal Grandmother
MGF = Maternal Grandfather	**PGF** = Paternal Grandfather

Condition		Condition	
□ Constipation	____________	□ Rheumatoid Arthritis	____________
□ Irritable Bowel	____________	□ Juvenile Diabetes	____________
□ Lactose Intolerance	____________	□ Lupus	____________
□ Acid Reflux	____________	□ Thyroid disease	____________
□ Stomach Ulcer	____________	□ Psoriasis	____________
□ Celiac Disease	____________	□ Migraines	____________
□ Ulcerative Colitis	____________	□ Seizures	____________
□ Crohn's Disease	____________	□ Depression	____________
□ Gallstones	____________	□ Anxiety	____________
□ Hepatitis B	____________	□ Autism	____________
□ Hepatitis C	____________	□ Eating Disorder	____________
□ Other Liver Disease:	____________	□ Other Mental Illness:	____________
□ Nasal Allergies	____________	□ Adult-Onset Diabetes	____________
□ Asthma	____________	□ Heart Disease	____________
□ Eczema	____________	□ High Blood Pressure	____________
□ Food Allergies	____________	□ High Cholesterol	____________
□ Anemia	____________	□ Colon Polyps	____________
□ Tuberculosis	____________	□ Colon Cancer	____________
□ Problems with Anesthesia	____________	□ Other Cancer:	____________
		□ Cystic Fibrosis:	____________
		□ Hirschsprung's Disease:	____________

Is there anything else we should know about the patient and family?

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____

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Samantha Hensley, A.P.R.N.
Amanda Smith, A.P.R.N.
Taylor Carral, A.P.R.N.

Laboratory Authorization Notification Form

Dear Parents,

Please be advised that Pediatric Gastroenterology, Hepatology, and Nutrition of FL do not know each individual patients insurance coverage for laboratory testing. It is the parent/guardian responsibility to verify benefits for **ALL** lab testing ordered prior to performing these lab services to prevent an unexpected bill. For example, Calprotectin and Stool Pathogen Panel is the two most commonly denied lab testing's; the bills can range from $300.00 to $2500.00 if no authorization is obtained for these labs prior to them being completed, if the insurance requires. Please contact our office if any testing requires authorization so that we can obtain this for you. If authorization is required, please make sure that you allow us 7 business days to obtain the authorization for labs. **DO NOT** get the testing done prior to getting notification of approval as this may result in you receiving a bill. We will need to know the date you are going to get the testing done and which lab you plan on going to for these labs.

*Please note that if a Celiac Panel is ordered, you can **NOT** get this lab done at All Children's as they do send this test to Prometheus; which is an out of network lab for all insurance companies, your lab testing will be denied and you will receive a bill.*

The information you may need for the insurance company on the 2 most commonly denied testing's is:

Fecal Calprotectin CPT 83993	Stool Pathogen Panel:
Quest test code #16796	Quest CPT 87506 & test code #38470
LabCorp test code #123255	LabCorp CPT 0097U & test code #183480

If you need any of this information for all other lab testing's when calling the insurance, please call our office and we will give this information to you!

I understand that this is my responsibility to verify if **ANY** laboratory testing needs prior authorization and that I will be responsible for the bill if authorization is not obtained. I understand that the doctor's office is not liable to do an appeal if I receive a bill.

Patient's Name (print): ______________________________

Parent/Guardian Signature: ____________________ Date: __________

601 5th Street South, Suite C620 - 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
6709 Ridge Road, Suite 202 - Port Richey, FL 34668
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
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