Ana M. Hernandez-Puga. M.D.
9220 SW 72 St. Suite 102
Miami, FL 33173
Phone: 305-275-1700

Patient Medical History

Name:_____Birth Date: _____

Pregnancy History: *please circle if yes*

Took Medications Took other drugs Alcohol Smoking Vaginal infections Urine infections Hypertension
Diabetes Other problems: _____

Birth history: *Circle one:* full term pregnancy Premature birth at_____weeks Adopted- at what age? _____
Has he/she been told he's adopted?_____

What hospital was baby born at?_____Was the delivery vaginal? _____

What was baby's birth weight?_____Length?_____

Did the baby have any problems? If yes, please describe:

_____

Feeding: *(circle one)* breast fed bottle fed both

Past illnesses, surgeries, hospitalizations: *Has your child ever had (please circle)?*

More than 2 ear infections Heart problems Chickenpox Any major illness Kidney/ urinary tract infection

More than 2 strep infections Pneumonia Wheezing/asthma/bronchitis Hepatitis

Broken bones Convulsions Reactions to any immunizations or medications

Has your child ever been hospitalized overnight? Please describe:_____

Has your child ever had surgery? Please describe: _____

Has your child gone to an ER in the last year? Please describe: _____

Does your child have any allergies? Yes or No If yes to what?_____

Does your child have regular dental care? _____

Is your child on medications? Yes or no If yes please list: _____

Family History: *Please circle if close blood relative has the following. If (+) please indicate relation:*

Allergies Cancer Mental health disorder Learning Problems Strokes Tuberculosis

Anemia Convulsions/epilepsy Heart disease before age 50 Mental retardation (ex. down syndrome)

Asthma/bronchitis Cystic Fibrosis High blood pressure Migraines Substance abuse Tay Sachs/ metabolic disease

Birth defects Diabetes Depression Kidney disease Muscular dystrophy Thyroid disease

Other illnesses: _____

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9220 SW 72 ST #102
Miami, FL 33173
Tel: 305-275-1700
Fax:1-888-569-3931

PATIENT INFORMATION

Date: _____

(Please list all children in the family even if the child is not being seen today)

	Child 1	Child 2	Child 3	Child 4	Child 5
Last Name					
First Name					
Middle					
DOB					

PARENTAL INFORMATION

MOTHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language_____
Step Father _____

FATHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language_____
Step Mother _____

Pharmacy Name _____ Address _____ Phone # _____
Who do the children reside with? ☐ Both ☐ Father ☐ Mother ☐ Other _____
Who has legal custody of child/children? ☐ Both ☐ Father ☐ Mother ☐ Other _____
Please provide any applicable legal documents.

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Other _____
Which phone # should we list as your primary contact? _____ Is it ok to leave a message at this #?_____
For patients over the age of 18: What is <u>your</u> preference in communication? _____Is it ok to email you? _____
☐ Phone _____ ☐ Email_____

INSURANCE INFORMATION

PLEASE NOTE: YOU WILL BE ASKED TO PRESENT YOUR INSURANCE CARD AT **<u>EVERY</u> VISIT**

PRIMARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

SECONDARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

EMERGENCY CONTACT (Other than Parent)

Name_____ Relationship _____
Home Phone_____ Cell Phone _____ Work Phone _____

Signature of Parent/Guardian: _____ **Date:** _____

How did you hear about our practice? ☐ Yellow Pages Online ☐ RTP Links ☐ Friend/Family/Neighbor ☐ Other Physician
☐ Online (name of website) _____ ☐ Other _____

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PATIENT'S NAME:_____ DATE OF BIRTH:_____

ACKNOWLEDGEMENT OF HIPAA RIGHTS

_____ I do hereby acknowledge that AnaHP MD LLC has provided me with a notice of the privacy practice, as required by the Federal HIPAA Law. I understand that I will be provided a copy of the Policy, upon my request. I understand the Privacy Practices are posted on www.doctoranahp.com.

_____ I authorize for AnaHP MD LLC to leave medical information on voicemail at the phone numbers listed on my child's account.

RELEASE OF INFORMATION

_____ I authorize the release of any medical information necessary to process a claim

_____ I authorize payment of medical benefits to myself or the named provider of professional services rendered.

PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN

WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN

_____ Yes, my child may be treated with Parent or Guardian

_____ Yes, my child may be treated when accompanied by:

Name	Relationship	Name	Relationship

_____ Yes _____ No My child over 16 years old may present and be treated unaccompanied by an adult.

Signature of Parent or Legal Guardian _____ Date:_____

Ana M. Hernandez-Puga, MD

Notice of Policies

Payment Policy

Please be prepared to present your insurance card and Identification Card at every visit. Ensure that our pediatricians actively participate with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to pay in full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Checks, and Cash.

Patients may receive and are responsible for bills for services sent to another facility such as a laboratory or diagnostic center which may not be covered by the insurance. Patients will be responsible for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan.

We occasionally have parents who are divorced and the court makes one party responsible for all or part of the payments due. We will collect the entire amount due at the time of the visit. We will issue receipts so that one parent can obtain reimbursement from the other.

Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) alone with a $25 late fee. After the second episode of returned check, we will only accept cash or credit card as a form of payment.

Additional Fees

There will be a $10.00 fee for each sheet of Florida Department of Health School Entry Health Exam and Certification of Immunization ("Blue and Yellow" Forms.) WIC forms are $5 each. There are additional forms that may need to be completed such as sports clearance forms, summer camp forms, allergy forms for school, etc. Please note our policy is $10 per sheet completed by nurse or doctor. A copy of medical records released to a patient will have a fee of a $1 per page. Ear piercing performed by the physician will be charged $100.00 with a set of earrings included.

Late/Missed Appointment Policy

We appreciate a 24 hour notice on cancellations. This allows the office time to fill the empty appointment slot with someone else that needs to be seen. Missed appointments that are NOT cancelled the day before the scheduled appointment will incur a fee of $25 or your co-payment, whichever is higher. We will try to accommodate any sick patient who arrives late with the next available open appointment.

Walk-In Policy

We see all patients by appointments and offer same day appointment scheduling. Unless deemed urgent, patients who arrive without an appointment will be given the next available open appointment.

Referral Policy

Many insurance companies require authorization through your pediatrician before seeing a specialist. This process can take up to 5 business days to complete. If your pediatrician believes your child should see a specialist, call the specialist, confirm the doctor is on your insurance plan, and make an appointment. Call our office back with the name of the specialist, the appointment date, and time. Allow 3-5 business days for the completion of your referral.

Prescription Refill Policy

Prescription refill requests should be phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, medication name, dose, pharmacy name, pharmacy address and phone number. Allow up to 3 business days for us to prepare the prescription. Certain chronic and recurrent conditions may require a visit for re-evaluation before a refill is provided. We do not call in or refill antibiotics or oral steroids without having seen the patient first.

Thank you for understanding our policies. Please let us know if you have any questions.

I have received and read a copy of Ana M. Hernandez-Puga, MD's Policies and agree to abide by them:

_____ / _____

Signature of Responsible Party Date

ANA HP MD , LLC
Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by ANA HPMD, LLC ("**Practice**"), and the Practice's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion of medical intake forms;
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications;
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider;
- Two-way interactive audio-video interaction between you and your Provider;
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files;
- Delivery of a consultation report; and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 8 hours a day, 5 days a week, during regular business hours.
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling the office to schedule an appointment.
- More efficient care evaluation and management.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT ANA HPMD, LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 305-275-1700.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

Patient Acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.

2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.

4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.

5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.

6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.

8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

9. I understand I have the right to object to the videotaping of the telehealth consultation.

10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason

if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.

11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.

13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.

14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.

15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

□ **ACCEPT**. By checking the Box for this "**TELEHEALTH INFORMED CONSENT**" I hereby state that I have read, understood, and agree to the terms of this document. [Note – Box should not be pre-checked.]

PATIENT'S NAME:

PATIENT'S SIGNATURE:

DATE:

If signing on behalf of a minor:

PARENT/LEGAL GUARDIAN'S NAME:

PARENT/LEGAL GUARDIAN'S SIGNATURE:

DATE: