Pediatric Gastroenterology & Nutrition of Tampa Bay

Thiru S. Arasu, M.D. Rosa J. Cuenca, M.D.
Shivinder Narwal, M.D.
Pediatric Gastroenterologist

3003 W. Dr. Martin Luther King Jr. Blvd.
Tampa, Florida 33607

Tampa Phone: (813) 870-4438 Fax: (813) 870-4153
Brandon Phone: (813) 324-2613 Fax: (813) 324-2614

*Kristin Phillips, A.R.N.P. * Melissa Berner, A.R.N.P.* Julianna Osborne, A.R.N.P.* Kelly Terranova, P.A.*

PATIENT INFORMATION

Patient Name:	Gender: ☐ Female ☐ Male	DOB: ____/____/____
Patient Address:	SS#:	
	Race: ☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Declined	
	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined	
Phone 1: ( ) ☐ Home ☐ Grandparent ☐ Mom Cell ☐ Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other: _____	Preferred Language:	
Phone 2: ( ) ☐ Home ☐ Grandparent ☐ Mom Cell ☐ Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other: _____	E-mail address:	

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

First Guarantor/Guardian :	Relationship to Patient:	
Address: ☐ Check if same as patient	Second Guarantor/Guardian :	
	Relationship to Patient:	Social Security #:
Home Phone: ( )	Other Phone: ( )	
Social Security #: / Date of Birth:	Date of Birth:	
Employer:	Employer:	
Work: ( ) Extension:	Work: ( ) Extension:	

PRIMARY CARE PHYSICIAN

Physician Name:	State:	Zip:
Address:	City:	
Is this the referring Physician? ☐ YES ☐ NO	Phone #:	Fax#:

If No, please list the Referring M.D.:

Pharmacy Name & Address:	Pharmacy Phone: ( )

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insured Person:	Insured Person:
Insured DOB:	Insured DOB:
Insured SS#:	Insured SS#:

I hearby authorize Thirus S. Arasu, MD, PA/dba Pediatric Gastroenterology & Nutrition of Tampa Bay to treat the patient listed above. I hearby authorize payment directly to the above name physicians of the amount due me in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I authorize any physician, hospital or clinic to provide full detail of my or my dependent medical history and treatment to the above names physician group. In addition, I authorize the physician group listed above to release any information necessary to assist the medical treatment and/or insurance payment.

X	
Signature of Parent / Guardian / Responsible Party	**Date Signed**

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PATIENT:_____ ***DOB:*** _____

PARENT/GUARDIAN: _____

CO-PAY'S & OUTSTANDING BALANCES:
Co-pays are due at the time of service. This is your responsibility due from you according to your insurance plan and is to be collected at the time of visit. Outstanding Balances need to be paid in full unless you have an active payment plan with our billing department.

LABS & X-RAYS:
We require all patients to follow up with our physicians and/or Nurse Practitioners to receive results of any labs or X-rays. This is necessary so that our physicians can answer any questions you may have regarding the care of your child as well as discuss any future plan and/or treatment options with you. When we order labs and/or X-rays, please have them completed in enough time prior to your next visit. We suggest 1 week before your next appointment.

NO SHOW POLICY:
If you have an appointment with our office and are unable to attend, you must give our office 24-hour notice so that we may give the appointment to another needy child. In the event that 24-hour notice cannot be given, please give our office a call as soon as possible.

If we do not receive a call within 24 hours prior to your scheduled appointment, you will be responsible for a $25.00 No Show Fee. If you had a procedure scheduled and do not call 24-hours prior to the procedure, you will be responsible for a $50.00 No Show Fee for the procedure. These are not covered by your insurance and must be paid before the next visit. After the third missed appointment, we will no longer be able to offer medical care for your child.

RETURNED CHECK CHARGE:
If we receive a returned check from your bank due to non-sufficient funds, account closed, etc. you will be charged an administrative fee of $35.00. This fee and any balance due will need to be paid by you prior to your next appointment. Please note that this is not covered by your insurance.

COLLECTIONS ON ACCOUNTS:
If your account is placed with a collection agency due to non-payment for any guarantor balances, you will be responsible for any costs associated with these collection efforts. Possible cost could include collection percentage for outside company fees and attorney/court fees that may apply. It is important that you communicate with our billing department if payment arrangements need to be made.

COMPLETION OF FORMS:
Please note that there is a $25.00 minimum charge for the completion of all paperwork, including FMLA, Homebound, short term and long term disability paperwork. Payment will be collected at the time paperwork is received in our office. Paperwork will be completed as quickly as possible, and our office will call you when it is completed. FLMA, Short Term, Long Term Disability paperwork $35.00, Homebound paperwork $25.00.

MEDICATION HISTORY: (Check Box for Consent to obtain Medicine History)
□ **Yes** □ **No** For your child's safety, we are able to view your child's medication history electronically from your pharmacy. This will allow us to view any interactions between medications we prescribe and other medications that your child is currently on.

PHOTO'S OF PATIENTS: (Check Box for Consent of photo)
□ **Yes** □ **No** I give permission to Pediatric Gastroenterology & Nutrition of Tampa Bay to photograph the patient to their system.

Print Name: _____ **Signature:**_____ **Date:** _____

******By signing I acknowledge that I have read and understand the policies set by the practice.******

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Patient Name: _____ **DOB:**_____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. However, we are not obligated to alter internal policies to conform to your requests.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation): *Note: Biological Parents have rights unless documentation is presented stating otherwise.*

Name_____ Relation:_____ Phone: _____

Name_____ Relation:_____ Phone: _____

Name_____ Relation:_____ Phone: _____

Parent/Guardian printed name:_____**Relation to Patient:**_____

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