NEW PATIENT INFORMATION

Patient's Name :_____Age:_____Sex:_____
Patient's S/S # :_____Birthdate:_____
Address :_____City:_____State:_____
Zip Code: _____Home Phone:_____Primary Language:_____
Pharmacy Name: _____Pharmacy phone:_____

FATHERS'S INFORMATION

Father's Name:_____ Birthdate:_____
S/S #:_____DL # :_____State:_____
Address:_____City:_____State:_____Zip:_____
Home Phone :_____Cell:_____Does your
phone accept text messages (Yes / No) E- mail_____
Place of employment:_____Occupation:_____
Work Phone :_____

MOTHER'S INFORMATION

Mother's Name:_____Birthdate:_____
S/S #:_____DL # :_____State:_____
Address:_____City:_____State:_____Zip:_____
Home Phone :_____Cell:_____Does your
phone accept text messages (Yes / No) E- mail_____
Place of employment:_____Occupation:_____
Work Phone :_____

INSURANCE INFORMATION

Name of Insurance company:_____
Name of Policy Holder: (Mom or Dad) _____Birthdate:_____
Insurance ID #:_____Group #: _____
Is Insurance PPO___ HMO___ Other____ Copay____

EMERGENCY INFORMATION

In case of an emergency whom should we contact?
Name:_____Relationship:_____Phone:_____
Who other than parents will bring child to the doctor?
(This will only be for Sick visits... well visits parents must be present)
Name :_____ DL #:_____
Name :_____ DL #:_____

A PARENT, LEGAL GUARDIAN OR ABOVE NAMED ADULT MUST BE PRESENT AT TIME OF VISIT. NO CHILD EVEN 18 YEARS OLD WILL BE SEEN ALONE. AS A FORM OF PAYMENT WE ACCEPT CASH AND CREDIT CARDS ONLY. PLEASE SIGN ACKNOWLEDGING ABOVE INFORMATION.

SIGNATURE:_____ DATE:_____

Wellington Pediatrics
Simo & Bruck MDS, LLC
Michael L. Bruck, M.D. F.A.A.P.
Amy Z Aqua, M.D. F.A.A.P.
10115 W. Forest Hill Blvd., Suite 402
Wellington, Fl. 33414
Ph: 561-791-1935 Fax: 561-791-0115

FINANCIAL POLICY

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have questions.

1. All patients must complete this form prior to being seen by the Doctor
2. FULL PAYMENT IS DUE AT THE TIME OF THE SERVICES unless other arrangements have been previously approved by the office manager.
3. We accept cash, Master card, Visa, Discover and American Express.
4. AN ADULT MUST ALWAYS ACCOMPANY MINORS. The adult accompanying a minor is responsible for full payment at the time of the visit.
5. IF YOUR INSURANCE COMPANY HAS NOT PAID THE FULL BALANCE WITHIN 90 DAYS OF THE VISIT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF UNPAID CLAIMS.
6. Returned check fee $36.00
7. A 24 hour notice is required on ALL re-scheduled or canceled appointments. A $10 fee will be charged for a missed appointment during normal hours a $20 fee will be charged for a missed appointment after hours. A $40 fee will be charged for any missed ADD/ADHD appointment.
8. We charge $5.00 for any type of "medical necessity letter" or any type of medical form that needs to be filled out.
9. Release of Medical records, we will release your child's medical records to your new physician at no charge. If you would like the medical records there is a fee of $1.00 per page up to 25 pages and 0.25 per page thereafter .
10. Please note that if you schedule your appointment after 5:00 pm, this is considered an after-hours appointment and there might be an extra charge assessed to your claim of that day for sick office visits or follow up appointments only. Some insurance plans cover this and some don't.
    THIS OFFICE WILL NEED A MINIMUN OF A T LEAST 48 HOURS FOR THE RELEASE OF ANY FORMS OR MEDICAL RECORDS TO BE SENT TO A DOCTORS OFFICE OR TO THE PARENTS.

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

Wellington Pediatrics
Simo & Bruck MDS, LLC
Michael L. Bruck, M.D. F.A.A.P.
Amy Z Aqua, M.D. F.A.A.P.
10115 W. Forest Hill Blvd., Suite 402
Wellington, Florida. 33414
Ph: 561-791-1935 Fax: 561-791-0115

CONSENT FOR MEDICAL TREATMENT AND MEDICAL RELEASE OF A MINOR

We/I, the undersigned parent(s) legal guardian (s) of_____ a minor child, do hereby consent to physical examination and care of said minor as deemed medically necessary by SIMO AND BRUCK MDS, LLC.

In the event of an emergency or non –emergency situation requiring medical treatment, I_____, hereby grant permission for any and all medical attention to be administered to my child/children, in the event of accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, the release of Patient Health Information and the administration of anesthesia, under the recommendation of qualified medical personnel.

I, _____, herby certify that my primary insurance company is: _____ and my secondary insurance is:_____ . I authorize SIMO AND BRUCKMDS, LLC to release information to my insurance.

Notice of Privacy Practices
Simo & Bruck, MDs, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the pediatric care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Angel Larrinaga
10115 W. Forest Hill Blvd., Suite 402
Wellington, FL 33414
Office: (561) 791-1935
Fax: (561) 791-0115

Aviso De Prácticas De Privacidad
Simo & Bruck, MDs, LLC

ESTE AVISO DESCRIBE CÓMO LA INFORMACIÓN MÉDICA SOBRE USTED PUEDE USAR Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR, LÉALA CON ATENCIÓN.

Cómo podemos usar y divulgar su información médica: Se describe como sigue es las maneras en que podemos usar y divulgar información de salud que le identifica a usted (información de salud). Excepto para los siguientes propósitos, vamos a utilizar y divulgar su información médica sólo con su permiso por escrito. Usted puede revocar tal autorización en cualquier momento por escrito a nuestra práctica.

Tratamiento:
Podemos usar y divulgar su información médica para su tratamiento y para proporcionarle los servicios de salud relacionados con el tratamiento. Por ejemplo, podemos divulgar información médica a doctores, enfermeras, técnicos y otro personal, incluyendo personas fuera de nuestra oficina, que participan en su atención médica y necesitan la información para proporcionarle atención médica.

Pago:
Podemos usar y divulgar su información médica para que nosotros u otros podemos facturar y recibir pago de usted, una compañía de seguros o un tercero para el tratamiento y los servicios que recibió. Por ejemplo, podemos dar su información de plan de salud para que pagarán por su tratamiento.

Operaciones de atención médicos:
Podemos utilizar y divulgar información médica para fines de atención médica de la operación. Estos usos y divulgaciones son necesarios para asegurarse de que todos nuestros pacientes reciban atención de calidad y para operar y administrar nuestra oficina. Por ejemplo, podemos utilizar y divulgar información para asegurarse de que el cuidado pediátrico que recibe es de la más alta calidad. También podemos compartir información con otras entidades que tienen una relación con usted (por ejemplo, su plan de salud) para sus actividades de atención médica de la operación.

Recordatorios de citas, salud y alternativas de tratamiento, beneficios y servicios relacionados. Podemos utilizar y divulgar información médica para contactarle y recordarle que usted tiene una cita con nosotros. También podemos usar y divulgar información médica para informarle sobre alternativas de tratamiento o beneficios relacionados con la salud y servicios que puedan ser de su interés.

Individuos involucrados en su cuidado o el pago de su atención. Cuando sea apropiado, podemos compartir información médica con una persona que participa en su atención médica o el pago de su atención, como su familia o un amigo cercano. También podemos notificar a su familia sobre su ubicación o condición general o divulgar dicha información a una entidad en un esfuerzo de alivio de desastre.

Investigación. Bajo ciertas circunstancias, podemos usar y divulgar información médica para la investigación. Por ejemplo, un proyecto de investigación puede involucrar comparar la salud de los pacientes que recibieron un tratamiento a aquellos que recibieron otro, para la misma condición. Antes de que usemos o divulguemos información médica para la investigación, el proyecto pasará por un proceso de aprobación especial. Incluso sin autorización especial, podemos permitir los investigadores registros para ayudarles a identificar a los pacientes que pueden incluirse en su proyecto de investigación o para otros propósitos similares, siempre y cuando no retire ni tomar una copia de cualquier información de salud.

Las actividades de recaudación de fondos. Podemos utilizar o divulgar su información médica protegida, según sea necesario, para poder ubicarte para actividades de recaudación de fondos. Usted tiene el derecho de optar por no recibir comunicaciones de recaudación de fondos. (Opcional) Si no quieres recibir estos materiales, por favor envíe una solicitud por escrito al oficial de privacidad.

SITUACIONES ESPECIALES:
Requeridas por la ley. Divulgaremos información de salud cuando así lo requiere la ley internacional, federal, estatal o local.

Para evitar una amenaza grave para la salud o seguridad. Podemos usar y divulgar su información médica cuando sea necesario para prevenir una amenaza grave a su salud y seguridad o la salud y seguridad del público u otra persona. Revelaciones, sin embargo, se hará sólo a alguien que puede ayudar a prevenir la amenaza.

Asociados de negocios. Podemos divulgar información médica a nuestros asociados de negocios que realizan funciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para dichas funciones o servicios. Por ejemplo, podemos utilizar otra compañía para realizar la facturación de servicios en nuestro nombre. Todos nuestros asociados de negocios están obligados a proteger la privacidad de su información y no se les permite usar o divulgar cualquier información que como se especifica en el contrato.

Violación de datos con fines de notificación. Podemos utilizar su información de contacto para proporcionar avisos requeridos legalmente de adquisición no autorizada, el acceso o la divulgación de su información médica. Podemos enviar aviso directamente a usted o notificar al patrocinador de su plan a través del cual recibe cobertura.

Donación de órganos y tejido. Si usted es un donante de órganos, podemos utilizar o divulgar información de salud a organizaciones que manejan la adquisición de órganos u otras entidades que participan en licitaciones; banca o transporte de órganos, ojos o tejidos para facilitar de órganos, ojos o tejidos donación; y trasplante.

Militares y veteranos. Si usted es un miembro de las fuerzas armadas, podemos divulgar información médica según lo requerido por las autoridades de comando militar. También podemos divulgar información médica a la autoridad militar extranjera correspondiente si eres un miembro de un ejército extranjero.

Compensación. Podemos divulgar información de salud para la compensación de trabajadores o programas similares. Estos programas proporcionan beneficios por accidente de trabajo o enfermedad.

Salud pública riesgos. Podemos divulgar información médica para actividades de salud pública. Estas actividades generalmente incluyen revelaciones para prevenir o controlar enfermedades, lesiones o incapacidades; nacimientos de informe y muertes; abuso de informe o negligencia; reacciones de informe a medicamentos o problemas con productos; notificar a las personas retiradas de productos que pueden estar usando; una persona que han estado expuesta a una enfermedad o puede estar en riesgo de contraer o propagar una enfermedad o condición; y la autoridad de gobierno apropiada si creamos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Solamente haremos esta divulgación si usted está de acuerdo o cuando lo requiera o autorice la ley.

SUS DERECHOS:
Usted tiene los siguientes derechos con respecto a la información médica que tenemos sobre usted:

Acceso a registros electrónicos. La tecnología de la información de salud para la salud económica y clínica. Ley de alta tecnología permite a las personas para pedir copias *electrónicas* de su PHI contenida en registros electrónicos de salud o solicitar por escrito o electrónicamente otra persona reciba una copia electrónica de estos registros. Las reglas finales de ómnibus amplían el derecho de una persona para acceder a los registros electrónicos o dirigir que ser enviado a otra persona para incluir no sólo registros electrónicos de salud sino también todos los registros en uno o más conjuntos de registros designados. Si la persona solicita una copia electrónica, deben ser proporcionado en el formato solicitado o en un formato de acuerdo mutuo. Entidades cubiertas pueden cobrar a individuos por el costo de cualquier medio electrónico (como una unidad flash USB) utilizado para proporcionar una copia de la PHI de la electrónica.

Derecho a inspeccionar y copiar. Usted tiene el derecho de inspeccionar y copiar información de salud que pueden utilizarse para tomar decisiones sobre su cuidado o el pago de su atención. Esto incluye registros médicos y de facturación, excepto las notas de psicoterapia. Para inspeccionar y copiar esta información de salud, debe hacer su petición, por escrito.

Derecho a enmendar. Si usted cree que la información de salud que tenemos es incorrecta o incompleta, puede pedirnos que enmendemos la información. Usted tiene el derecho de pedir una enmienda mientras la información se mantiene por o para nuestra oficina. Para solicitar una enmienda, usted debe hacer su petición, por escrito.

Derecho a una contabilidad de accesos. Usted tiene el derecho de solicitar una lista de ciertas revelaciones que hicimos de información médica para fines que no sean de tratamiento, pago y operaciones de atención médica o que proporcionaste autorización por escrito. Para solicitar una contabilidad de accesos, usted debe hacer su petición, por escrito.

Derecho a solicitar restricciones. Usted tiene el derecho a solicitar una restricción o limitación en la información médica que utilizamos o revelamos para tratamiento, pago u operaciones de atención médica. Usted también tiene derecho a solicitar un límite en la información de salud que divulguemos a alguien involucrado en su cuidado o el pago de su atención, como un familiar o amigo. Por ejemplo, usted puede pedir que no compartamos información sobre un determinado diagnóstico o tratamiento con su cónyuge. Para solicitar una restricción, usted debe hacer su petición, por escrito.

No estamos obligados á aceptar su petición. Si estamos de acuerdo, cumpliremos con su petición a menos que la información es necesaria para proporcionarle tratamiento de emergencia.

Derecho a la comunicación mediante solicitud confidencial. Usted tiene el derecho a solicitar que nos comuniquemos con usted acerca de asuntos médicos de una cierta manera o en cierto lugar. Por ejemplo, usted puede solicitar que sólo te contactamos por correo o en el trabajo. Para solicitar comunicación confidencial, usted debe hacer su petición, por escrito. Su petición debe especificar cómo o dónde desea ser contactado. Acomodamos las peticiones razonables.

Derecho a una copia impresa de esta notificación. Usted tiene el derecho a una copia impresa de esta notificación. Usted puede pedimos que le dará una copia de este aviso en cualquier momento.

CAMBIOS A ESTE AVISO:
Nos reservamos el derecho de cambiar este aviso a la nueva notificación se aplica a la información de salud que ya tenemos así como cualquier información que recibamos en el futuro.
Publicaremos una copia de nuestra notificación actual en nuestra oficina. La notificación contendrá la fecha de vigencia en la primera página, en la esquina superior derecha.

QUEJAS:
Si usted cree que sus derechos de privacidad han sido violados, puede presentar una queja con nuestra oficina o con el Secretario del Departamento de salud y servicios humanos. Todas las quejas deben hacerse por escrito.
Usted no será penalizado por presentar una queja.

Por favor firmar el "Reconocimiento"

Angel Larrinaga
10115 W. Forest Hill Blvd., Suite 402
Wellington, FL. 33414
Oficina: (561) 791-1935
Fax: (561) 791-0115

Wellington Pediatrics
Simo & Bruck MDS, LLC
Michael L. Bruck, M.D. F.A.A.P.
Amy Z Aqua, M.D. F.A.A.P.
10115 W. Forest Hill Blvd., Suite 402
Wellington, Fl. 33414
Ph: 561-791-1935 Fax: 561-791-0115

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name of Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

_____

(Practice Name)

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

Wellington Pediatrics
Simo & Bruck MDS, LLC
Michael L. Bruck, M.D. F.A.A.P.
Amy Z Aqua, M.D. F.A.A.P.
10115 W. Forest Hill Blvd., Suite 402
Wellington, Fl. 33414
Ph: 561-791-1935 Fax: 561-791-0115

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

Re: _____ **DOB:** _____

PLEASE SEND COPIES OF THE ABOVE NAMED PATIENT'S MEDICAL CHART.

Parent's Signature: _____ **Date:** _____

Witness's Signature: _____ **Date:** _____

Wellington Pediatrics
Simo & Bruck MDS, LLC
Michael L. Bruck, M.D. F.A.A.P.
Amy Z Aqua, M.D. F.A.A.P.
10115 W. Forest Hill Blvd., Suite 402
Wellington, Fl. 33414
Ph: 561-791-1935 Fax: 561-791-1935

MEDICINE REFILL POLICY

- Please call during office hours and leave a message for the nurse or send us a message via the patient portal. She will get approval from Doctor and the refill will be called in to the Pharmacy, if appropriate.
- Absolutely no refills on antibiotics.

AFTER HOURS POLICY

- 24 Hours Nurse triage by Nurse response:
  If concerned about child when we are closed call our office number and our answering service will connect you with our Nurse Triage for advice. You can always speak with the Physician if you are not satisfied with the Nurse Triage by asking service.
- If the Nurse Triage or Physician recommends child to be seen before office reopens, please go to one of the facilities listed below: Pediatrics AfterHours Clinic on Lantana & Jog road
  Palms West Hospital Children's ER on Southern Blvd

PLEASE DO NOT GO TO RETAIL CLINICS OR ADULT URGENT CARE CENTERS

Please sign below acknowledging understanding.

Thank You

Signature:_____

Date:_____

ARBITRATION AGREEMENT RELATED TO MEDICAL CARE, TREATMENT & ALL DISPUTES

The patient and undersigned Medial Care Provider ("MCP") – which includes any affiliated physicians, employees, any related medical group , professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree ti submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to pas, present or future medical care. Any dispute will go to binding arbitration.

BY SIGING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACY BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT OT A TRIAL BY JURY , OR BY A JUDGE.

The patient and/ or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way relates to medical services shall without exception be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy, it is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. All issues regarding the validity, enforceability and scope of this Agreement or any part of it shall also be subject to arbitration. If either party challenges the validity of this Agreement in court, the prevailing party shall be entitled to attorney's fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound as the Patient is to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other dispute. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this agreement are giving up their constitutional right to have any dispute decided in a court of law before a jury. All parties understand that they are giving up the right to have a dispute decided by a judge or jury through the court system. Resort to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against another physician, nurse or medical professional, or hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of MCP.

The signers agree that the maximum total amount of all non-economic damages combined shall never exceed $250,000, applied on *a per case* basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named defendants in the binding arbitration or in any other proceedings. Non-economic means damages for pain and suffering, disfigurement, embarrassment and anything else not are representing loss of past or future earning, medial or other costs. The arbitrators may choose to award damages in excess of $250,000 only when extreme hardship is demonstrated. As consideration for the limitation on any awards, the MCP will pay up to and only the first $2,500 of attorney fees for the Patient. The parties agree that is any punitive damages are awarded; they may not exceed three times any compensatory award. Save as required by Medicare/ Medicaid, the parties agree that any awards in the excess of $10,000 shall be paid in equal annual payments over 10 years without being reduced to present value. The arbitrators may reduce the time period in case of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable , and governmental benefits, and other monies paid to the injured patient or any other party) which shall diminish ay awards for non-economic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate tin any way to the claims of the Patient against the MCP . The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Statute of Limitations: In no case shall the statute of limitations exceed 12 months from the date any alleged injury or problem could or should have discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. **Severability:** If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The parties agree I general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury. **Timing:** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement/ Merger Clause:** This agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained withi

this agreement. All parties acknowledge and understand that this agreement cannot be changed, altered or modified in any way except by an instrument I writing, signed by all parties. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This agreement, its substantive provisions, the scope pf the Agreement,, the authority granted to the arbitrators and the limitations contained in this Agreement., are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/ medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the others chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by videoconference: the MCP will provide equipment and pay all costs of videoconference bridging and of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney. Save the first $2,500 as indicated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The agreement will then be rescinded for all future care, but you agree it will be valid for any and all are provided by the MCP to the patient for the entire period of all medial services up to rescission .**Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document and his/ her own behalf (if signed by the Patient), on behalf of the Patient (if signed by a person or persons other than the Patient).**No Undue Influence:** The individual signing this Agreement hereby acknowledge that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under any duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non –economic damages, including loss of wages or other compensation damage to reputation, full attorney's fees and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any Arbitration hearing: A qualified professional mediator with medico-legal background shall be mutually agreed upon.

BY SINGING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence, paragraph or provision may be crossed out, excised or removed.

To be completed by the Patient, Parent, or Authorized representative

Name of Patient_____

Your Relationship to Patient (check One): **( ) Mother**
( ) Father
( ) Other) Please specify)

_____

SIGNATURE of Patient , Parent, or Authorized Representative of Patient

MEDICAL CARE PROVIDER"S CONSENT TO ARBITRATION: In consideration of the execution of this Binding Arbitration Agreement, the undersigned, as legal representative of the Medical Care Provider, hereby agrees to be bound by all the terms set forth above.

MD

SIGNATURE of Medical Care Provider- Michael Bruck M.D., Individually and on behalf of Simo And Bruck MDS, LLC