Children's Urology Associates
an affiliate of MEDNAX

CHILDREN'S UROLOGY ASSOCIATES, PA
PATIENT PORTAL CONSENT FORM

By signing below, I authorize Children's Urology Associates, PA, to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be available to me. I understand that I have the right to receive a completed copy of this consent.

PATIENT NAME: _____
Last Name Middle First Name Date of Birth

ADDRESS: _____
Street City State Zip

PLEASE CLEARLY PRINT THE EMAIL ADDRESS AUTHORIZED TO RECEIVE THE EMAIL INVITATION:

- _____

COMPLETE THE FOLLOWING IF THE EMAIL ADDRESS DOES NOT BELONG TO THE PATIENT:

Recipient: _____
Last Name Middle First Name

_____
Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records that may contain information related to the testing, diagnosis or treatment for conditions including, but not limited to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by Florida Law. This consent will remain in effect unless I deactivate my account or written notice is provided Children's Urology Associates, PA.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment, payment for my treatment enrollment in a health plan, or eligibility for benefits. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

_____ YES I do wish to access my medical information and give my expressed consent for Children's Urology Associates, PA, to make my medical information available to me.

_____ NO I chose not to participate in Patient Portal.

PATIENT OR REPRESENTATIVE SIGNATURE:

_____
Signature

_____
Print Name

CHILDREN'S UROLOGY ASSOCIATES, PA:

_____
Signature

_____
Print Name

*Relationship to patient *Legal authority must be verified when an individual is signed on behalf of the patient

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize this practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS:

- _____
- _____
- _____
- _____

__ YES __ NO The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The Practice staff have my permission to leave messages concerning treatment (i.e., lab results) on my: (Please check all that apply)

__ Home Voice Mail or Answering Machine — Home Phone number: _____
__ Cell Phone — Cell Phone number: _____
__ Work Voice Mail — Work Phone number: _____

__ NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders) to the number(s) that I have provided.

_____ Print Name of Patient

_____ *Print name of Authorized Representative

_____ Patient/Authorized Representative Signature

_____ Date Signed

Authorized Representative's authority* to act on the patient behalf:

- Parent/legal guardian
- Power of Attorney

*Evidence of authority must be provided and on file with the practice.

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about 1) The privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal Regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or out privacy practices, please send an electronic message (e-mail) to privacy_office@mednax.com or a letter to:

PRIVACY OFFICER
MEDNAX SERVICES, INC.
1301 CONCORD TERRACE
SUNRISE, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient or Authorized Representative

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CONFIDENTIAL PATIENT HISTORY FORM
PLEASE ANSWER ALL QUESTION

NAME: _____ DATE OF BIRTH: _____ AGE: _____ MALE/FEMALE: _____
Preferred Language: _____ Ethnicity: Hispanic/Latino Non-Hispanic Latino
Race: African American __ Asian __ Caucasian __ Pacific Islander __ Native American __ American __

REFERRING PROVIDER: _____
Name Phone/Fax Number Address
PHARMACY: _____
Name Phone/Fax Number Address

REASON FOR TODAY'S VISIT: _____

Birth History:	NO	YES	If YES, please provide details here:	
Premature?				Birth Wt: lbs. oz.
C-Section?				
Delivery complications?				

Past Medical History:	NO	YES	If YES, please provide details here:
Allergies to medication?			
Taking medications?			
Health problems?			
Previous surgeries?			
Previous hospitalizations?			
Immunizations up to date?			
Developmental issues?			

SOCIAL HISTORY:
Members of patient's household: PARENT SIBLINGS GRANDPARENTS
Child Adopted/Foster: YES NO

FAMILY HISTORY: If YES, please indicate the family member's relationship to the patient.
Urinary reflux: _____ Renal Cysts: _____
Bedwetting: _____ Blood in Urine: _____
Kidney Stones: _____ Renal Failure: _____
Bleeding Disorders: _____ Undescended Testicles: _____

REVIEW OF SYSTEMS: Has your child experienced or been treated for any of the following? (Circle all that apply)
If none apply, please mark N/A next to each category.

GENERAL	**CARDIOVASCULAR**	**RESPIRATORY**	**GASTROINTESTINAL**
N/A	N/A	N/A	N/A
Chills	Chest Pain	Apnea	Abdominal Pain
Excessive wt. loss/wt. gain	Cyanosis	Asthma	Constipation
Malaise	Heart Murmur	Bronchitis	GI Reflux
Unexplained Fevers	Palpitations	Cough	Nausea
	Syncope	Croup	Stool Accidents
		Wheezing	Vomiting

PLEASE CONTINUE TO NEXT PAGE FOR ADDITIONAL REVIEW OF SYSTEMS

EAR, NOSE & THROAT	**ALLERGIES**	**ENDOCRINE**	**GENITOURINARY**
N/A	N/A	N/A	N/A
Ear Infections	Food/Drug Allergies	Diabetes	Bedwetting
Sinusitis/Strep Throat	Mononucleosis	Excessive Thirst	Blood in Urine
		Growth Delay	Daytime Accidents
		Precocious Puberty	Hydronephrosis
EYES	**INTEGUMENTARY**	**MUSCYLOSKELETAL**	Kidney Stones
N/A	N/A	N/A	Labial Adhesions
Contacts	Eczema	Back Pain	Painful Urination
Glasses	Psoriasis	Fracture/Broken Bone	Penile Infection
Pain	Rash	Joint Pain/Swelling	Swollen Testicles
		Muscle Pain	Testicular Pain
HEMOTOLOGIC/ LYMPHATIC	**NEUROLOGIC**	**PSYCHOLOGIC**	Undescended Testicles
N/A	N/A	N/A	Urinary Frequency
Anemia	Epilepsy	ADHD	Urinary Urgency
Blood Clotting Problem	Febrile Seizures	Anxiety	UTI
Bruising	Gait Problems	Depression	Vesicoureteral Reflux
Petechiae	Migraines	Substance Abuse	Injury to Genitals

OTHER ISSUES NOT LISTED ABOVE:

_____

_____

_____

HOW WELL DO YOU SPEAK ENGLISH? ____ VERY WELL ___ NOT WELL ___ NOT AT ALL

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CONSENT FOR PELVIC EXAMINATION

PATIENT NAME: _____ DATE OF BIRTH: _____

As written in Florida Statue 456.51 a Pelvic Examination requires an informed consent.

According to the Statues a Pelvic Examination is defined as "the series of tasks that comprise an examination of the internal and external, male or female genitalia or rectum, using a combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation." For the purpose of this consent, instrumentation includes vaginal speculum and/or catheterization.

A pelvic examination may be performed by the Nurse Practitioner (ARNP) _____, Physician Assistant _____ and/or Medical Doctor _____ who will be seeing your child today.

Potential risks of a pelvic exam may include (but are not limited to) pain or discomfort. There are a few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set or risks. If you have concerns, you should discuss with your healthcare provider.

I hereby give Pediatrix Medical Group, Children's Urology Associates, the permission to perform a clinically indicated "Pelvic Examination".

1. The purpose, procedure, risks involved and possible alternative methods of treatment have been explained to me. I also understand that the information given to me does not list every possible risk and that other, less likely problems could occur.
2. I understand I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the Physician, Nurse, or sonographer if I am having any discomfort and/or unusual symptoms during the procedure.
4. I have read this consent form and understand its terms, and I am signing it knowingly and voluntarily.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

NAME: _____ DATE: _____

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COVID-19 SCREENING

The safety of our patients and staff is of utmost importance to Children's Urology Associates. Given the recent COVID-19 outbreak, the following pre-visit screening questions are designed to help promote your safety, as well as the safety of our staff and the other patients. Please answer these questions truthfully and accurately. All your responses will remain confidential.

Question	Yes/No	Details
Have you or a member of your household had any of the following symptoms in the last 14 days?: • Sore Throat • Cough • Chills • Body Aches for unknown reasons • Shortness of breath for unknown reasons • Loss of smell/loss of taste • Fever, temperature at or greater than 100 degrees Fahrenheit	Y / N	
Have you or a member of your household been tested for COVID-19?	Y / N	
Have you or a member of your household been advised to be tested for COVID-19? Or advised to self-quarantine for COVID-19?	Y / N	
Have you or a member of your household visited or received treatment in a hospital, or other health care facility in the past 14 days?	Y / N	