# DMITRY PEDIATRICS

**Dmitry Shindelman, CPNP**
**Anna Shindelman, MD**

Today's Date:_____
VFC:
- o Yes
- o No

How did you hear about us?

Insurance company _____
Friends/relatives _____
Internet _____
Other (specify) _____

## PATIENT INFORMATION

Patient's name: _____
Last First MI

Date of birth: _____
mm dd yyyy

Gender:
- O Male
- O Female

Current Address:

House/street/apt _____

City/State/Zip _____

Patient's own phone # (if available): _____

Your Email address: _____

## INSURANCE INFORMATION

| Primary Insurance Carrier | Secondary Insurance Carrier |
|---|---|
| 1. Name _____ | 1. Name _____ |
| 2. ID number _____ | 2. ID number _____ |
| 3. Group number _____ | 3. Group number _____ |
| 4. Effective date _____ | 4. Effective date _____ |

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## PARENT'S INFORMATION

| **Mother's Name:** | **Father's Name:** |
|---|---|
| _____ _____ ____<br>first last MI | _____ _____ ____<br>first last MI |
| **Birthdate:** _____<br>mm dd yyyy | **Birthdate:** _____<br>mm dd yyyy |
| **Phone numbers:** Home: _____ | **Phone numbers:** Home: _____ |
| Work: _____ | Work: _____ |
| Cell: _____ | Cell: _____ |
| **Employer's Name:** _____ | **Employer's Name:** _____ |

## BRIEF HISTORY ON YOUR CHILD

CURRENT MEDICAL CONDITIONS_____
CURRENT MEDICATIONS _____
PAST SURGERIES _____
SIGNIFICANT PAST INJURIES/TRAUMA _____
ALLERGIES TO MEDICATIONS_____
ALLERGIES TO FOODS_____
OTHER ALLERGIES_____

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Dmitry Pediatrics. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Dmitry Pediatrics.

Signature_____ Date_____

# DMITRY PEDIATRICS
## HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

**I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

# Dmitry Pediatrics

Dmitry Shindelman, CPNP
Anna Shindelman, MD
1726 Flatbush Ave
Brooklyn, NY 11210

I, _____, the parent of _____

consent to receive SMS text messages from Dmitry Pediatrics for appointment reminders, marketing messages, and general two-way communication.

_____ (parent's signature)

_____ (date)

# Dmitry Pediatrics

Dmitry Shindelman, CPNP
Anna Shindelman, MD
1726 Flatbush Ave
Brooklyn, NY 11210

## SMS Messaging Terms and Conditions:

By opting in to receive SMS messages from Dmitry Pediatrics I agree to the following terms:

**1 - SMS Messaging Service**
By providing my phone number, I consent to receive SMS text messages from Dmitry Pediatrics for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg and data rates may apply. Reply HELP for support. Reply STOP to opt out.

**2 - Message Frequency**
I will receive up to 4 messages per month.

**3 - Message and Data Rates**
Message and data rates may apply based on your mobile carrier’s terms.

**4 - Privacy Policy**
My information will be handled in accordance with Dmitry Pediatrics Privacy Policy, which I am required to sign separately.

**5 - Opt-Out Instructions**
I can opt out at any time by replying “STOP” to any SMS message. Reply HELP for support. I may also contact Dmitry Pediatrics directly at (718) 338-0807 or DmitryPediatrics@gmail.com.

**6 - Liability**
Dmitry Pediatrics is not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers.

By opting in, I confirm that I am the owner or authorized user of the phone number provided and that I am at least 18 years old.

_____ (parent’s signature)

_____ (date)

# Dmitry Pediatrics

Dmitry Shindelman, CPNP
Anna Shindelman, MD
1726 Flatbush Ave
Brooklyn, NY 11210

## Privacy Policy

Effective Date: 09/08/2026

Dmitry Pediatrics respects your privacy and is committed to protecting your personal information. This Privacy Policy explains how we collect, use, and share information when you opt in to receive SMS messages from us.

**Information We Collect:**

When you opt in to receive SMS messages, we collect:

- Your phone number
- Consent to send SMS messages

**How We Use Your Information**

We use your information to:

- Send you the SMS messages you've opted in to receive
- Provide updates, promotions, or other relevant content based on your preferences

**Sharing Your Information**

We do not share your phone number or SMS opt-in information with third parties for marketing purposes.

**Your Rights**

You can opt out of receiving SMS messages at any time by replying with "STOP" to any message we send you.

**Data Security**

We implement reasonable measures to protect your personal information from unauthorized access or disclosure.

**Contact Us**

If you have questions or concerns about our privacy practices, contact us by calling (718) 338-0807 or e-mailing us at Dmitry Pediatrics@gmail.com

_____ (parent's signature) _____ (date)