North Florida Pediatrics

New Patient Packet

Name of person completing packet: _____ Date: _____

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Male or Female? _____ Male _____ Female Social Security Number: _____ Date of Birth: _____

Address:
_____ City _____ State_____ Zip_____

Email: _____ Home Phone: _____ Cell Phone: _____

Race: ____American Indian ____Asian ____Native Hawaiian ____White ____Black/African American ____Hispanic ____Other: _____

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Do not wish to report

Preferred Language: ____English ____Spanish ____Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Male or Female? _____ Male _____ Female Social Security Number: _____ Date of Birth: _____

Address:
_____ City _____ State_____ Zip_____

Email: _____ Home Phone: _____ Cell Phone: _____

Relationship to Patient: ____Mother ____Father ____Grandparent ____Foster Parent ____Other:_____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Male or Female? _____ Male _____ Female Social Security Number: _____ Date of Birth: _____

Address:
_____ City _____ State_____ Zip_____

Email: _____ Home Phone: _____ Cell Phone: _____

Relationship to Patient: ____Mother ____Father ____Grandparent ____Foster Parent ____Other:_____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address/Location: _____

Emergency Contact

Name: _____ Date of Birth: _____

Phone Number: _____ Relationship to Patient: _____

Address:
_____ City _____ State_____ Zip_____

Patient Name: _____ Date of Birth: _____

Patient Allergies

Please list any and all patient allergies to food and/or medications:

_____

_____

Patient Hospitalizations/Surgeries

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Siblings

Please list any siblings of the patient who are patients of North Florida Pediatrics

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Consent for Treatment

Patient (Minor) Name: _____ Date of Birth: _____

I, _____ am the natural or adoptive parent, guardian, or person authorized by court order to give consent for the above listed minor. I authorize North Florida Pediatrics to provide medical treatment to the above listed minor.

Consent for other adult to bring the patient to our office for treatment

I, authorize North Florida Pediatrics to discuss the above minor's care and provide treatment to the child while in the care of the following authorized adults. I understand that for the safety and security of my child, only adults listed on this form will be permitted to accompany my child to the doctor. The following are the adults I authorize to bring my child to the doctor and be involved in their care:

Name: _____Relationship to Patient: _____ Date of Birth: _____

Name: _____Relationship to Patient: _____ Date of Birth: _____

Name: _____Relationship to Patient: _____ Date of Birth: _____

Parent/Guardian Signature:	**Date:**

Patient Name: _____ Date of Birth: _____

North Florida Pediatrics Financial Policy:

Thank you for choosing **North Florida Pediatrics, PA** as your healthcare provider. We are committed to giving you and your family the best possible care.

You are required to read and sign our **Financial Policy** *prior to treatment.*

Regarding Insurance

We accept assignment of insurance benefits for your visits. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that your insurance company has not paid your account in full within 90 days, the balance will automatically become the responsibility of the patient/guardian. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance policy, meaning payment of these charges will be your responsibility.

Regarding insurance plans where we are a participating provider. All co-pays and deductibles are due at the time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parent (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied.

Release of Information:

I do hereby authorize any physician examining and/or treating me to release any third party (such as an insurance company or governmental agency) example: Blue Cross Blue Shield, Medicare or any medical and psychiatric claim for payment for such treatment and/or diagnosis.

Physician Insurance Assignment:

I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as describes.

Medicaid/Medicare:

Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSINGMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE BENEFITS BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE AND FOR THE ENTIRE AMOUNT DUE FOR PROFESSIONAL SERVICES RENDERED IF THE EXPENSE IS NOT COVERED BY MY POLICY.

Policy Holder or Responsible Party Signature:	Date:
Print Name:	Relationship to Patient:

Patient Name: _____ Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand North Florida Pediatrics' Notice of Privacy Practices containing a description of the uses and disclosure of my health information. I further understand that North Florida Pediatrics may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of North Florida Pediatrics' *Notice of Privacy Practices.*

Signature:	Date:
Print Name:	Relationship to Patient:

Acknowledgement of Receipt of Florida Bill of Rights

I acknowledge that I have received and understand the Florida Bill of Rights.

Signature:	Date:
Print Name:	Relationship to Patient:

Patient Name: _____ Date of Birth: _____

North Florida Pediatrics Consent for the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment and/or Health Care Operation:

I understand that, as a part of my health care, North Florida Pediatrics receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that North Florida Pediatrics and its physicians, other health care professionals, and staff may use this information for the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have received a *Notice of Private/Information Practices* that fully explains the uses and disclosures that North Florida Pediatrics will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. North Florida Pediatrics has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that North Florida Pediatrics cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that North Florida Pediatrics reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent to the use of disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that, if I do not consent, North Florida Pediatrics may refuse to provide me health care services unless applicable state or federal law requires North Florida Pediatrics to provide such services.

I understand that I do have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that North Florida Pediatrics is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or North Florida Pediatrics notifies me that it is no longer going to honor the request.
I request the following restrictions (if any) on the use or disclosure of my individually identifiable health information:

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home. I further understand that North Florida Pediatrics must honor this request if the method of communication is reasonable. North Florida Pediatrics may not ask me why I want the alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members.
I object to uses and disclosures as follows:

I understand I may revoke this consent in writing, but that the revocation will not be effective to the extent that North Florida Pediatrics has already taken action in reliance on my earlier effective consent.

I understand that health information that is subject to specific privacy rules mandated by the state of Florida or federal laws (mental health, substance abuse, STD, HIV/AIDS, genetic information) will only be used and disclosed in accordance with those laws.

Signature:	Date:
Print Name:	Relationship to Patient:

Confidential Communications Request

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them, and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system.

However, it should be noted that our current notice of privacy practices does allow us to leave non-detailed messages such as appointment reminders, a request to return a call to the office, a reminder to schedule a physical or receive vaccines, etc.

Patient Name: _____ DOB: _____

Name of Parent/Guardian Completing form: _____ DOB: _____

Address: _____

City, State & Zip Code: _____ Phone: _____

I Do Consent for *detailed* messages to be left on:

☐ My home answering machine
☐ My cell phone
☐ Other:

☐ I Do Not Consent for detailed messages to be left on any answering machine or voice mail; I prefer to be contacted personally.

☐ I Do Not Consent for any documentation to be sent to my address on record, I prefer correspondence to be mailed to:

_____

***This will remain in effect until you rescind it in writing.**

Signature:	Date:
Print Name:	Relationship to Patient:

Patient Name: _____Date of Birth: _____

Consent for Release
of Sensitive Protected Health Information

Sensitive Protected Health Information includes the following:	
Sexual Health/STDs	HIV/AIDS Testing or Results
Family Planning/Birth Control/Pregnancy	Substance/Alcohol abuse

This form is for designating who should have access to or knowledge of your sensitive health information. Only individuals listed on this form will have access to the information. Please initial to indicate what information may be released.

_____ **I DO NOT consent to any of my personal health information being shared with anyone.**

_____ I request that the following health information be shared:

_____ All of my health care information, including any/all Sensitive Protected Health Information.

_____ Information regarding prescription drug coverage.

_____ Information regarding Family Planning/Birth Control/Pregnancy.

_____ Information regarding treatment for drug or alcohol abuse.

_____ Information regarding Sexual Health/STDs.

_____ Information regarding behavioral health services or psychiatric care.

_____ Information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

_____ Other:_____

Please indicate which individuals may have access to the information represented above.

Name: _____Relationship to Patient: _____ Date of Birth: _____

Name: _____Relationship to Patient: _____ Date of Birth: _____

Name: _____Relationship to Patient: _____ Date of Birth: _____

Name: _____Relationship to Patient: _____ Date of Birth: _____

Passcode (Optional): If you wish, you may indicate a passcode in the form of a single word, or 4-digit pin. If you select a passcode, we will request this passcode before speaking with anyone concerning your sensitive health information. (The recipient must be listed on this form, AND provide the correct passcode, to receive the information.)
Passcode:

Patient Signature:	**Print Name:**	**Date:**
Witness Signature (NFP Staff Member):	**Print Name:**	**Date:**