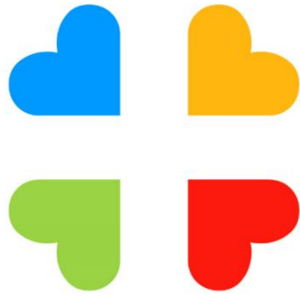


North Florida
Pediatrics

Patient Demographic Packet

Name of person completing packet:	Date:

Patient Information:			
First Name:	Middle Name:	Last Name:	
Male of Female? ☐ Male ☐ Female	Social Security Number:	Date of Birth:	
Address:			
Email:	Home Phone:	Cell Phone:	
Race:			
☐ American Indian	☐ Asian	☐ Native Hawaiian	☐ White
☐ Black/African American	☐ Hispanic	☐ Other: ____________	☐ Do not wish to report
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 of Female? ☐ Male ☐ Female	Social Security Number:	Date of Birth:		
Address:				
Email:	Home Phone:	Cell Phone:		
Relationship to Patient:				
☐ Mother	☐ Father	☐ Grandparent	☐ Foster Parent	☐ Other: ____________
Employment Information:				
Employer:	Occupation:			
Work Address:	Work Phone:			

Responsible Party:				
First Name:	Middle Name:	Last Name:		
Male of Female? ☐ Male ☐ Female	Social Security Number:	Date of Birth:		
Address:				
Email:	Home Phone:	Cell Phone:		
Relationship to Patient:				
☐ Mother	☐ Father	☐ Grandparent	☐ Foster Parent	☐ Other: ____________
Employment Information:				
Employer:	Occupation:			
Work Address:	Work Phone:			

Emergency Contact:	
First Name:	Last Name:
Relationship to Patient:	Phone Number:

Patient Name:	DOB:

Preferred Pharmacy:

Pharmacy Name:	Pharmacy Phone:
Pharmacy Address/Location:	

Patient Allergies:

(Please list any and all patient allergies to foods and/or medications)

Patient Hospitalizations/Surgeries:

Date:	Type:
Date:	Type:
Date:	Type:

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

Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:

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

Patient (Minor) Name:	DOB:

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 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:	DOB:
Name:	DOB:
Name:	DOB:
Parent/Guardian Signature:	**Date:**

Primary Health Insurance:

Insurance Company Name:	Policy Number:

Subscriber's First Name:	Subscriber's Middle Name:	Subscriber's Last Name:

Subscriber's DOB:	Subscriber's Social Security Number:
Subscriber's Address:	
Subscriber's Employer:	

Subscriber's Relationship to Patient:

☐ Mother	☐ Father	☐ Grandparent	☐ Foster Parent	☐ Other: ____________________

Secondary Health Insurance:

Insurance Company Name:	Policy Number:

Subscriber's First Name:	Subscriber's Middle Name:	Subscriber's Last Name:

Subscriber's DOB:	Subscriber's Social Security Number:
Subscriber's Address:	
Subscriber's Employer:	

Subscriber's Relationship to Patient:

☐ Mother	☐ Father	☐ Grandparent	☐ Foster Parent	☐ Other: ____________________

Patient Name:	DOB:

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 paid your account in full within 90days, 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:	DOB:

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:

Patient Name:	DOB:

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 Notice of Privacy Practices

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

Signature:	Date:
Print Name:	Relationship to Patient:

North Florida Pediatrics

Medical Records Release

PLEASE RELEASE MEDICAL RECORDS TO:

☐ Lake City Office	☐ Live Oak Office	☐ Jasper Office	☐ Cross City Office
1859 SW Newland Way Lake City, Fl. 32025 Phone: (386) 758-0003 Fax: (386) 755-4432	1101 S. Ohio Avenue Live Oak, Fl. 32064 Phone: (386) 339-1060 Fax: (386) 339-1067	1117 NW Hwy 41, Suite B Jasper, Fl. 32052 Phone: (386) 792-3864 Fax: (386) 792-1530	149 NE 241st Street Cross City, Fl. 32628 Phone: (352) 498-3337 Fax: (352) 498-3773

I hereby request and authorize the request of records of: ______________________________ DOB: ___________________
(Por la presente solicito y autorizo los registros de:) (Patient Name/Nombre del Paciente) (Fecha de Nacimiento)

The requested medical records should be released from: ____
(Los registros médicos solisitados deben ser obtenidos de:) (Previous Physician/Médico Anterior)

Phone #: ________________________ Fax #: _____________________
(Número de Teléfono del Médico Anterior) (Número de Fax del Médico Anterior)

Information to be released:
(Información para ser compartido:)

_____ Complete Medical Record
(Historia Clínica Completa)
_____ Summary of Office Notes
(Resumen de Notas de Oficina)
_____ Immunizations
(Vacunas)
_____ Labs and/or Diagnostic Tests
(Exámenes de Laboratorios y/o Diagnosticos)

_____ Emergency Room Visit on: _________________
(Visita a la sala de Emergencia en:)
_____ Hospital Admissions: _____________________
(Admisiones en Hospital:)
_____ Newborn Records
(Archivos de Recién Nacidos)
_____ Other: (specify) __________________________
(Otro: (Especifique)]

Reason for transfer of records:
(La Razón para la Transferencia de Archivos:)

☐ Continued Care (Continuación de Atención) ☐ Relocating (Reubicación) ☐ Change of Insurance (Cambio de Seguro) ☐ Other: ____________________________ (Otro:)

I do not have to sign this authorization to receive treatment from North Florida Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that North Florida Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the designated **Privacy Officer** at north Florida Pediatrics at the above address.

(Yo no tengo que firmar esta autorización para recibir tratamiento de parte de North Florida Pediatrics. De hecho, Yo tengo el derecho a rehusar la firma de esta autorización. Cuando mi información es usada o divulgada de acuerdo a esta autorización, puede ser sujeta a una nueva revocación por el recibidor y perder la protección bajo la Regla de Privacidad Federal de HIPPA. Yo tengo el derecho de revocar esta autorización por escrito con la excepción de que North Florida Pediatrics ha actuado de buena fe sobre esta autorización. Mi revocación por escrito debe ser sometida al Oficial designado a los documentos de Privacidad de North Florida Pediatrics a la dirección de arriba.)

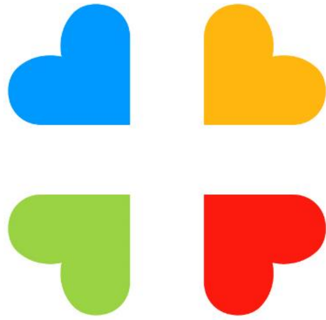
Signature: ____ Date: _________________________
(Firma) (Fecha)

Print Name: ________________________________ Relationship to Patient: __________________________
(Imprimir el Nombre) (Relación al Paciente)

Witness: ___________________________
(Testigo)

***This authorization expires one year after the date signed.**

"A Confidentiality Statement should be included on fax cover sheets.- 'The document accompanying this transmission contains privileged and confidential information intended only for the individual to who it is addressed. If the reader of this fax is not the intended recipient, you are hereby notified that any viewing or dissemination, distribution, or copy of this fax is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.'"



North Florida Pediatrics

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: