ABC Pediatrics of Okaloosa, PA

182 E Redstone Ave
Suite B
Crestview, FL 32539

Luis Gomez, MD FAAP
Alberto Barbon, MD FAAP
Lela Stroud ARNP
Sharon Skrabacz, ARNP

1403 Cat-Mar Rd
Niceville, Fl. 32578

IMMUNIZATION POLICY

Patient Name: ____________________ **DOB:** ______________

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives, and have complete confidence in the safety of vaccines. We believe that all children and young adults should receive the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We feel certain that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The childhood immunization schedule is the result of years of scientific study and data on millions of children by thousands of the brightest scientists and physicians.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to inform you of the benefits of vaccinating your child. Should you have doubts, please discuss these with your health care provider in advance of your visit. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) from preventable illnesses.

Finally, if you should decide that you do not want to vaccinate your child according to our recommendations, we will kindly ask you to find another health care provider who shares your views. As medical professionals, we could not feel more strongly that vaccinating children on schedule with currently available vaccines is in the best interest for all children and young adults. Thank you for your time in reading this policy.

By signing below you are agreeing that you have been informed of this policy and intend to comply.

______________________________ ______________

Signature Date

Updated 8/24/15

Thank you for selecting our Pediatric healthcare team! We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please complete this form. If you have any questions, please ask us – we will be happy to help!
How did you hear about us? ______________________

PATIENT INFORMATION (CONFIDENTIAL):

Date: ______________________

Name: ______________________ Prefer to be called: ______________
FIRST MIDDLE LAST SUFFIX (JR, III...)

Address: ______________________City: __________ State: ____ Zip: ______________

DOB: ______________ SSN: ______________________ ☐ Male ☐ Female

Home Phone: (____) __________ Cell Phone: (____) __________ Other Phone: (____) __________

Person to contact in case of emergency: ______________________Phone: (____) __________

GUARANTOR:

Mother's Name: ______________________ **DOB:** __________**SSN:** __________

Address ______________________City: __________ State: ____ Zip: _____ Phone: (___) _______
IF DIFFERENT FROM THE PATIENT

Mother's Employer: ______________________ Employer Phone: (____) ______________

Father's Name: ______________________ **DOB:** __________**SSN:** __________

Address: ______________________City: __________ State: ____ Zip: _____ Phone: (___) _______
IF DIFFERENT FROM THE PATIENT

Father's Employer: ______________________ Employer Phone: (____) ______________

INSURANCE INFORMATION:

Primary Insurance Name: ______________________ ID #______________Group #: __________

Relation to Patient: __________ Name of Insured: ______________ **SSN:** __________ **DOB:** ________

Insured's Address: ______________________City: __________ State: ______Zip: __________
IF DIFFERENT FROM THE PATIENT

How much is your co-pay? ______ your deductible per calendar year? _______ your coinsurance? _____

Secondary Insurance Name: ______________________ ID#: ______________ Group #: __________

Relation to Patient: __________ Name of Insured: ______________ **SSN:** __________ **DOB:** ________

Insured's Address: ______________________City: __________ State: ______Zip: __________
IF DIFFERENT FROM THE PATIENT

Our office will gladly file your insurance claims for your convenience. As a courtesy to our patients, we will accept assignment from your insurance company and wait for 30 days for your insurance to pay your claim. You will be expected to pay the difference between the full fee/allowable and the insurance estimate at the time services are rendered unless other financial arrangements are discussed in advance. You will remain responsible for your entire account balance regardless of any insurance coverage or any insurance estimate given to you. If a claim remains unpaid after 30 days, you will receive a statement for the balance due on your account.

I understand and agree to the insurance acceptance guidelines outlined above. I, the policy holder, do give ABC Pediatrics permission to bill the above insurance on my behalf for any and all services performed by the providers associated with this business.

______________________ __________
Signature Date

FINANCIAL COMMITMENT:

I understand that the fee for services rendered are due at the time of service unless specific financial arrangements are made in writing in advance. **I understand that I am responsible for all deductibles, co-pays, coinsurances, etc..., and any charges not covered by my insurance company. If my account is not paid in full within 60 days, I may be discharged from the practice or subject to collection charges and/or collection action.**

______________________ __________
Signature Date

HEALTH HISTORY

Your child's health is important to us. Please complete this form to help us give the best care possible to your child.

Child's Name ____________________ Date: ____________

Date of Birth ____________ Age ______ Boy or Girl

Child's School ____________________ Grade ________

Mother's Name ____________________ Occupation ____________

Home # ____________ Cell # ____________

Father's Name ____________________ Occupation ____________

Home # ____________ Cell # ____________

Address ____________ City/ST ____________ Zip ______

Previous physician ____________ City/ST ____________ Phone ________

Reason for visit to our office ____________________

CURRENT MEDICATIONS		MEDICATION ALLERGIES	
Substance	*Dosage*	*Medication*	*Reaction*

BIRTH HISTORY

Birth Weight ____________

Was the birth Vaginal ____ or Caesarean ____

Was the baby Term ____, Early ____, or Late ____

If Caesarean, why ____________

Was the baby Breast fed ____ or Bottle ____

Any problems following birth of baby ____________

If yes, please explain ____________

____

____

____

During pregnancy did mother:

Smoke: Yes ____ No ____

Drink alcohol: Yes ____ No ____

Use drugs or medications: Yes ____ No ____

If yes, what was taken ____________

____

When was it taken ____________

____

Did infant have any of the problems listed below

Birth defect ____, Breathing problem ____,

Infection ____, Jaundice ____, Transfusion ____

Other ____________

During pregnancy did the mother have any medical conditions? If yes, please list: ____________

____

Hospitalizations: Other than birth has your child ever been hospitalized? If yes, please list : ____________

____

Serious illness or injury: If your child has had a serious illness or injury please list ____________

____

HEALTH HISTORY

Child's Name ______________________________ Date of Birth ____________________

FAMILY AND SOCIAL HISTORY

Please list family members living in same household as child such as mom, dad, sisters, brothers, etc.

Name/Relationship	*Age*	*Date of Birth*	*Health Conditions*

Have any family members had the following conditions? If so, please circle.

Deafness	Nasal allergies	Asthma	Tuberculosis	Heart disease (before 50 years old)
Anemia	Bleeding disorder	Liver disease	Kidney disease	High blood pressure (before 50 years old)
Epilepsy	Convulsions	Alcohol abuse	Drug abuse	Mental illness
Diabetes	Bed wetting	Immune problems	HIV / AIDS	Other ____________________

CHILD'S PAST HISTORY

Does your child have, or has she/he ever had any of the following conditions? If so please circle.

Chickenpox	Ear Infections	Nasal allergies	Vision problems	Hearing problems
Asthma	Bronchitis	Pneumonia	Heart problems	Anemia
Abdominal pain	Bleeding problems	Constipation	Eczema	Blood transfusion
Headache	Bladder infections	Diabetes	Thyroid	Kidney infections
Convulsions	Neurologic	Acne	Other, please list: ____________________	

Do you have any concerns regarding your child's physical development? ____________________

____

Do you have any concerns regarding your child's emotional development? ____________________

____

Do you have any other concerns you wish to speak with the provider about?

____

____

____

____

____

____

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Medical Caretaker Release

Patient Name: ________________ DOB: ____________

I ________________, do hereby authorize the following individual(s) to act on my behalf when I am unable to accompany my child for a medical visit. This individual may receive any and all medical information and act as my child's representative in my absence. I release ABC Pediatrics of any and all responsibility or obligations for releasing this information.

Please provide the following information on each person you will allow to act as your child's representative.

FIRST NAME	LAST NAME	DOB	RELATIONSHIP	PHONE #

______________________________ ____________________

Signature of Parent/Guardian **Date**

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OFFICE POLICIES

Patient Name: ____________________________ **DOB:** __________________

FINANCIAL RESPONSIBILITY: Patients must arrive at their scheduled appointment with their insurance card, photo ID and insurance co-pay/coinsurance/deductible if applicable. Co-pays required by the patient's policy must be paid at the time of the appointment. ***The parent or authorized caretaker bringing the child to be seen is responsible for payment.***

SEPARATED/DIVORCED FAMILES: For those families where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible for payment, no exceptions. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. **ABC Pediatrics will not act as a mediator in collecting our payments.**

LATE CANCELLATION / NO SHOW FEE POLICY: A late cancellation or no show fee of $25.00 will be charged to all patients who do not provide **24 hour notification** to cancel a scheduled appointment or for patients who miss or no show for their scheduled appointment. Multiple no shows may result in being discharged from the practice. ***This fee is NOT payable by insurance and is your responsibility.***

RECORD COPIES: You are entitled to a copy of your Childs' records. If you are changing providers and want us to send the records directly to your new provider there is NO FEE for this service. Please request a medical records release from our front desk and we will send the records to any provider you request. If you would like a copy for your own records there is a FEE of $1.00 per page for the first 25 pages and $.25 thereafter. Please allow up to 72 hours for all records requests to be completed once a release has been signed.

FORMS: We are happy to complete the shot record and/or physical forms for you at the time of your child's well visit at no charge. If you need additional forms or letters completed, there is a FEE of $5.00 per form/page. Please allow up to 72 hours for us to complete your request. The fee is due upon receipt and is not billable to your insurance.

PRESCRIPTION REFILLS: We will strive to refill your prescriptions within 24 hours. However, we request that you call in your request at least 48 hours before you are out to ensure we have everything necessary to accommodate your request. Some prescriptions are not refillable without a follow up appointment due to the nature of the medication or illness.

WELL VISIT COVERAGE: When you child is scheduled for a WELL VISIT, it will be billed as such to your insurance plan. If, during your visit, you have **ADDITIONAL CONCERNS** that require a diagnosis and/or other treatment, it may be considered a Problem Oriented Exam and you may incur additional office charges. **Please take the time review your policy to ensure that your child's well visit and immunizations are covered benefits.** Feel free to call your insurance company and ask about your coverage. If Well-visit coverage is not a benefit with your policy, the state of Florida does make provisions for immunizations but it is necessary that we are aware of this before your child is seen.

INFORMATION CHANGES: Please notify us of any changes in address, phone number, insurance, etc… as soon as you are aware of them.

INSURANCE: It is your responsibility to make sure that we have your up to date insurance information. Changes in your insurance coverage need to be given to us within 30 days to ensure proper billing. If we do not have the correct insurance within 30 days of the date the patient was seen, the balance for that date may become the parent's responsibility. **Feel free to call your insurance regarding coverage. It is your responsibility to understand your insurance coverage and its limitations.**

AFTER HOURS: We currently use Bayside Answering Service for after hours. Please call (855)207-2878 if you have an urgent situation and you need medical counseling.

By your signature below, you are agreeing that you have been informed of the above policies.

Signature: ____ **Date:** ____________________

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182 E Redstone Avenue, Suite B
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Phone (850)689-0900
Fax (850) 689-0912

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Request: ____________

Date of Birth: _________________________ SSN #: ___________________________

Please choose the records you would like released:

( ) Outpatient notes
( ) X-Ray/Radiology reports
( ) Immunization Records
( ) Other (please specify): ____
( ) Lab reports
( ) Pathology Reports
( ) All Medical Records

For the specific purpose(s) I have checked below:

( ) Continuation of medical care
( ) Changing physicians and discontinuing care at this office
( ) Office of Disability Insurance
( ) School &/or Immunization
( ) other ______________________________
( ) Attorney
( ) Insurance
( ) Moving & Transferring records to new Physician
( ) Personal Use

RECORDS ARE TO BE RELEASED **FROM** / TO (PLEASE CIRCLE ONE):

____
____
____

RECORDS ARE TO BE RELEASED FROM / **TO** (PLEASE CIRCLE ONE):

ABC PEDIATRICS OF OKALOOSA
182 E Redstone Avenue, Suite B
Crestview, FL 32539

If the number of pages of records being released to our office is more than 20, please mail to the address above. PLEASE DO NOT FAX!

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke the authorization, we will no longer use or disclose medical information about you for the reasons covered by the authorization. Please understand that we are unable to take back any disclosures we have already made with you permission. Unless the authorization is revoked, *this authorization will expire one year from the date signed.*

Re-disclosure: I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

By signing this release, I understand that I may be authorizing the release of **ALL** information in my medical records.

Signature: ________________________________ Date: __________
PARENT OR LEGAL REPRESENTATIVE