



ABC Pediatrics of Okaloosa, PA

600 Hospital Drive
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: _____ FIRST MIDDLE LAST SUFFIX (JR, III...) Prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Male Female

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

Email: _____ Emergency Contact: _____ Phone: (____) _____

Preferred Pharmacy: _____ Preferred Lab: _____ Consent to Text: (yes) or (no)

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.

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.

<i>Name/Relationship</i>	<i>Age</i>	<i>Date of Birth</i>	<i>Health Conditions</i>

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 FAMILIES: 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 \$50 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 **WELL** or **EXTENDED** appointments. For all other missed appointments, a \$25 fee will be charged. 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 Child's 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 your 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:** _____

NOTICE OF PRIVACY PRACTICES

Effective Date: 4-14-03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations that is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAY WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, and off-site storage of medical records. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

We may also use and disclose medical information to/for the following:

- | | | |
|--|---|--|
| * to remind you that you have an appointment | * Public Health Authorities | * Food and Drug Administration |
| * to assess your satisfaction with our services | * Workers Compensation Agents | * Legal Authorities |
| * Organ and Tissue Donation Organizations | * Military Command Authorities | * for law enforcement purposes as required by law or in response to subpoena |
| * Health Oversight Agencies | * National Security & Intelligence Agencies | |
| * Funeral Directors, Coroners, Medical Directors | * Protective Services for the President | |
| * to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status | | |

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at 850-689-0900.

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 600 Hospital Drive, Crestview, FL, 32539. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read a copy of the privacy practices.

Signature

Printed Name

Date

FOR OFFICE USE ONLY:

DATE ACKNOWLEDGEMENT WAS RECEIVED: _____ EMPLOYEE: _____

OR REASON ACKNOWLEDGEMENT WAS NOT OBTAINED: _____



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1403 Cat-Mar Road
Niceville, FL, 32578
Phone (850)729-3575
Fax (850) 897-1436

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Request: _____

Date of Birth: _____ SSN #: _____

Please choose the records you would like released:

- | | |
|--|--|
| <input type="checkbox"/> Outpatient notes | <input type="checkbox"/> Lab reports |
| <input type="checkbox"/> X-Ray/Radiology reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> All Medical Records |
| <input type="checkbox"/> Other (please specify): _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Continuation of medical care | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> Changing physicians and discontinuing care at this office | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Office of Disability Insurance | <input type="checkbox"/> Moving & Transferring records to new Physician |
| <input type="checkbox"/> School &/or Immunization | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> other _____ | |

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

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

ABC PEDIATRICS OF OKALOOSA
1403 Cat-Mar Road
Niceville, FL 32578

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

Relationship to Patient: _____