Pensacola Pediatrics, P.A.
Office Policies, Consent to Treat & HIPAA Notification

YOUR INFORMATION:
Please provide your most current and preferred contact information such as home and cell numbers, address and email address. Also, please bring your **insurance card to EACH VISIT** to ensure accurate filing and payment from your insurance carrier.

CELL PHONE USAGE:
Please refrain from using your cell phone when your child is in the exam room with our staff and when checking in or out of the office.

APPOINTMENTS:
Patients with pre-scheduled appointments are seen both during the week and on Saturdays. We also provide some evening and Saturday appointments for minor illnesses and injuries. If you have an appointment scheduled for one child and would like an additional child to be seen, please make every effort to call in advance. We will do our best to accommodate you. I have received, read and agree to the "Cancellation and Missed Appointments" policy.

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Initial

PRESCRIPTION REFILL / FORM COMPLETION:
Please allow 48 (week-day) hours for all forms to be completed and prescription refill requests to be processed. Long forms may be charged for. Please note that in compliance with Federal Law, some medication prescriptions must be picked up at our office. These prescriptions will not be sent electronically or called in to your pharmacy. You will be notified in advance if this is the case. Please be prepared to show identification, if requested, when picking up these prescriptions.

CONSENT TO TREAT:
I am the parent or legal guardian for the patient(s) listed below and, on behalf of the patient(s), I hereby request and consent that the children listed below be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I also authorize the Designated Adult(s) listed below to consent, if I am not present, to the care that a physician deems advisable. I understand treatment and services may include:

- Lab tests
- Screening tests (tests that can identify an illness early, before a person shows signs of having the disease)
- Diagnostic tests (tests that show if a person has a certain illness or health problem), and routine exams
- Therapies
- Immunizations as recommended by the American Academy of Pediatrics.

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Initial

TREATING MINOR WITHOUT A PARENT OR LEGAL GUARDIAN:
Pensacola Pediatrics, P.A. requires a dated, signed Authorization Consent To Treat Minor form in the following circumstances:

- When a minor is accompanied to their visit by an adult other than a birth parent or legal guardian, and that adult was not previously identified on this form.

— SEE OTHER SIDE —

- Example: stepparents, grandparents, babysitters, family or friends
- An adolescent minor patient is attending their appointment without their parent or guardian.

Non-emergency care may be denied without signed permission.

PAYMENT / RESPONSIBLE PARTY:

Please pay the amount your insurance requires and any outstanding balance at time of service. Please contact your insurance company to verify the benefits available, including well baby care and vaccinations. I will pay for services rendered if the insurance company does not pay Pensacola Pediatrics, P.A. This includes, but is not limited to coinsurance, copayment, non-covered services, denial of coverage, lack of insured's co-operation and unmet deductibles. I have received, read and agree to the "Financial Policy".

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Initial

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:

I (the legal guardian and/or financially responsible party) hereby authorize Pensacola Pediatrics to release medical information to third parties including, but not limited to, other healthcare providers, insurers, and the secure Florida Shots record system. I assign and permit payment directly to Pensacola Pediatrics of any benefits due for services rendered.

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Initial

I have received a copy of Pensacola Pediatrics Notice of Privacy Practices (HIPAA). _____
Initial

Designated Adult(s): The following have my authorization and power to exercise his or her best judgment upon the advice of Pensacola Pediatrics, P.A. to ensure care for the children listed below.

Name: _____ Phone: _____ Relationship to patient: _____

Name: _____ Phone: _____ Relationship to patient: _____

Name: _____ Phone: _____ Relationship to patient: _____

I HAVE RECEIVED A COPY, READ, UNDERSTOOD AND AGREED TO PENSACOLA PEDIATRICS, P.A. OFFICE POLICIES, CONSENT TO TREATMENT, THE NOTICE OF PRIVACY PRACTICES (HIPAA), CANCELLATION AND MISSED APPOINTMENTS POLICY AND FINANCIAL POLICY.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____ _____
Printed name of parent or guardian signing Date

Child/Children(s) Name: _____

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— SEE OTHER SIDE —