PENSACOLA PEDIATRICS, P.A.

We ask for a lot of information. We need it to give your child the care they need, provide you with information and bill your insurance.

Today's Date:_____ Your primary physician here: _____ ID:_____

Patient Last Name: _____ Patient's First Name: _____ Initial: ___

Nickname: _____ Birth Date: _____ SS#: ___-___-_____ ❑ Male / ❑ Female

Patient Address: (Street)_____ (City)_____ (State)_____ (Zip)_____

Primary Phone #: _____-_____-_____

Other Children Seen by Us? ❑ YES / ❑ NO

Ethnicity: ❑Hispanic ❑Not Hispanic ❑Declined

Race: ❑ American Indian ❑ Asian ❑Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other ❑ Declined

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Provide ALL contacts: First (who most often brings child), Second and the Insured

First Parent or Guardian Contact

Relationship to patient: ❑Mother ❑Father ❑Other_____

Last Name: _____ First Name: _____ Initial: ___

Social Security #: _____ Date of Birth: _____

Address: (Street)_____ (City)_____ (State)_____ (Zip)_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation:_____ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Second Parent or Guardian

Relationship to patient: ❑Mother ❑Father ❑Other_____

Last Name: _____ First Name: _____ Initial: ___

Social Security #: _____ Date of Birth: _____

Address: (Street)_____ (City)_____ (State)_____ (Zip)_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation:_____ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

INSURED'S Last Name: _____ First Name: _____ Initial: ___

❑ Male / ❑ Female Birth Date: _____ Relation to Patient: _____

Insurance Carrier: _____ Member ID#: _____

Group #:_____ Group Name: _____ 2nd Insurance? ❑ YES / ❑NO

(If another (secondary) insurance please put information on back)

Patient Balances (co-pays, deductibles, and coinsurance amounts) are due today.

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

YOUR INFORMATION:
I will provide and update my current contact information including home and cell numbers, address and email address. I will bring my child's **insurance card to EACH VISIT and my government issued ID** to ensure accurate filing and payment from your insurance carrier. I authorize Pensacola Pediatrics or its agents to contact me via email or by phone with the understanding that my mobile number will not be shared and that message frequency may vary. Message and data rates may apply.

_____
Initial

CELL PHONE USAGE:
I will refrain from using my cell phone for personal reasons when with our staff.

APPOINTMENTS:
Patients with pre-scheduled appointments are seen both during the week and on Saturdays. There are some evening and Saturday appointments for minor illnesses and injuries. If an appointment is scheduled for one child and I would like an additional child to be seen, I will call in advance. I have received, read and agree to the "Cancellation and Missed Appointments" policy.

_____
Initial

PRESCRIPTION REFILL / FORM COMPLETION:
It may take 48 (week-day) hours for all forms to be completed and prescription refill requests to be processed. Long forms may be charged for. 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 a 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 to the children listed below be examined and treated by all the medical, nursing and other healthcare personnel who may participate in the patient's care. I understand that medical care is not an exact science and that I agree that no guarantees have been made to me as of the outcomes of the services provided. Further I agree that if a healthcare worker is exposed to my child's blood that I give consent for a sample of the child's blood to be tested for infectious agents. I also authorize the Designated Adult(s) listed below to consent, if I am not present, to the services that our staff deems advisable. I understand examination and treatment services may include:

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

_____
Initial

To ensure a collaborative relationship I agree to PP's policies and procedures. I understand that failure to cooperate with the policies and procedures may result in termination of care.

— SEE OTHER SIDE

Pensacola Pediatrics, P.A. (PP)

TREATING MINOR WITHOUT A PARENT OR LEGAL GUARDIAN:

I will provide a dated, signed Authorization Consent To Treat Minor form when a minor is sent alone or with an adult other than a birth parent or legal guardian (e.g. stepparents, grandparents, babysitters, family or friends) and that adult was not previously identified on this form.

Non-emergent care may be denied without signed permission.

PAYMENT / RESPONSIBLE PARTY:

I will pay, at time of service, for all charges not paid by insurance. This includes, but is not limited to deductibles, copays, non-covered services, denial of coverage, insured's failures to ensure coverage, provide information or verify patient's benefits, including well baby care and vaccinations. If collection or legal action is needed, I will pay all of PP's costs.

I have received, read and agree to the "Financial Policy". _____
Initial

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:

I (the legal guardian and/or financially responsible party) authorize Pensacola Pediatrics (PP) to communicate directly with and act as my agent in providing information to my insurance carriers. I hereby authorize PP 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 PP of any benefits due for services rendered.

_____
Initial

I have been offered the opportunity to review Pensacola Pediatrics Notice of Privacy Practices (HIPAA) and am aware copies are available in their offices and on their website.

_____
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 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 and DOB: _____

_____

_____

— SEE OTHER SIDE —

PENSACOLA PEDIATRICS, P.A.

Release of Medical Records TO BE RECEIVED BY Pensacola Pediatrics, P.A.

Please check the office at which the patient is established.

	LOCATION	ADDRESS	CITY	PHONE	FAX
☐	Cordova	4951 Grande Dr	Pensacola, FL 32504	850-473-0100	850-473-0500
☐	Nine Mile	9301 Beatrice Dr.	Pensacola, FL 32514	850-476-7555	850-466-3777
☐	Tiger Point	1368 Country Club Rd.	Pensacola, FL 32563	850-934-9876	850-916-0736
☐	Scenic Hills	965 E. Nine Mile Rd.	Pensacola, FL 32514	850-466-3776	850-497-6939
☐	Milton	5834 Berryhill Rd.	Milton, FL 32570	850-623-5437	850-626-7803
☐	Pace	5755 Quintette Rd.	Pace, FL 32571	850-995-8087	850-994-5292
☐	Navarre	8738 Ortega Park Dr.	Navarre, FL 32566	850-934-5776	850-710-7140
☐	Airport	5868A Creek Station Dr.	Pensacola, FL 32504	850-471-5060	850-471-5070

Release Records FROM *(Physician, facility or individual):* _____

_____

Address Line 1: _____

Address Line 2: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Email Address: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Records to be Released:

☐ All Medical Records ☐ Immunizations Only ☐ Itemized Billing

☐ Other: _____

Dates of Service:

☐ Please provide a complete copy of all dates of service.

☐ Please provide a complete copy of records from: _____ through _____ .

Purpose for Disclosure:

☐Transfer of Care *(Changing to a new physician/moved to a new area.)*

☐ Continuity of Care *(Sending to a specialist or secondary facility.)*

At the request of the individual

This authorization will expire upon receipt of these records at Pensacola Pediatrics.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing expect to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the HIPAA privacy Officer at Pensacola Pediatrics, 4951 Grande Drive, Pensacola, FL 32504. My treatment or payment for my treatment cannot be conditioned on the signing of the authorization.

_____**I DO** _____ **I DO NOT** authorize the release of information, including, if applicable, specific laboratory test of HIV infection (Human) Immunodeficiency Virus, the causative agents of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Signature: _____ Date: _____

Print Name: _____ Phone #: _____