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.
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.

_____
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.

_____
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".

_____
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.

_____
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: _____

_____

_____

— SEE OTHER SIDE —

TRANSFER INTO

PENSACOLA PEDIATRICS, P.A.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION and REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
PHYSICIAN'S NAME

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

I HEREBY REQUEST THAT MY CHILD'S MEDICAL RECORDS BE RELEASED TO:

PENSACOLA PEDIATRICS, P.A. *(Circle Location)*

4951 Grande Dr.	9301 Beatrice Drive	1368 Country Club Rd.	2120 E. Johnson Ave. #103
Pensacola, FL 32504	Pensacola, FL 32514	Gulf Breeze, FL 32563	Pensacola, FL 32514
(850) 473-0100	(850) 476-7555	(850) 934-9876	(850) 494-3965
(850) 473-0500 Fax	(850) 466-3777 Fax	(850) 916-0736 Fax	(850) 497-6939 Fax

_____
PATIENT'S NAME Date of Birth

I authorize you to use and/or disclose certain protected health information (PHI) about me to Pensacola Pediatrics, P.A.

- ❑ All Office Records
- ❑ Immunization Record Only
- ❑ Discharge Summary Only
- ❑ ER/Urgent Care Visit including Lab/Xray Results
- ❑ Newborn Records to include H&P, Hepatitis B Immunization Record, Obstetrical Nursing Assessment, Labs and D&C Summary if applicable.
- ❑ Other

This information will be used or disclosed for the following purpose:

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 this 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 agent 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.

Phone:_____

Signed by: _____ _____ _____
Signature Print Name Date