PARENT OR GUARDIAN INFORMATION

Name: **Mother/Guardian** ______________________
Address: ______________________
Home Phone: ______________________
Employer Name: ______________________
Employer Address: ______________________
Work Phone: ______________________
Social Security #: ______________________
Date of Birth: ______________________
Email: ______________________

Name: **Father/Guardian** ______________________
Address: ______________________
Home Phone: ______________________
Employer Name: ______________________
Employer Address: ______________________
Work Phone: ______________________
Social Security #: ______________________
Date of Birth: ______________________
Email: ______________________

Insurance Information: Who is the policyholder of the Insurance? MOTHER / FATHER (Please Circle One)
Insurance Company: ______________________
Policy Number: ______________________
Group Number: ______________________
Insured: ______________________

Emergency Information:
Person to Contact: ______________________
Address: ______________________
Phone: ______________________
Relationship: ______________________

Referral Information: Whom may we thank for this referral?

Name ______________________ Address ______________________

Patient Responsibility Statement and Medical Release Information

I/we, the undersigned, understand that we are responsible for any unpaid balance on this account. North Pinellas Children's Medical Center will file the necessary insurance claims, excluding secondary insurance claims, but I/we understand that we are responsible for any balance left unpaid after 120 days of the date of service. Failure to satisfy this obligation may cause the entire balance to be placed with a collection agency or attorney. I/we will be responsible for any charges incurred for collecting this debt; this includes, but is not limited to, collection fees, credit bureau fees, and any legal expense.

I hereby authorize you to release any and all information which you may possess relating to my examination and illnesses. I understand I may revoke this consent in writing at any time.

Signed ______________________ Date ______________________

Relationship if other than patient ______________________

(Please complete Dependant Child information on reverse side.)

DEPENDANT INFORMATION

CHILD #1

First Name ______________________ MI ________ Last Name ______________________

Male / Female (please circle)

Date of Birth ______________________

Social Security # ______________________

Child's Primary Care Doctor ______________________

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #2

First Name ______________________ MI ________ Last Name ______________________

Male / Female (please circle)

Date of Birth ______________________

Social Security # ______________________

Child's Primary Care Doctor ______________________

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #3

First Name ______________________ MI ________ Last Name ______________________

Male / Female (please circle)

Date of Birth ______________________

Social Security # ______________________

Child's Primary Care Doctor ______________________

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #4

First Name ______________________ MI ________ Last Name ______________________

Male / Female (please circle)

Date of Birth ______________________

Social Security # ______________________

Child's Primary Care Doctor ______________________

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

31860 US Hwy 19 N
Palm Harbor, FL 34684
(727) 787-6335
Fax (727) 787-7691

10537 State Road 54
New Port Richey, FL 34655
(727) 376-8404
Fax (727) 376-8552

11301 Countryway Blvd.
Tampa, FL 33626
(727) 891-6501
Fax (727) 891-6502

POS® Reorder # 1114403 (Rev. 06/11)

Date ______________________

Child's Name ______________________ **DOB** ______________________

Parents' Names ______________________

Siblings' Names ______________________

____

FAMILY HISTORY

Circle all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunts, uncles, or first cousins.

Please **specify who** (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

Asthma	High blood pressure	Anemia
Sinus Allergies	High cholesterol	Bleeding disorder
Eczema	Heart attack / stroke	Anesthesia reactions
Cystic fibrosis	Diabetes	Depression / anxiety
Birth defects	Kidney problems	Substance abuse
Seizures	Digestive problems	Cancer (specify type)
ADHD	Liver problems	Other ______________

BIRTH HISTORY **- circle italicized options** that apply.

Did mother receive prenatal care? *Yes* *No*

Was baby born *full term* (37-42 weeks) or *premature* (if preemie, how early? ______________________)

Was it a *vaginal delivery* or *cesarean section* (if c-section, state reason ______________________)

Did mom have any problems or complications during this pregnancy? *No* *Yes* (circle)

Diabetes, high blood pressure, preeclampsia, preterm labor, other ______________________

Did mom have any of the following infections during this pregnancy? *No* *Yes* (circle)

Yeast, herpes, gonorrhea, chlamydia, syphilis, HIV, urinary tract infection

Did mom test positive for group B strep (GBS) during this or a previous pregnancy? *No* *Yes*

If yes, did she receive antibiotics during labor? *No* *Yes* *Don't know*

What was baby's birth weight? ____________ Mom's blood type ____________

Did baby have any problems in the newborn nursery before hospital discharge? *Yes* *No* (circle)

Jaundice, low blood sugar, feeding problems, breathing problems or needed oxygen,

Heart murmur, suspicion of infection, sepsis, pneumonia, other ______________________

Name of birth hospital ______________________ How long did he / she stay? ______________

Did he / she have to go to the NICU or special intensive care unit for newborns? *No* *Yes*

Was baby at least 48 hours old when the newborn metabolic screen (PKU) was done? *No* *Yes*

Did he / she pass the newborn hearing screen with both ears? *No* *Yes*

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PAST MEDICAL HISTORY - Please explain any Yes answers

Any hospitalizations?	No	Yes
Any surgeries?	No	Yes
Any serious injuries, concussions, or broken bones?	No	Yes
Taking any medications, vitamins, herbals, or fluoride?	No	Yes
Any allergies to medications?	No	Yes
Any allergies to foods?	No	Yes
Any reactions to any immunizations?	No	Yes
Any chronic cough or recurrent wheezing or pneumonia?	No	Yes
Ever diagnosed with asthma or reactive airway disease?	No	Yes
Any nasal or sinus allergies?	No	Yes
Any eczema or skin problems?	No	Yes
Any vision or hearing impairments?	No	Yes
History of frequent ear infections?	No	Yes
Any heart problems or heart murmur?	No	Yes
Any stomach or digestive problems?	No	Yes
Any kidney or urinary tract problems?	No	Yes
Any seizures, tics, or migraines?	No	Yes
Any developmental delays or learning disabilities?	No	Yes
Any severe behavioral problems or psychiatric illness?	No	Yes

LEAD RISK ASSESSMENT (Check all that apply)

___ Home or daycare built before 1970 ___ before 1950 ___ has chipping / peeling paint
___ Child eats dirt, clay, or paint chips ___ likes to suck on windowsills or blinds
___ Child's friends, playmates, or neighbors with high lead levels
___ Parent's job / hobby involves lead exposure ___ Folk remedy with lead (Azarcon)
___ None of the above

TB RISK ASSESSMENT (Check if your child has close contact with an adult who . . .)

___ Is homeless or living in a shelter
___ Is living or working in a prison
___ Is living or working in a nursing home
___ Has TB, HIV, AIDS, or abuses drugs
___ Immigrated from Central or S. America, Haiti, Russia, E. Europe, India, or SE Asia
___ Is a healthcare worker (If yes, are they screened regularly? _________)
___ None of the above.

POS® Reorder # 1114401 (Rev. 06/11)

practice; not part of the health information which you would be permitted to inspect and obtain copy of, such as, psychotherapy notes; not created by our practice.

The right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. We are not required to agree to your request. In order to request a restriction you must make your request in writing to the Privacy Officer/Practice Manager at North Pinellas Children's Medical Center.

The right to receive an accounting of how and to whom your protected health information has been disclosed. Use of your health information as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim. To obtain an accounting of disclosures you must submit your request in writing to the Business Office, North Pinellas Children's Medical Center. All requests for an "accounting of disclosures" must state a time period, which may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but we will charge for additional lists within the same 12-month period. We will notify you of the cost involved with additional requests and you may withdraw your request before you incur any costs.

The right to receive a printed copy of this notice. To obtain a copy of this notice, ask the patient service representative at the reception window.

Duty of North Pinellas Children's Medical Center

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Practice Manager
North Pinellas Children's Medical Center
31860 US Hwy 19 N
Palm Harbor, FL 34684

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can contact the Privacy Official/Practice Manager if you have any questions. You may also contact the Secretary of Health and Human Resources to file a complaint.

Effective Date

This notice is effective April 14, 2003.

POS® Reorder # 0309273

Notice of Privacy Practices

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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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may may be consulted by staff members. We might disclose your health information to a pharmacy when ordering a prescription for you. We may also disclose HRS/Immunization records to daycare facilities, public/private schools and colleges.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services provided, and the medical condition being treated. We may contact your health insurer to certify that you are eligible for benefits (and the range of benefits).

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of North Pinellas Children's Medical Center. For example, we may disclose your protected health information to visiting Medical School students. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign the patient's name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatments. We will share your protected health information with third party "business associates" that perform various activities of our practice. For example, we may use your medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, transcription, storage/copying services for our practice, and for other health plans to determine coverage.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting (such as reporting child abuse or neglect). We may have to respond to a court or administrative order, if you are involved in a law suit or similar proceedings (subpoena, discovery request or other lawful process).

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Release of Information to Family

Our practice may release your health information to family members involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter bring a child into the pediatric office for treatment of a cold. In this example, the baby sitter may have access to the child's medical information.

Military

Our practice may disclose your health information if you are a member of United States military forces and if required by the appropriate authorities.

Other uses and disclosures require your authorization.

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. We reserve the right to require annual updates to information and authorizations.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to call/leave appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Deceased Patients. We may release your health information to a medical examiner or coroner to identify a deceased person or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. We may release your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate the donation and transplantation if you are an organ donor.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to receive confidential communications concerning your medical condition and treatment. For example, you may request to be called at home, rather than at work (unless emergency situation).

The right to inspect and obtain a copy of your protected health information, not including psychotherapy notes. You must submit your request in writing to the Medical Records Coordinator at North Pinellas Children's Medical Center. We have forms available at the reception area. We will charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or obtain a copy in certain circumstances (such as a court restraining order); however, you may request a review of our denial. Custodial and non-custodial birth parents have the same rights, unless we receive a copy of a signed/notarized court order directing us not to release the record.

The right to ask us to amend or submit corrections to your protected health information if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to the Privacy Officer/Practice Manager at North Pinellas Children's Medical Center. You must provide a reason that supports your request for amendment. We will deny your request if you fail to submit the request (supporting reason) in writing.

We may deny your request if you ask for us to amend information that is in our opinion: accurate and complete; not part of the health information kept by or for the

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I, ____, have received a
(Patient or Legal Representative…..PLEASE PRINT)

copy of this office's Notice f Privacy Practices.

____
Please Print Name of Patient (1 Child Per Sheet)

______________________________________ ______________
Signature of Patient or Legal Representative **Relationship**

____
Date

I request the following restrictions to the use or disclosure of my health information:

____
____
____
____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgment
( ) Other (Please Specify)

____
____

____
Witness Signature **Title** **Date**

North Pinellas Children's Medical Center
Financial Policy

As a courtesy to our patients, we will accept "assignment of benefits" from insurance carriers and will bill your insurance carrier for you. To do this, we must be provided with complete insurance information. We do not accept secondary insurance, you will be responsible for any payment and will need to file with your insurance carrier. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service.

If you are a self-pay patient without insurance coverage, all fees are due and payable at the time services are rendered unless prior arrangements have been made with our billing department.

If you are a parent of a minor, it is the responsibility of the parent who is seeking treatment for the child to ensure that payment is rendered accordingly.

It is also the parent's responsibility to understand their insurance coverage, so we encourage all parents to contact their insurance company prior to treatment. Before being seen, we will verify coverage from your insurance carrier.

All co-payments and deductibles are due up front and payable by check, cash or credit card (Visa, MasterCard, and American Express). Any check returned by your bank for any reason, will be assessed a $25.00 return check fee which will be added to your account and must be paid in full by either cash or credit card prior to any follow up visits.

By signing below I understand that I am responsible for the payment of services provided. If for any reason I am delinquent in my payments, I will be responsible for the cost of collections and possibly incur an interest rate up to 11/2 percent a month on an overdue bill. I acknowledge receipt of the financial policy and a copy shall remain in my child's chart.

______________________________________ ____________________
Parent/Guardian Signature Date

Child's Name __________________________________ D.O.B

Child's Name __________________________________ D.O.B

Child's Name __________________________________ D.O.B

Child's Name __________________________________ D.O.B

Pharmacy Update

Please help us process your prescriptions properly by updating the information below.

Pharmacy name: ______________________________

Pharmacy telephone number: ______________________________

Pharmacy address: ______________________________

Patient name: ____________________ Patient date of birth: ____________________

Patient name: ____________________ Patient date of birth: ____________________

Patient name: ____________________ Patient date of birth: ____________________

Patient name: ____________________ Patient date of birth: ____________________

Patient name: ____________________ Patient date of birth: ____________________

Parent / Guardian name: ______________________________

Address: ______________________________

Daytime telephone: ______________ / ______________________________

Evening telephone: ______________ / ______________________________

Parent / Guardian signature: ____________________ Date: ____________________

NORTH PINELLAS
Children's Medical Center
Board Certified Pediatricians

Authorization to Consent to Treat a Child

I (we) ____
Name(s) and address(es) of parents

designate ____
Name and address of designee

the power to consent in our absence to medical care for our child(ren):

_________________________________ _______________________________
Name and age of child Name and age of child

_________________________________ _______________________________
Name and age of child Name and age of child

Parent(s) phone number: ____
Child(ren)'s physician(s): ____
Physician's address and phone number: ____________________________________
____
Medical insurance company: ____
Policy #: __________________________ Group #: __________________________
Dates of expected absence from ____________________ to ___________________

CHILD(REN)'S MEDICAL HISTORY

Chronic conditions____

Medications that need to be given on a regular basis:

___________________ ____
Child's Name Medication name, dosage, frequency

___________________ ____
Child's Name Medication name, dosage, frequency

___________________ ____
Child's Name Medication name, dosage, frequency

___________________ ____
Child's Name Medication name, dosage, frequency

Allergies: ____
Dietary or other restrictions: ____

Parent Signature:____
Date:___________________________

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