Welcome to North Florida Pediatric Associates! We are pleased that you have selected us to be your child's primary care provider. We look forward to providing your child with personalized, comprehensive healthcare. As continuity and coordination of patient care are essential in meeting your child's healthcare needs, our team of physicians, nurse practitioners, nurses, medical assistants, and office staff work closely together to support and promote your child's care.

We have a wonderful team of providers that consists of doctors and nurse practitioners. Each of our providers has dedicated their life to providing passionate and quality medical care to children. Our physicians and nurse practitioners work collaboratively to see all of our patients and meet their needs.

We are a pro-vaccination clinic and adhere to the AAP and CDC guidelines for vaccines.

The office is open Monday through Friday 7:30am-4:00pm. Most weeks we have evening clinics provided on Monday, Tuesdays and Thursdays from 4:00pm-7:00pm. All patients are seen by appointment only. We are unable to accommodate walk-ins, but we do have same-day sick appointments available that you may call to schedule. These are given on a first-come first-served basis.

When starting our application process, we must receive all of your child's medical records from any former primary care physician and in some cases specialists before we can schedule any appointment. Please be aware that once we have submitted this request to your previous primary care physician's office, it can take anywhere from 1-4 weeks to receive the records depending upon their office policies.

Once approved and before your first appointment, please contact your insurance company and notify them of your new primary care physician. This can delay your care if not done prior to your appointment. Always being your child's health insurance card, your photo ID and a complete list of medications the child is taking to every appointment. If you are unable to make a scheduled appointment, please contact us as soon as possible. Any patient that fails to attend their first appointment and notify us at least 24 hours in advance will become inactive and cannot be reinstated as a patient at this office.

Many helpful tools can be found on our website at northfloridapeds.com

We look forward to working with you.

PATIENT DEMOGRAPHICS

Patient Last Name: _____ First Name: _____Middle Initial: _____

DOB: _____ Gender: _____ Male ____ Female ____ Other

Parent/Legal Guardian

Name: _____

Check One: ___Mother___Father___Legal Guardian

DOB: _____

Address: _____

_____

Email: _____

Cell Phone: (____)_____

Employer: _____

Work Phone: (____)_____

Name: _____

Check One: ___Mother___Father___Legal Guardian

DOB: _____

Address: _____

_____

Email: _____

Cell Phone: (____)_____

Employer: _____

Work Phone: (____)_____

Who is the primary caregiver: ___Both___Mother___Father___Legal Guardian

Other (Please explain): _____

Guarantor/Patient Confidential Communication Preference (Please list the phone and email to be used for main point of contact)

List the number and email: _____

Emergency Contact (other than parent)

Name: _____ Relationship: _____

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

Insurance Information:

Primary Insurance Company Name: _____

Member ID Number: _____ Group Number:_____

Policy Holders Name: _____

Preferred Pharmacy: _____

Address: _____

Phone: (____)_____

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

North Florida Pediatric Policies

Consent to Treatment and Authorization to Release Medical Information

I/we voluntarily consent to medical treatment and diagnostic procedures provided by North Florida Pediatric Associates (NFPA). I/we consent to testing for infectious diseases, such as, but not limited to Flu, Strep, SARS, Lead, Gonorrhea, Chlamydia, and testing for drugs if deemed advisable by my physician or nurse practitioner. I/we also consent to minor procedural treatment, such as but not limited to, bilirubin blood draws, and urinary catheterization. I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have read to me/us this consent and understand and agree to its contents.

Authorization for Release of Information and Assignment of Insurance Benefits

NFPA is authorized to release any medical information required in the processing of application or submission of information for financial coverage and the continuation of care, such as, but not limited to third party referrals to receive therapy services and treatment from specialist, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or testes for infectious disease. I/we also agree to the release of medical, vaccination, medication history or other information about me/the minor to the state vaccination registry, pharmacy benefit managers via Surescripts, and/or government regulatory agencies (federal or state) as required by law. For Medicaid/Medicare beneficiaries: I/we have provided all necessary information for proper assignment fo Medicaid/Medicare benefits.

Patient Billing and Financial Policy

As a courtesy, North Florida Pediatric Associates will file a claim for all services to your insurance company. Therefore, at registration, you will be asked for your insurance information. It is your responsibility to ensure we have your most current insurance information and to notify us of any changes.

It is also your responsibility as the guarantor to verify that North Florida Pediatric Associates is a **participating provider with your insurance company** and to be familiar with your plan benefits (i.e., deductibles, copayments, in and out of network costs).

I understand that unpaid claims that are not paid by my insurance company within 30 days from the date of service will be transferred to patient responsibility and will be due upon receipt of the statement or at next office visit. I also understand that balances for items that my insurance company deems as “non-covered” or “not medically necessary” are also my financial responsibility.

Payments are due at the time of service; you are expected to make payment in full. We accept cash, check, American Express, MasterCard, Visa and Discover.

The parent/ Guardian or authorized individual that brings the child to an appointment is responsible for payment at the time of services rendered.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

North Florida Pediatric Policies

Missed Appointment / No Show Policy (Please initial to acknowledge you have read and understand)

An appointment is considered a **NO- SHOW** if:

- **The patient has not arrived within 15 minutes of the scheduled appointment time.**
- **We do not receive a 24- hour notice for cancellation of all appointments other than same day scheduled appointments.**

Patients who miss or no- show for a double well appointment (bringing two children at the same time) will be restricted from scheduling double well appointments in the future. _____ **(Initial)**

Patients who miss or no- show for a first well (new patient) appointment, your family will no longer be eligible to establish care at North Florida Pediatric Associates. _____ **(Initial)**

If you no- show 3 appointments within a calendar year, we reserve the right to dismiss your family from the practice. _____ **(Initial)**

If you miss or no- show an appointment, you will be charged a **$25.00** No- Show fee. _____**(Initial)**

Vaccine Policy

At North Florida Pediatrics, we believe in the effectiveness of vaccines to prevent serious illness and to promote health and wellness. We believe that vaccinating children and young adults is the single most important health-promoting intervention that we as health care providers and that you as parents/ caregivers can perform. We strongly agree with and follow the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC) guidelines for all recommended vaccines starting at birth.

We understand the choice to vaccinate may be emotional for some parents/ caregivers, but our providers and staff will do everything we can to help support you and educate you on the importance of vaccinating. However, please understand, the decision to "delay" or to not vaccinate at all is against our practice policy and recommendations. Any parent who refuses to adhere to the AAP and CDC recommended vaccine schedule without a medical reason to do so may be discharged from our practice following a 30-day written notice from North Florida Pediatric Associates.

Our providers are always happy to answer any questions and are open to discuss any concerns you may have about vaccines and vaccinating.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

North Florida Pediatric Policies

Office Policies (Please initial to acknowledge you have read and understand)

_____ Appointment Scheduling

Our providers work collaboratively using both physicians and nurse practitioners to mee your child's needs. We alternate appointments between physicians and nurse practitioners. All children are seen by appointment only. We do not take walk-ins. We ask that you always call when your child is sick so we can provide you a same day appointment slot to minimize your wait as much as possible.

_____ Nurse Advice/After Hours Care

You can call our office any time to speak to a nurse. Based on age, severity of illness, and/or symptoms, you may be offered an appointment if available or given instructions for home care. Our advice protocols are approved by the American Academy of Pediatrics to be sure your child is receiving the most up to date information available. We contract with a Nurse Advice Line to provide guidance/counseling after normal office hours. One of our providers is on back up and may be paged by the nurse if needed. Please send all non-urgent questions/concerns through the secure patient portal or leave a message on our voicemail to be addressed during regular office hours.

_____ Responsibility for Medical Care

Every minor child (under 18 years) seen in our office for medical services MUST be accompanied by a parent, legal guardian or by an adult who has been authorized by the parent/legal guardian.

_____ Expanded Office Visits ("Sick concerns at the time of an Annual Physical or Nurse Visit)

If your child is scheduled for an Annual Preventative (Well Child) visit but is experiencing symptoms that are addressed by the physician (example: visits that requires a new prescription medication, a referral to new specialist or extensive counseling is required) - you will be charged a "sick" office fee, in addition to other expected visit charges. As such, your insurance company may charge you a co-pay/co-insurance or defer charges from part of your visit to your deductible. We have no control over your insurance policy benefits.

_____ Outside Billing

Although most labs are drawn and collected in our office, few are performed here. For those labs we typically outsource to Quest or LabCorp. It is your responsibility to let us know which one your insurance requires. If you receive a bill from an outside laboratory, contact them to resolve any questions. We do not take financial responsibility for any outside laboratory costs.

_____ Prescription Refills and Pick-Ups

Medication refills will only be done during regular office hours. For Prescription pick-ups, please allow 3-5 business days to complete. Once completed, we can have the prescription ready for pick-up during normal office hours. The parent or guardian may be required to show a picture ID and sign for receipt of the prescription.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

_____ Referrals and Prior Authorizations

Except in true medical emergencies, five (5) business days must be given to our office to complete routine referral or prior authorizations. Self-referrals will be considered as out of network and may result in financial liability to the patient. We do not accept responsibility for patient noncompliance with their individual insurance policies.

_____ Forms and Letter Requests

At some point you will likely require a form to be completed for your child. We request that you bring these forms to your child's annual preventative (Well Child) visit, and we will be happy to complete them during the visit, except for certain state forms. However, any form submitted at another visit/times or sibling forms (if requested on a date other than their annual preventative visit) will require 3-5 business days to complete. Once completed, we can have the forms available for pick-up at the office, return by secure email or by fax.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Pediatric Medical History Form

Child's Name: _____ Date of Birth _____

Legal Guardian(s): _____

Medications (to include: Name of Medication, Dose, Prescribing Provider and Frequency of use):

_____

_____

Medication Allergies: ____ No ____ Yes

If yes, what was the reaction: _____

_____

Immunization History (please provide a copy of your child's immunization record):

To the best of my knowledge, my child is up to date on his/her immunizations ____ No ____ Yes

If no, why: _____

Birth History

Please indicate any medical problems during pregnancy: _____

Did your child require a NICU stay: ____ No ____ Yes If yes, why: _____

Please indicate any medical problems during the newborn period: _____

Name of the hospital & city/state where infant was born: _____

Mother's name at the time of birth: _____

Hospitalizations

Has your child ever stayed overnight in a hospital? ____ No ____ Yes

If yes, when and why: _____

_____

Additional Information

Race: ____ American Indian/Alaskan Native ____ Asian ____ Black/African American ____ Native Hawaiian

____ Other Pacific Islander ____ White ____ Declines to Respond

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino ____ Declines to respond

Preferred Language: _____

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Pediatric Medical History Form

Surgical/Outpatient Procedure History (ex: Ear Tubes, Tonsillectomy, etc.): _____

_____

Social History

Is the child cared for by anyone other than the biological parents? ____ No ____ Yes

If yes, by whom and how frequently: _____

Does anyone if your home smoke? ____ No ____ Yes

Please list any siblings the child has including step and half: _____

_____

Personal Medical History (Please check if your child has had any other following medical problems)

____ ADD/ADHD	____ Chicken pox	____ Headaches	____Liver disease/Hepatitis
____ Allergies	____ Concussion	____ Hearing problems	____Recurrent ear infections
____ Anemia	____ Diabetes	____Heart Murmur	____Reflux/GERD
____ Asthma	____ Eczema	____ Seizures	____ Congenital Heart Disease
____ Bleeding Disorder	____ Fracture	____ High Blood Pressure	____Urinary Tract Infections
____ Bronchiolitis	____ Kidney Disease	____ Vision Problems	____ Handicaps/Disabilities

Other Provers (Please list any other specialists your child sees. Ex: Physical Therapy, ENT, etc.):

_____

_____

_____

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Pediatric Medical History Form

Family History (Please indicate if your child has a family history: parents, siblings, maternal/parental grandparents, aunts, or uncles, of any of the following)

Diagnosis	Family Member	Diagnosis	Family Member
___ ADD/ADHD	_____	___ Hearing Problems	_____
___ Alcohol/Drug Abuse	_____	___ High Cholesterol	_____
___ Allergies	_____	___ High Blood Pressure	_____
___ Birth Defects	_____	___ HIV/AIDS	_____
___ Blood Disorders	_____	___ Learning Disability	_____
___ Cancer, Type	_____	___ Mental Illness	_____
___ Heart Disease	_____	___ Migraines	_____
___ Depression	_____	___ Scoliosis	_____
___ Developmental Delay	_____	___ Seizure Disorder	_____
___ Diabetes	_____	___ Speech Problems	_____
___ Genetic Disorder	_____	___ TB/Lung Disease	_____
___ Hepatitis/Liver Disease	_____	___ Thyroid Disease	_____
___ Stroke	_____	___ Other	_____

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Alternative Caregiver Form

Patient Name _____ Date of Birth _____

I authorize the following individuals to bring my child to their appointment.

If no one else is authorized, please mark "No One". (Please note the emergency contact will not receive any information if not on this form)

Name	Relationship to patient	Phone Number

Please initial the following:

____ I attest that the above named individuals are all 18 years of age or older as of this date

____ I authorize the above-named individuals to consent to treatment for my child. This may include but is not limited to consent for necessary medication, immunizations, procedures and hospitalization. North Florida Pediatric Associates may relay any medical information, including protected health information about my child that is necessary for the above-named individuals to provide informed consent to the treatment.

____ I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings the child.

____ I agree that the above-named individuals will have access to the billing information associated with the required payment during the time of the accompanied appointment. I understand that payment is expected at the time of services rendered.

____ I agree to hold North Florida Pediatric Associates and its staff harmless for any disagreement between the above-named individuals and myself regarding the treatment process.

____ I understand that I can revoke this authorization, in writing, for any or all of these.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Relationship to patient: _____

Authorization to Receive Protected Health Information

This form permits North Florida Pediatric Associates to receive the patient's protected health information for the purposes described below.

Patient Name: _____ Date of Birth: _____

Entity to Receive:

North Florida Pediatric Associates

2255 Killearn Center Blvd. STE 100

Tallahassee FL, 32309

Phone: 850-877-1182 Fax: 855-513-7271

Entity to Disclose Protected Health Information:

Name: _____

Address:_____

City/State/Zip: _____

Phone: _____ Fax: _____

Purpose of Disclosure:

____ Changing PCP/Discontinuing Care

____Moving out of area

____ Personal Reasons

____ Attorney Request

____Other: _____

Specific Information to be Released:

√ Complete Medical Record

√ Mental Health/Counseling

√ Lab Reports

√ Financial Information

√ Newborn Screen

I understand that the information in my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse.

I understand that my information may not be protected from re-disclosure by the requestor of the information. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that I may revoke this authorization at any time and that I must submit my request in writing to North Florida Pediatric Associates. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that this form will expire after the retrieval of information.

All changes or updates to this form must be made in writing.

Parent/Legal Guardian Signature: _____ Date: _____

Parent Legal Guardian Printed Name: _____

Relationship to patient: _____