(850) 877-1162
3606 Maclay Blvd. Ste 102
Tallahassee, FL 32312
northfloridapeds.com

Today's Date:_____/_____/_____

Tell us About Your Child

Patient's Full Name: _____

Patient's Birth Date_____/_____/_____Age _____

School _____ ○ Male ○ Female

Race_____ Ethnicity_____

Patient primarily lives with:

○ Both parents ○ Mother ○ Father ○ Other

Primary Address _____

City_____State_____Zip _____

Who may we thank for referring you to our office?

○ Friend _____
○ Facebook/social media
○ Insurance company
○ Other_____

Parent One Information

○ Mother ○ Father ○ Legal Guardian

Name_____DOB_____

Phone (_____)_____H W C SS _____

Email _____

Occupation _____

Employer _____

Parent Two Information

○ Mother ○ Father ○ Legal Guardian ○ Not in the picture

Name _____DOB_____

Phone (____)_____H W C SS _____

Occupation _____

Employer _____

Health Insurance

Insurance Co. Name _____

Member Number _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date_____/_____/_____

Policy Owner's Employer _____

Health History

Pediatrician/PCP_____

Date of Patient's Last Physical_____

Is your child in good health? Y N

If no, please elaborate_____

Is your child up-to-date on their immunizations? Y N

Has your child ever any significant diagnosis, injury, or medical event? Y N

If yes, please elaborate_____

Does your child have any **allergies** to food or medications? if so, to what? Y N

○ Penicillin/Amoxicillin ○ Eggs ○ Latex ○ Nuts
○ Dyes ○ Adhesives ○ Bees ○ Other_____

What reaction did they have?_____ When?_____

Does your child carry an EpiPen? _____

Is your child taking any medications? Y N

if so, please list: medication / dosage / frequency _____

**I am the parent, legal guardian, or personal representative of the child listed above. There are no court orders in effect that prohibit me from signing this consent.

North Florida Pediatric Associates

3606 Maclay Blvd. Suite 102
Tallahassee, Florida 32312

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent or Guardian Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

AUTHORIZATIONS

I authorize the release of any medical information necessary to process the insurance claim form for services and/or quality assurance activity required by your plan or entity rendered by North Florida Pediatric Associates. I also request payment of government benefits to the party who accepts assignment. I do authorize payment of medical benefits to North Florida Pediatric Physicians/Providers.

FINANCIAL RESPONSIBILTY:

Patient/Responsible party shall pay to North Florida Pediatric Associates such sums as are now or may become due for services rendered to the patient and for which the patient's health maintenance organization or insurer is not liable for payment for fees to NFPA. Guarantor must sign for ALL minors or dependents. The guarantee of the account hereby assumes full financial responsibility for payment for all medical services by the named patient in accordance with the terms as set forth in the Authorization above.

PRINT PATIENT'S NAME PATIENT'S DOB

PARENT/GAURDIAN SIGNATURE DATE

RECEIPT OF PATIENT PRIVACY NOTICE:

A copy of the Patient Privacy Notice from NFPA has been made available to me for my review. I understand that for the office to review or discuss my medical/financial issues with anyone besides me, I will complete the Medical /Financial Information Disclosure form.

USE AND DISCLOSURE:

I understand that as part of my health care, NFPA originates and maintains an electronic health record describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatments. The use and disclosure of Protected Health Information for treatment, payment or operations is described in the Patient Privacy Notice. Your records may be shared with your other providers electronically or via phone, fax, or health information exchange.

PARENT/GAURDIAN SIGNATURE DATE

MEDICATION REPOSITORY:

Any pharmacy that participates with a central repository will have an updated list of your medications. In order to provide you with the best possible care, the providers would like your permission to access this repository.

PARENT/GAURDIAN SIGNATURE DATE

Medical / Financial Information Disclosure

I, _ _ _ _ _ _ _ _ _ _ _ _ _ _, the undersigned, hereby authorize North Florida Pediatric Associates, P.A., its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s). The individuals listed below are involved in my child's care and have authorization to talk to our staff on the phone and/or seek medical care and authorize treatment including vaccines.

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

○ **At this time, I do not want to authorize anyone other than parent/guardian.**

○ **At this time, I authorize the following to bring my child to his/her appointment and/ or to be contacted regarding my child.**

	NAME	RELATIONSHIP	TELEPHONE
#1			
#2			
#3			

I understand that authorization to anyone other than myself and child's other parent is voluntary, and I can revoke authorization at any time:

Authorized by: _____

(Guardian Signature) (Print Guardian Name)

Thank you for choosing North Florida Pediatrics as your child's healthcare provider. In order to familiarize you with how our office works, we are providing you with this information. We ask that you read and sign this form indicating that understand and agree to the following:

What you need to know

Our Practitioners: Our practice consists of three doctors: Anna Koeppel, MD; Robert Kickish, MD and Frank Walker, MD. Each of our providers have dedicated their lives to providing passionate and quality medical care to children. When your doctor is not available, we have nurse practitioners available to care for your child for continuity of care. The progress note of that visit is reviewed by your child's doctor.

Clinic Hours: For your convenience, North Florida Pediatrics is open Monday through Friday 7: 15A.M-5:00P.M. All children are seen by appointment only. We also offer after-hours appointments on week day evenings. We ask that you always call when your child is sick, so we can provide you a work-in time to minimize your wait as much as possible.

When Your Child Is Sick: Please call our office during phone hours to speak to a nurse. Based on age, severity of illness, and/or symptoms, you will be offered an appointment or give instructions for home care. Not every illness requires a visit. Our triage nurses have 30+ years combined pediatric experience. They also use a telephone triage protocol approved by the American Academy of Pediatrics to be sure your child is receiving the most up to date information available.

Afterhours Nurse for Urgent Questions: We have afterhours pediatric nurses available to assist with questions regarding your sick child. You can reach the nurse by dialing our office number (850) 877-1162. Please leave a message for the nurse and you will be contacted within an hour. If you do not hear from the nurse within 1 hour, please call again as we may have had trouble with your message.

Non-Urgent Calls: All others calls regarding appointments, forms, medical records, or billing will be taken during our phone hours of operation from 8: 00A.M-4: 30P.M Monday through Friday. Please follow auto attendant prompts to reach the correct department.

Missed Appointments: Please give us 24 hours' notice if you cannot attend your appointment. If you no-show an appointment, you are responsible for calling to reschedule that appointment. If you are scheduled with a doctor and you no-show the appointment, you will most likely be rescheduled to see a nurse practitioner. No-show appointments may also be subject to a no-show fee equal to your insurance copay.

Late Appointments: If you arrive more than 30 minutes late we will make every attempt to see your child after other timely arrived patients. Your appointment may be moved to the end of the providers schedule or rescheduled for another day or time in agreement with you.

Changes in Insurance: You are responsible for informing our office in the event of an insurance change. Please remember to bring your child's new insurance card to the next appointment.

Our Website: Our website, NorthFloridaPeds.com, provides you with many resources regarding your child's health. The resources available to you include the use of our patient portal where you can find summaries of visits, reminders about upcoming appointments, and allows you to contact our office through a secure messaging system. Any questions or requests will be addressed in 3 to 5 business days. Another resource we provide is a Symptom Checker. On the home page of our website, you can input your child's symptoms and receive medical advice from the same American Academy of Pediatrics approved content our nurses use.

Financial Responsibility: You are ultimately responsible for all payment obligations regarding the care and treatment of your child. All copay and/or contracted amounts based on your insurance plan and due at the time of service.

_____ _____

Parent/Guardian

North Florida Pediatric Associates

3606 Maclay Blvd. Suite 102
Tallahassee, Florida 32312
(850) 877-1162
(850) 671-5009 Fax

Anna T. Koeppel, M.D. [ ]
Robert A. Kickish M.D. [ ]
Frank C. Walker, Jr. M.D. [ ]
Maci McDermott, M.D. [ ]

Authorization to Disclose Protected Health Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (* signifies required field)

***Patient Name:** _____ ***Date of Birth:** _____
(Last, First, Middle) *(MM, DD, YYYY)*

***Telephone#:** _____

***From:**
Name *(coming* from): _____
Address: _____
City: _____ State _____ Zip _____
Telephone: _____ Fax: _____

***To:**
Name *(going to):* _____
Address: _____
City: _____ State _____ Zip _____
Telephone: _____ Fax: _____

TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: ***(Include dates when appropriate)***

* From: (DATE) _____ To: (DATE) _____

( ) Medical Records ( ) Immunization Records ( ) Mental Health/ Counseling ( ) HIV/AIDS ( ) Financial

* **PURPOSE OF DISCLOSURE:** ( ) Changing PCP & discontinuing care at this office
( ) Leaving town & transferring records to new physician ( ) Attorney ( ) Personal reasons ( )
Insurance ( ) Office of Disability Determination ( ) Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, 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 agree to such release.

I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations.

I **understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six (6) months from the date signed below.

I **understand** that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in **CFR164.524.** If I have questions about disclosure of my health information I can contact the Privacy Officer.

***Signature of Patient or Legal Representative** ***Relationship** ***Date**

_____