PATIENT DEMOGRAPHICS

Patient Last Name: _____ **First Name:** _____ **Middle Initial:** _____

DOB: _____/_____/_____ **Gender: Male** _____ **Female** _____ **SSN:** _____

MOTHER/LEGAL GUARDIAN	FATHER/LEGAL GUARDIAN
Name: _____	**Name:** _____
DOB: _____/_____/_____ **SSN:** _____	**DOB:** _____/_____/_____ **SSN:** _____
Address: _____	**Address:** _____
_____	_____
Home Phone: (_____) _____-_____	**Home Phone:** (_____) _____-_____
Cell Phone: (_____) _____-_____	**Cell Phone:** (_____) _____-_____
Work Phone: (_____) _____-_____	**Work Phone:** (_____) _____-_____
Email: _____	**Email:** _____

Who is the primary caregiver? **Both** _____ **Mother** _____ **Father**_____

Other (Please explain): _____

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: _____

Additional Information

Race: (check one) American Indian/Alaskan Native___ Asian___ Black/African American___ Native Hawaiian___ Other Pacific Islander___ White___ Declines to Respond___

Ethnicity: (check one) Hispanic or Latino___ Not Hispanic or Latino___ Declines to Respond___

Preferred Language: _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

I hereby certify that the information above is accurate and true.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Print Name: _____

NORTH FLORIDA PEDIATRIC ASSOCIATES

Patient Communication Information

Patient Name: _____ DOB: _____

To help better communicate with our patients we are asking all patients to fill out this Patient Communication Log.

Have you accessed our Patient Portal? Yes or No (circle one)

If No, would you like to access our Patient Portal? Yes or No

If Yes, please print your email address here: _____

Once we activate your email address you will receive an email confirmation from us. This will include the link to our portal, your log in and your password. If you forgot you log in and/or password, please see the receptionist to reset your information today.

How would you like us to confirm your appointments? You can select one or both.

By Voice Mail? Yes or No

By Text (SMS) Message? Yes or No

What is the preferred number? _____

Is this your **Home**, **Work**, or **Cell Number**? (Please circle one)

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Name: _____

Please Print

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize North Florida Pediatric Associates to disclose the following protected health information about my child to the following family member(s) or person(s) involved in my child's care or payment for my child's care:

**Provide the names of authorized people, OTHER than parents. If no one else is authorized to receive information, please mark "No One". **

Name:	Relationship to Patient	Phone Number:

Check all that may apply:

____ All of my child's medical information.
_____Information necessary to schedule appointment.
_____Lab or test results.
_____Information necessary to provide, call in or pick up prescriptions for my child.
_____ Information necessary to help my child's family member(s) take care of my child.
_____ Information necessary to allow my child's family member(s) to pick up or arrange for medical equipment to be provided for my child.
_____ Information necessary to bill for or submit claims for care provided to my child to government or private insurance payors.

My consent will remain in effect as long as my child is a patient with North Florida Pediatric Assoc. unless I notify NFPA in writing with changes.

Parent/Legal Guardian Name: _____
(Please Print)

Parent/Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____

North Florida Pediatric Associates
3606 Maclay Blvd. Suite 102
Tallahassee, Florida 32312
Phone: (850) 877-1162 Fax: 855-513-7271

Anna Koeppel, M.D
Maci McDermott, M.D
Sarah Alvarez, M.D

Authorization to Disclose Protected Health Information

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

Telephone Number: _____

Person or Entity to Receive Information:	Person or Entity to Disclose Information:
Name/Organization: _____	Name/Organization: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Purpose of Disclosure

___Changing PCP & Discontinuing Care at this Office
___Leaving Town & Transferring Records to New Physician
___Personal Reasons
___Attorney
___Insurance
___Other: _____

Specific Information to be Disclosed

___Complete Medical Records
___Immunization Records
___Mental Health/Counseling
___Lab Reports
___Financial
___Other: _____

* **I understand that** once my records have been transferred to another local Primary Care Physician, NFPA has released all care permanently.
* **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 redisclosure 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 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.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please Print)

PATIENT BILLING AND FINANCIAL POLICY

As a courtesy, North Florida Pediatric Associates will file a claim for all services to your insurance. Therefore, at registration, you will be asked for your current insurance information. It is your responsibility to assure 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, co-payments, in and out of network costs).

To summarize, you will be responsible for **payments at time of** service for the following reasons:

- Your insurance company requires you to pay deductibles.
- Co-payments required by your insurance company.

You will be responsible for a bill for the following reasons if:

- The service is not a covered benefit.
- Co-insurance is required by your insurance company.

Payments are due at 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 child to an appointment is responsible** for payment at time of services rendered.

MISSED APPOINTMENT/NO SHOW POLICY

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 in at the same time) will be restricted from scheduling double well appointments in the future.
Patients who miss or no show a first well (new patient) appointment, your family will no longer be eligible to establish care at North Florida Pediatric Associates.
If you no show 3 appointments within a 24-month period, we reserve the right to dismiss your family from the practice.

You may leave a voicemail within 24 hours of your scheduled appointment and it will not be considered a no show.

_____	_____
Patients Name	Signature of patient or representative
_____	_____
Print Name/Relationship to Patient	Date

NORTH FLORIDA PEDIATRIC ASSOCIATES

VACCINE POLICY

Patient Name: _____ DOB: _____

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 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. Please understand however, 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 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.

By signing, you understand and acknowledge our vaccine policy at North Florida Pediatrics

Parent/Legal Guardian Signature: _____ Date _____

Parent/Legal Guardian (Please Print): _____

Revised 04/05/2021

NORTH FLORIDA PEDIATRIC ASSOCIATES OFFICE POLICIES

Thank you for choosing North Florida Pediatrics as your child's healthcare provider. 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:

Please initial each section to acknowledge you have read and understand.

---

* **Our Practitioners:** Our practice consists of three (3) doctors: Anna Koeppel, MD; Maci McDermott, MD and Sarah Alvarez, MD. When your doctor is not available, we have six (6) nurse practitioners: Lindsay Calabro, Brett Everett, Naomi Mardesich, Janie Pitts, Elizabeth Strickland, and Amber Thompson, available to care for your child. Each of our providers have dedicated their lives to providing passionate and quality medical care to children. _____**Initial**

* **Clinic Hours:** North Florida Pediatric Associates is open Monday through Friday 7:30A.M--4: 00P.M as well as evening clinics on Monday, Tuesday, and Thursdays from 4: 30P.M to 7:30P.M. 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 work-in time to minimize your wait as much as possible. _____**Initial**

* **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 todate information available. _____**Initial**

* **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 as soon as possible. _____**Initial**

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

* **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 nurse's use. _____**Initial**

* **Patient Portal and Healow App:** We use the Patient Portal and Healow app to communicate with our patients. The Healow app allows patients to check-in for scheduled appointments, view referral information, update demographics, view/change upcoming appointments and much more. _____**Initial**

* **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. _____**Initial**

* **Patient Dismissals:** North Florida Pediatric Assoc. believes the physician/patient relationship to be a professional one based upon mutual trust. If a breakdown in this relationship occurs, we reserve the right to refuse treatment. Reasons for dismissal include (but not limited to): _____ **Initial**
  - **Dishonesty**
  - **Aggressive, inappropriate, or threatening behavior to staff (actual or implied)**
  - **Persistent non-compliance with treatment plans**
  - **Request of services beyond our scope of care**
  - **Multiple no shows**
  - **Transfer to another local primary care physician**

* **Profanity:** We will not tolerate the use of profanity towards our staff or providers. _____**Initial**

I have read and understand the policy above:

Parent/Legal Guardian Signature: _____ **Date:** _____

Revised 04/05/2021

NORTH FLORIDA PEDIATRIC ASSOCAITES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, MAYBE UED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or. Disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new.
rights. to understand and control how your health information is used. · HIPAA provides penalties for covered entities that misuse personal health information·.

As required by HIPAA, we have prepared this explanation of how we are required to 'maintain the privacy' of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following, purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination or making a referral to a specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as ·conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree toa restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Scarlette Sipple, Administrator North
Florida Pediatric Associates
3606 Maclay Blvd Ste 102
Tallahassee, FL 32312
850-877-1162 ext 209

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775