Celebration Pediatrics

1530 Celebration Boulevard, Suite 301, Celebration, Florida 34747
Phone (407) 566-9700 Fax (877) 534-5105

Patient Information/Información del paciente

Last Name/Apellido:	First Name/Primer Nombre:	Middle Name/Segundo Nombre:	Sex/Sexo:	DOB/Fecha de Nacimiento:

Race: ☐ African American ☐ Asian ☐ Native American/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
Ethnicity: ☐ Latino/Hispanic ☐ Not Latino/Hispanic
Primary Language Spoken in Home/Idioma primario hablado en la casa: ______________________

Patient's Preferred Provider/Preferido Proveedor:

Parent /Guardian's Information (Información de los padres o el Guardián del paciente)

Last Name/Apellido:	First Name/Primer Nombre:	MI:	Sex/Sexo	DOB/ Fecha de Nacimiento:
Address/Dirección:	City/Ciudad:	State/Estado		ZIP/Zona Postal:
Home Phone/Número de teléfono de la casa:	Cell Phone/Celular:			
E-Mail Address/Correo Electrónico:				
Employer/Empleador:	Occupation/Ocupación:			

Parent /Guardian's Information (Información de los padres o el Guardián del paciente)

Last Name/Apellido:	First Name/Primer Nombre:	MI:	Sex/Sexo	DOB/ Fecha de Nacimiento:
Address/Dirección:	City/Ciudad:	State/Estado		ZIP/Zona Postal:
Home Phone/Número de teléfono de la casa:	Cell Phone/Celular:			
E-Mail Address/Correo Electrónico:				
Employer/Empleador:	Occupation/Ocupación:			

Medical Insurance/Seguro Médico

Name of Insurance/Nombre del Seguro:	Effective Date/Fecha Efectiva:	Telephone Number/Numero de teléfono:
Policyholder's Name/Nombre del Asegurado:		DOB/Fecha de Nacimiento:
Member ID Number/Numero de Identificación:	Group Number/Numero de Grupo:	

Signature of Person Completing This Form/Firma de persona llenado esta forma:	Date/Fecha:

How did you hear about Celebration Pediatrics?

☐ Currently Established ☐ Friend/Family ☐ Hospital ☐ Insurance Company ☐ IP Website ☐ OB/GYN ☐ Other

Name of Friend, Doctor, Hospital or Other Source of Referral: ______________________

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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, ____(Guardian's full name), hereby authorize the release or use of my dependents individually identifiable health information (PHI "Protected Health Information") and medical record information by Celebration Pediatrics Associates, PA, in order to carry out treatment, payment, or health care operations on behalf of the patient: ____ (patient's full name) ________________ DOB.

You should review the Celebration Pediatrics Associates, PA Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent from.

We reserve the right to change the terms of the Notice to Privacy Practices at any time. If we do make changes to the terms, you may obtain a copy of the revised notice.

You retain the right to request that we further restrict how your dependent's PHI is released or used to carry out treatment, payment, or health care operation. Our practice is not required to agree to such requested restriction: however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I acknowledge and agree that the practice may disclose my dependent's PHI and medical record information, confirm or change appointment times and speak to the office on my dependent's behalf with the following individuals who are family members, legal representatives, guardians, healthcare surgeons, or have power of attorney:

Name	Date of Birth	Relationship

Any additional individuals should be listed on the back of this form if needed.

I agree and have been given notice that the practice may also disclose the following types of information contained in my dependent's medical record to the appropriate authorities as we are required by Florida State Law 384.25 (please initial all categories below)

_______HIV/Aids information   ______ Mental Health Information   _______Substance Abuse Information
_______Sexually Transmitted Disease information   ______If patient is under the age of 18, pregnancy information

I understand that if the practice needs to contact me, it will be via the primary phone number listed in my guarantor file. I always agree to keep this number updated and understand that my dependent's demographics are my responsibility. I acknowledge that I can update demographics through several sources. I can update them in the office directly, through a call to the office, or through my dependent's patient portal. Should the practice need to communicate with me and my phone is unavailable, after 3 attempts a certified letter will be sent through the mail. I elect for correspondence to be directed to me in the optional form of:

☐ Email ______________________________ or ☐ Fax # ______________________________

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective to the extent that the practice has already taken action based on the prior consent.

The practice may refuse to treat your dependent if you (or an authorized representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the practice has the right to refuse to provider further treatment to you as of the time of the revocation (except to the extent that the practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

______________________________ ________________ __________AM/PM
Signature of Guardian or Authorized Representative   Date   Time

Please describe your relationship to the patient and include a description of the Representative's authority to act on their behalf.

____

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PEDIATRIC PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________________ DOB: ____________

Birth History

Birth Weight_____ Preg#____Mom's age_________Was the birth ☐ Vaginal? ☐ Cesarean? ☐ Early? ☐ Late?

If birth was early, how many weeks early?______If Cesarean, why? ______________________________

Did mother have any illnesses/problems with her pregnancy? ☐ Yes ☐ No Explain __________________

Did baby have any problems right after birth? ☐ Yes ☐ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

☐ Smoke Cigarettes (amount) ________________ ☐ Drink Alcohol (amount) ____________________

☐ Use "street" drugs (type) __________________ ☐ Use Prescription Drugs (type) _______________

Was initial feeding ☐ Breast Milk? ☐ Formula

Current and Past History

Is your child currently on any medication?	☐ Y	☐ N	Explain: ____________________
Does your child have any serious or chronic illnesses?	☐ Y	☐ N	Explain: ____________________
Has your child had serious injuries or accidents?	☐ Y	☐ N	Explain: ____________________
Has your child had any surgeries?	☐ Y	☐ N	Explain: ____________________
Has your child ever been hospitalized?	☐ Y	☐ N	Explain: ____________________
Is your child allergic to any medications?	☐ Y	☐ N	Explain: ____________________

Does Your Child Have or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	☐ Y	☐ N	Explain: ____________________
Nasal allergies or eczema	☐ Y	☐ N	Explain: ____________________
Frequent ear infections or sore throat	☐ Y	☐ N	Explain: ____________________
Problems with ears or hearing	☐ Y	☐ N	Explain: ____________________
Problems with eyes, vision or teeth	☐ Y	☐ N	Explain: ____________________
Frequent headaches or other neurologic problems	☐ Y	☐ N	Explain: ____________________
Frequent abdominal pain	☐ Y	☐ N	Explain: ____________________
Constipation requiring doctor visits	☐ Y	☐ N	Explain: ____________________
Bladder/kidney problems or bedwetting	☐ Y	☐ N	Explain: ____________________
Any heart problems/murmur	☐ Y	☐ N	Explain: ____________________
Anemia or bleeding problem	☐ Y	☐ N	Explain: ____________________
Thyroid or other gland problem	☐ Y	☐ N	Explain: ____________________
Diabetes	☐ Y	☐ N	Explain: ____________________
ADD/ADHD	☐ Y	☐ N	Explain: ____________________
Mental Health Issues	☐ Y	☐ N	Explain: ____________________
Use of drugs or alcohol	☐ Y	☐ N	Explain: ____________________

Household Information

Please list all those living in the child's household

Name	Relationship to child	DOB

Are there siblings not listed above? If so, please list their full names and ages and where they live

Sibling Name	Location	Age

Child Care: ____

Smokers in household? ☐ Y ☐ N

Family Medical History (Parents, Siblings, Grandparents, Aunts, and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse ☐ Y ☐ N Who: ____________ Comments ____________________
Allergies ☐ Y ☐ N Who: ____________ Comments ____________________
Asthma ☐ Y ☐ N Who: ____________ Comments ____________________
Birth Defects ☐ Y ☐ N Who: ____________ Comments ____________________
Blood disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Bone disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Cancer ☐ Y ☐ N Who: ____________ Comments ____________________
Diabetes ☐ Y ☐ N Who: ____________ Comments ____________________
Endocrine Disease ☐ Y ☐ N Who: ____________ Comments ____________________
Ear / Nose / Throat ☐ Y ☐ N Who: ____________ Comments ____________________
Disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Heart Disease ☐ Y ☐ N Who: ____________ Comments ____________________
High Blood Pressure ☐ Y ☐ N Who: ____________ Comments ____________________
High Cholesterol ☐ Y ☐ N Who: ____________ Comments ____________________
Immune Disorder ☐ Y ☐ N Who: ____________ Comments ____________________
Joint Problems ☐ Y ☐ N Who: ____________ Comments ____________________
Kidney Disease ☐ Y ☐ N Who: ____________ Comments ____________________
Liver Disease ☐ Y ☐ N Who: ____________ Comments ____________________
Lung Disease ☐ Y ☐ N Who: ____________ Comments ____________________
Migraine Headaches ☐ Y ☐ N Who: ____________ Comments ____________________
Metabolic Disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Obesity ☐ Y ☐ N Who: ____________ Comments ____________________
Seizure Disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Skin Disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Stroke History ☐ Y ☐ N Who: ____________ Comments ____________________
Thyroid Disorders ☐ Y ☐ N Who: ____________ Comments ____________________
Mental Health History ☐ Y ☐ N Who: ____________ Comments ____________________
Other Medical History ☐ Y ☐ N Who: ____________ Comments ____________________
Other Medical History ☐ Y ☐ N Who: ____________ Comments ____________________

____________________________________ ____________ ____________________________

Signature of Person Completing This Form Date Relationship to Patient

Celebration Pediatrics

CELEBRATION PEDIATRICS
BILLING AND FINANCIAL POLICY

Please initial in the space provided and sign your name acknowledging your consent and agreement.

Insurance: _________(initial)

If you have insurance, we will provide insurance claim filing for the insurance plans with which we participate; however, if we do not accept your insurance plan or if a **claim is denied or a balance is due, you are responsible for payment of the balance owed and we expect payment within 30 days from the date we notify you of such determination. It is your responsibility to pay any co-pay's, deductible, co-insurance or any other balance not paid for by the insurance or third-party payer within 30 days**.

It is the responsibility of the patient/guardian to provide us with current insurance plan information prior to services rendered in order for accurate billing of services to be filed. You are also responsible for contacting your insurance company to make sure we are in network with your particular plan. It is important that you are familiar with the guidelines of your plan requirements regarding authorizations, deductibles, co-payments and other vital requirements.

In consideration of services rendered, you agree to transfer and assign to Celebration Pediatrics all rights, title and interest in any payment due to you or otherwise payable to you for services rendered.

Self-Pay: _________(initial)

In consideration of the services rendered, you agree to pay Celebration Pediatrics in accordance with the regular rates and terms of service/costs for Celebration Pediatrics. Payment is due in full at the time services are rendered. You affirm that you are duly authorized as the patient or as patient's guardian/agent to execute this document and accept its terms.

Medicare/Medicaid: _________(initial)

Patient's certification authorization to release information and payment request. You certify the information given to Celebration Pediatrics in applying for payment under Title XVIII/XIX of the Social security act is correct. You authorize any holder of medical or other information about you to release to Social Security Administration/Division of Family services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. You further certify all insurance proceeds pertaining to treatment or services provided shall be assigned to Celebration Pediatrics.

Laboratory Charges: _________(initial)

We collect and send specimens to a laboratory for processing. We are NOT responsible for laboratory charges. If you have any questions regarding the laboratory charges, you must call the laboratory listed on your bill.

Office Charges: _________(initial)

Credit Cards: For your convenience, we will keep your credit card information on file to be used for balances on your account that are your responsibility (co-insurances, co-pays, and deductibles, not to exceed $150.00

FMLA: There is a $25 fee for FMLA paperwork that is processed withing 7 business days. This fee is due **PRIOR** to any paperwork being faxed or picked up. There is a $50 fee for expedited FMLA paperwork.

Returned Check Fee: A **<u>$35.00 fee</u>** will be assessed to your account for any returned checks

No Show Policy: A **$25.00 fee** will be assessed to your account for any "NO SHOW" or CANCELLATION on a same day SICK appointment. All future appointments require a 24-hour cancellation notice PRIOR to the appointment, or the **$25.00 fee will apply**.

Tele-Care Call Policy: All calls after normal business hours requesting medical advice will be referred to the Arnold Palmer's Tele-Care Nurse Program. There is a **$20.00 fee per call** for this service. ***This fee is YOUR responsibility. This service is NOT covered by any insurance plan.***

Collections/Past due Accounts: _________(initial)

You understand and agree that all accounts must be brought current within 30 days of the service that was rendered. Should your account lapse past the 30 days your account will placed in a collections status and be transferred to our outside collection agency if payment in full or payment arrangements are not made.

You authorize Celebration Pediatrics and hereby give all of its affiliated entities, employees, agents and Independent Contractors permission to call you through the use of dialing equipment artificial voice or similar technology, even if you are charged for the call. You expressly agree that such automated calls may be made by Celebration Pediatrics and all of its affiliates, contractors and agents. With such consent, you specifically waive any claim you may have against Celebration Pediatrics, its affiliates, contractors and/or agents for making such calls, including any claim under the Telephone Consumer Protection Act. You also expressly agree that this provision applies to the use of text messaging. You authorize
Celebration Pediatrics, its affiliates, contractors and/or agents to use any cell phone or other telephone number to contact you for any purpose, including collection of an outstanding invoice at the number set forth below. If you have a change in address or telephone number, it is your responsibility to provide Celebration Pediatrics with your updated contact information.

I have read, understand and agree to Celebration Pediatrics' Billing and Financial Policy:

________________________________   ____________________
Patient Name   Patient Date of Birth

________________________________   ____________________
Parent/Guardian Printed Name   Date

____
Parent/Guardian Signature

____
Telephone Number for Receiving Calls

____
Telephone Number for Receiving Texts

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AUTHORIZATION TO REQUEST OR RELEASE HEALTH INFORMATION

1. I, ______________________________ the parent or guardian of:

   Name: ______________________ DOB: __________
   Name: ______________________ DOB: __________
   Name: ______________________ DOB: __________
   Name: ______________________ DOB: __________

Hereby authorize Celebration Pediatrics Associates, PA to:

☐ **Request records from**:

Physician and/or Practice Name ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

☐ **Release records to**:

Physician and/or Practice Name ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

2. The following type of medical information: (list dates and test if specifics needed)
   - Lab results: ______________
   - Image results: ______________
   - Immunizations: ______________
   - Physicals: ______________
   - Entire Medical Record: ______________
3. By indicating “Entire Record” all medical information, information regarding any sexually transmitted disease, psychiatric treatment, drug and/or alcohol abuse, HIV testing, ARC and/or AIDS information in my records will be released. If you prefer certain medical information not be released, please contact the appropriate office staff.
4. This information for which I am authorizing disclosure will be used for the following purpose:
   ☐ Referral ☐ Relocation ☐ Transfer of care ☐ Insurance ☐ Legal review
   ☐ Other (Please Specify) ______________________________
5. This authorization will expire on: ______________________________
6. If I fail to specify a date, this authorization will expire in 6 months from the date it was signed.
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization in writing, the revocation will not apply to information that has already been released.
8. I understand that the information has been disclosed, the recipient may re-disclose it and federal privacy laws may not protect the information

______________________________ ______________________________
Signature of Authorized Representative Date

______________________________ ______________________________
Witness Phone number of Authorized Representative

Fee for copying chart is $1.00 per page up to 25 pages, .50 cents per page thereafter. Authorization must be signed and payment before chart will be copied. Please allow 7-10 working days to copy chart.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Celebration Pedatrics, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 02/01/03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Celebration Pediatrics, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Celebration Pediatrics, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Celebration Pediatrics is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer at (407) 354-0717.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist

him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: 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 to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

FOR

Celebration Pediatrics