NEWBORN PACKET

Parent/Guardian Information

Patient Name (Last, First, MI) _____ Nickname _____

Date of Birth _____ Gender: __M __F Referred by _____

Guardian / Parent # 1 (Mother /Legal Guardian) Check One Guarantor _Y __N

Name (Last, First, MI) _____SS# _____ Hm. Ph. _____

Date of Birth _____Gender: __M __F Email _____Wk. Ph. _____

Employer _____ Cell ph. _____

Home Address _____ City _____ST____Zip _____

Guardian / Parent # 2 (Father /Legal Guardian) Check One Guarantor _Y __N

Name (Last, First, MI) _____SS# _____ Hm. Ph. _____

Date of Birth _____ Gender: __M __F Email _____Wk. Ph. _____

Employer _____ Cell ph. _____

Home Address _____ City _____ST_____Zip _____

Insurance Company (Primary Insurance Only)

Name of Primary Insurance: _____

Policy Holder / Insured _____ Relationship to Patient _____

Policy # _____Group # _____

Parent/Guardian 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 60 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/we hereby authorize you to release any and all information which you may possess relating to my child's examination and illnesses. I understand I may revoke this consent in writing at any time.

Signed: (Parent/Legal Guardian) _____ Date: _____

Print Name (Parent/Legal Guardian) _____

Relationship to patient _____

PATIENT CONTACT FORM

Patient _____ **DOB** _____

I authorize CMC to register my email address so that I may voluntarily have electronic access(portal) to view and manage my child's information, medical records, request prescriptions, view past appts, eStatements, etc. Y N (circle one)

Mother/Legal Guardian

Please mark yes or no on which of the numbers we have permission to contact you and/or leave a message.

Y N Home _____
Y N Cell Phone _____
Y N Work _____

May we email and/or text your appointment reminders? Y N

Email Address: _____

Father/Legal Guardian

Please mark yes or no on which of the numbers we have permission to contact and/or leave a message.

Y N Home _____
Y N Cell Phone _____
Y N Work _____

May we email and/or text your appointment reminders? Y N

Email Address: _____

Do you have any health information that you would like to keep confidential from any person(s)? Y N
If so, please describe: _____

_____

May we fax your child(ren)'s shot record to his/her school if you verbally request us to do so? Y N
Name of school(s) _____

_____
Parent/Guardian Signature Date

_____ _____
Printed Name Relationship to Patient

For Office Use Only

We attempted to obtain the above information, but the information could not be obtained because:
( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the information
( ) An emergency prevented us from obtaining the information
( ) Other (Please Specify)

_____

_____

_____ _____ _____
Witness Signature Title Date

CHILDREN'S MEDICAL CENTER

Dear Parent,

All of us at Children's Medical Center are concerned about the safety and security of your children. With increasing frequency, we are advised of Amber Alerts and missing children all over the country. Therefore, we require your express written authorization of a third party to accompany your child for his/her visit with any of our doctors.

By designating adults other than a parent/legal guardian, authorization is granted to these individuals to provide authority and power to exercise his or her best judgment upon the advice of any such medical or emergency personnel, either in person or via telephone.

The policy outlined below is designed to help you understand the rules that apply to anyone under the age of 18 who requests medical treatment from Children's Medical Center:

Florida law authorizes the parent or legal guardian of a minor child (anyone under the age of 18) to give informed consent for most medical decisions on behalf of the child. It is the expectation of Children's Medical Center that a parent or legal guardian accompany any minor who seeks routine care, such as physical or vaccination. We will remind you of this when you schedule an appointment.

Unfortunately, we are unable to accept verbal authorization or letters from a parent or guardian granting third party consent to medical care. The attached third-party consent form will be needed for routine and non-routine care whenever a parent or guardian is not present. Caregivers (adult over the age of 18) may accompany the minor and grant consent only after the parent or legal guardian completes the attached third-party consent form with Children's Medical Center.

If a minor is brought unaccompanied into one of our offices for an emergency or acute illness, we will contact the parent(s) or guardian of the minor via telephone to obtain verbal consent. Please note that we will not perform this action for normal or routine medical care. In cases of normal or routine medical care, the appointment will be rescheduled until such time that a parent or legal guardian may accompany the child, or the parent or legal guardian completes the third-party consent form. Emergency treatment may be rendered without consent only if, in the provider's judgment, there is serious risk to the patient without such treatment.

In addition, there are certain types of situations where a minor may give their own consent to treatment, such as an emancipated or self-sufficient minor (as described by FL laws). Minors age 12 and above may consent for birth control, treatment of pregnancy, or treatment for sexually transmitted diseases. In these cases, the minor will be asked to provide documentation verifying their status. A married minor may consent to treatment for himself/herself and for his/her spouse, if the spouse is unable to give consent and has not designated a person other than the spouse to make healthcare decisions. A minor parent may consent to treatment for his/her own minor children. An unwed minor may consent to treatment related to pregnancy, the prevention of pregnancy, childbirth and termination of pregnancy. Fla Stat. § 743.065. A minor may consent to treatment for his/her own sexually transmissible diseases.

If you have any further questions regarding this, please call Children's Medical Center and we will assist you further.

Medical Treatment of a Minor

Consent/Authorization Form for Designated Adult

This form grants authority to a designated adult(s) to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parent/legal guardian, and it may not be feasible or practical to contact them. I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis, treatment, and account balance may be released to the designated adult(s) listed on this form.

Patient Name: _____ DOB: ___/___/_____

Patient Name: _____ DOB: ___/___/_____

Patient Name: _____ DOB: ___/___/_____

I/We _____(Name of parent/legal guardian) do hereby grant my authorization and consent to the Designated Adult(s) listed below. If the injury or illness is life threatening, I authorize the Designated Adult to summon any/all professional emergency personnel to attend, transport, and treat the minor. I agree to assume financial responsibility for all expenses of care with Children's Medical Center.

Designated Adult Name: _____ Phone # (____)_____-_____

Relationship to patient: _____

Designated Adult Name: _____ Phone # (____)_____-_____

Relationship to patient: _____

NOTE: Designated Adult **MUST** show proof of identification(Driver License) when bringing your child in for medical treatment.

I agree unless I give specific instructions otherwise, I hereby authorize the Designated Adult listed above to receive protected health information such as test results or prescription information (exclusive of that information further protected by law) from any healthcare provider employed at Children's Medical Center.

The power to consent to medical care for my child(s) in my absence.

Parent/Legal Guardian Signature: _____ Date: _____

For Office Use Only

Designated Adult- Driver License#: _____

Designated Adult- Driver License#: _____

_____ _____ _____

Witness Signature Title Date

CHILDREN'S MEDICAL CENTER
History

Date

Child's Name _____ **DOB** _____

Parents' Names _____

Mother's Maiden Name _____

Siblings' Names _____

If Twin (check one) Twin A / _Twin B

FAMILY HISTORY

Check 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
_Sinus Allergies
_Eczema
_Cystic fibrosis
_Birth defects
_Seizures
_ADHD

_High blood pressure
_High Cholesterol
_Heart attack / stroke
_Diabetes
_Kidney problems
_Digestive problems
_Liver problems

_Anemia
_Bleeding disorder
_Anesthesia reactions
_Depression / anxiety
_Substance abuse
_Cancer (specify type)
_Other _____

BIRTH HISTORY – check 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 pregnancy? _*Yes* _*No*
_*Diabetes, high blood pressure, preeclampsia, preterm labor, other* _____

Did mom have any of the following infections during pregnancy?_*Yes* _*No*
_*Yeast, herpes, gonorrhea, chlamydia, syphilis, HIV, urinary tract infection*

Did mom test positive for group B strep (GBS) during this or a previous pregnancy?____*Yes* ____*No*
If yes, did she receive antibiotics during labor?___*Yes,* _____*No* _____ *Don't know*

What was the baby's birth weight? _____ Mom's blood type _____

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

_ *Jaundice, low blood sugar, feeding problems, breathing problems or needed oxygen,*
_ *Heart murmur, suspicion of infection, sepsis, pneumonia, other* _____

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

History – page 2

Was baby at least **24** hours old when the newborn metabolic screen (PKU) was done?___*Yes* ___*No*

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

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.

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 or file any secondary insurance; Medicare; Out-of-State Medicaid; Motor Vehicle Accident: or, Worker's Compensation. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service. Please note that some ***Well Visits*** may include a ***Sick Visit*** and may incur a co-payment, co-insurance or deductible with these types of visits.

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

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, American Express, Discover, and Care Credit). Payments can be made in-person, phone, or via the ***Portal***. ***eStatements*** will be available via Children's Medical Center ***Portal*** (monthly patient statements). 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 on an overdue bill. I acknowledge receipt of the financial policy and a copy shall remain in my child's chart.

Parent /Legal Guardian Signature _____ Date_____

Child's Name_____ DOB _____

CONSENT / AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent/Agreement, please sign your name below to accept the terms of this agreement.

1. ***Consent to treat:*** As a consenting adult, I agree to permit the staff of Children's Medical Center to provide medical care to my child/children.

2. ***Teaching facility:*** As a patient of Children's Medical Center, all treatment will be provided by physicians, staff members, students and residents under the supervision of the physician.

3. ***Patient Rights (If any of these pertain to you, please notify the front desk manager):***
   - Ask to view or get a copy of your child/children's records. A reasonable fee may be charged for copies provided.
   - Ask for corrections to be made to your child/children's records.
   - Receive a notice of how your health information may be used and shared (HIPAA Privacy Practices).
   - Request a restriction from others' accessing your child/children's records. In the case of custody and other court orders, a full copy of the signed court documentation must be provided.
   - Request Children's Medical Center staff follow special instructions to communicate with you confidentially, other than what is provided on the patient registration form.
   - Request a report on when/why your child/children's records were released without your consent
   - File a complaint with the provider and the US Government if you believe your rights have been denied or you feel your child/children's health information is not being protected.

4. ***Right to discontinue treatment:*** It is the policy of Children's Medical Center to discharge a patient after three or more no show appointments or excessive cancellations. Children's Medical Center has the right to discontinue treatment and discharge a patient for any appropriate reason, such as non-compliance with recommended care and treatment, problems between parents/family members that interfere with the child/ children's care, no shows or excessive cancellations. In such cases, the parent or guardian agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the parent or legal guardian that treatment is being discontinued.

5. ***Medical Records Releases:*** All records pertaining to the treatment and diagnosis of patients are the property of Children's Medical Center. Parents/Guardian who have signed up for the ***Patient Portal*** have access to a summary of their child/children's visits at no charge. Parents/legal guardian who wish to receive a more detailed copy of the child/children's records or need them to be sent to another physician, e.g. moving out of the area or changing doctors, must complete an ***Authorization to Release Medical Records***. The completed form with the parent/legal guardian original signature must be received by the office before records can be released. If records are requested to be sent to a new provider directly, they will be provided at no charge. If records are sent to the parent/legal guardian or other party/non-provider, a reasonable

processing fee allowed by the State of Florida will be charged. Payment of this fee must be received in our office prior to processing the medical records.

6. ***CMC Patient Policies:*** The Children's Medical Center brochure contains policies for each location's Office Hours, Scheduling Appointments, Refilling Prescriptions, Emergency Care, After Hours Access, and Referrals.

   I acknowledge I have received a copy of the Children's Medical Center brochure.

   Parent/Legal Signature_____

   Date _____

7. ***Payment for services:*** I am expected to pay for the treatment received. Children's Medical Center has the right to revise fees at any time, for any services which have not yet been started. During my child(s) medical care, worsening of symptoms or unexpected new conditions may arise that may require multiple visits to clinic, and I understand that there will be a charge for each of my visits even if for the same condition.

8. ***Risks of treatment:*** The physician is available to answer any questions concerning the risks involved with specific treatment, procedures and immunizations. Informed consent will be obtained prior to any such treatment.

9. ***Follow-up appointments:*** I understand that by accepting treatment at Children's Medical Center, I also consent to future follow-up appointments for the purpose of assessing the outcome of the treatment or testing provided to the patient.

10. ***Consent to treatment:*** By signing below, I am indicating that I have read, and I understand the terms of the Consent/Agreement for Treatment. I am either the parent/legal guardian or have the authority to give consent for the patient. I give consent to Children's Medical Center to perform necessary or appropriate tasks for proper medical care and physical examination, diagnosis, and treatment.

    My questions regarding this consent/agreement have been answered.

List Child's Name and Date of Birth for Each Child:

Name: _____ DOB:_____

Name: _____ DOB: _____

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Date

PHARMACY

Please help us process prescriptions properly by updating the information below

Date: _____

Pharmacy Name: _____

Pharmacy telephone number: _____

Pharmacy address: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Parent / Legal Guardian name: _____

Daytime telephone: _____

Evening telephone: _____

Parent / Legal Guardian signature: _____

Children's Medical Center

Payment & No-Show/Cancellation Policies

Self-Pay Policy
Self-pay payments are required to be collected at time of service. If you are unable to make payment in full, prior arrangements need to be made before the visit with our Business Office staff. Business Office # (727) 209-1177

If you are unable to pay for services on the day of the appointment, you can:
- Reschedule the ***Well Visit Appointment*** for another day
- You can select "**Credit Card on File**" or ***Care Credit*** to be used for each visit. (Parent/Legal Guardian) will sign authorization for use of "Credit Card on File" and will be notified when card is used)

If your child is unaccompanied to the visit, please plan to
- Send payment with child
- Notify CMC with credit card number to credit payment for the visit

Payment can be made by calling our Business Office (727) 209-1177 in advance of the visit or in person. For your convenience, CMC accepts Visa, MasterCard, American Express, Discover, cash, or check.

Co-Pay Policy
Co-payments are a contractual obligation with your insurance company. The parent/legal guardian is required to pay co-payments and CMC is required to collect co-payments at the time of service. Please note some ***Well Visits*** may include an ***Office Visit*** and may incur a co-pay with these types of visits.

If you are unable to pay the co-pay for the services on the day of the appointment, you can:
- Reschedule the ***Well Visit Appointment*** for another day
- You can select "***Credit Card on File***" or ***Care Credit*** to be used for each visit. (Parent/legal Guardian will sign authorization for use of "Credit Card on File" and will be notified when card is used)

If your child is unaccompanied to the visit, please plan to
- Send payment with child
- Notify CMC with credit card number to credit payment for the visit

Payment can be made by calling our Business Office (727) 209-1177 in advance of the visit or in person. For your convenience, CMC accepts Visa, MasterCard, American Express, Discover, Care Credit, cash, or check.

Deductible Plan Policy
A $ **75.00** (Effective 2/3/2020)** charge toward your deductible plan is required to be collected at each visit, until the deductible is met.

If you are unable to pay the deductible charge for the services on the day of the appointment, you can:

- Reschedule the ***Well Visit Appointment*** for another day
- You can select "***Credit Card on File***" or ***Care Credit*** to be used for each visit. (Parent/Legal Guardian will sign authorization for use of "Credit Card on File" and will be notified when card is used)

If your child is unaccompanied to the visit, please plan to

- Send payment with child
- Notify CMC with credit card number to credit payment for the visit

Payment can be made by calling our Business Office (727) 209-1177 in advance of the visit or in person. For your convenience, CMC accepts Visa, MasterCard, American Express, Discover, Care Credit, cash, or check.

**** Effective 2/3/2020**

No-show/Cancellation Policy
If you need to cancel an appointment, please call us as soon as possible to enable us to free that time for another patient. If you do not cancel in advance (2 hours prior to appointment time) or fail to show for an appointment, it will be considered a ***No-Show***. If you incur three (3) or more No-Show appointments within a year period, you could be discharged from our practice.

I acknowledge and agree to these policies.

Parent/Guardian Signature: _____

Date:_____

CHILDREN'S MEDICAL CENTER

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your immediate family? YES NO

If **YES**, please name the members allowed:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTE: This consent is valid for one year, unless specifically revoked/ changed by parent/legal guardian

CHILDREN'S MEDICAL CENTER
VACCINE STATEMENT

We, the Pediatricians of Children's Medical Center, are honored that you have chosen our group to be your child(s) health care provider.

We know that parents care about their children's health and we want you to know we care, too. For this reason, we are committed to follow the American Academy of Pediatrics guidelines for immunizations. You can be confident the patients in our practice are protected against the many dangerous and potentially deadly diseases that vaccines are designed to prevent. For this reason, we follow the recommended vaccine schedule, unless there is an established medical contraindication against vaccinating.

Vaccines work; vaccines are safe; vaccines are necessary; and, vaccines have saved millions of lives.

All vaccines are rigorously safety tested, monitored, and inspected by the Food and Drug Administration (FDA); all vaccine data is reviewed by the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) before being officially recommended to be given to children.

There are alternative vaccine schedules you may hear and read about. Unfortunately, the misrepresentation of vaccine facts is often used to scare and misinform parents. In trying to make the best decision for your child, know that there is no scientific data proving that a decision not to vaccinate or to follow an alternative vaccine schedule is safer or more effective than following the Academy guidelines.

If a parent chooses not to vaccinate their child, the pediatricians of Children's Medical Center may not be best suited for your pediatric needs and we would encourage you to seek medical care elsewhere. We believe we do have a moral and ethical obligation to protect the children in our practice through immunizations.

_____ _____

Parent Signature Date