NORTH PINELLAS
Children's Medical Center
Board Certified Pediatricians

NEWBORN PATIENT PACKET

NORTH PINELLAS CHILDREN'S MEDICAL CENTER
VACCINE STATEMENT

We, the Pediatricians of North Pinellas Children's Medical Center, would be honored for you to choose our group to be your Children'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 be in compliance with 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. 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 are 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 North Pinellas 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.

31860 US Hwy 19 N
Palm Harbor, FL 34684
(727) 787-6335
Fax (727) 787-7691

10537 State Road 54
New Port Richey, FL 34655
(727) 376-8404
Fax (727) 376-8552

12780 Race Track Road, Suite 305
Tampa, FL 33626
(813) 891-6501
Fax (813) 891-6502

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

Date of Birth _____ Gender: M F Referred by _____

Guardian / **Parent # 1** (Mother / Stepmother) 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 / Stepfather) 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 # 3** (Other _____) 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

Policy Holder / Insured _____ Relationship to Patient _____

Policy # _____ Group # _____

Patient 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 120 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 herby 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 _____ Date _____

Relationship if other than patient _____

NORTH PINELLAS
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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	High blood pressure	Anemia
Sinus Allergies	High cholesterol	Bleeding disorder
Eczema	Heart attack / stroke	Anesthesia reactions
Cystic fibrosis	Diabetes	Depression / anxiety
Birth defects	Kidney problems	Substance abuse
Seizures	Digestive problems	Cancer (specify type)
ADHD	Liver problems	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*

Was baby at leat 48 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*

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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.

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North Pinellas 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 secondary insurance; you will be responsible for any payment and will need to file with your insurance carrier. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service.

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

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, and American Express). 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 and possibly incur an interest rate up to 11/2 percent a month on an overdue bill. I acknowledge receipt of the financial policy and a copy shall remain in my child's chart.

_____ _____

Parent / Guardian Signature Date

Child's Name _____ D.O.B. _____

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PATIENT CONTACT FORM

Patient _____ DOB _____

I authorize NPCMC to register my email address so that I may voluntarily have electronic access to view and manage my child's information, medical records, request prescriptions, view past appts, etc Y N

At which of the following numbers do we have permission to contact you?

Y N Home _____
Y N Cell Phone (Carrier) _____
Y N Work _____
Y N Other _____

May we leave a message for you at work? Y N

May we leave a message for you at home? Y N

May we email and/or text you appointment reminders Y N Email Address: _____

In addition to you and your insurance company, with whom may we discuss your child(ren)'s health information?

Y N	Your Spouse	Name/Telephone	_____
Y N	Child's Step Parent	Name/Telephone	_____
Y N	Caregiver	Name/Telephone	_____
Y N	Child's Grandparent	Name/Telephone	_____
Y N	Child's Babysitter	Name/Telephone	_____
Y N	Other Representative	Name/Telephone	_____

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) _____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and the opportunity to specify alternative means of communication of my protected health information.

I acknowledge that I have read and received a copy of the Privacy Notice.

_____ _____
Parent/Guardian/Representative 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 situation prevented us from obtaining the information**
- ( ) **Other (Please Specify)**

_____
_____

_____ _____ _____
Witness Signature Title Date

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CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and 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 North Pinellas Children's Medical Center to provide medical care to my child/children.

2. ***Teaching facility:*** As a patient of North Pinellas 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 under HIPAA (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 North Pinellas 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 and 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 North Pinellas Children's Medical Center to discharge a patient after three or more no show appointments or excessive cancellations. North Pinellas 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 patient's representative agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the parent or patient's representative that treatment is being discontinued.

5. ***Medical Records Releases:*** All records pertaining to the treatment and diagnosis of patients are the property of North Pinellas Children's Medical Center. Parents/patient representatives who have signed up for the Patient Portal have access to a summary of their child/children's visits at no charge. Parents/patient representatives 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/patient representative's original signature must

be received by the office before records may 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 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 record release.

6. ***NPCMC Patient Policies:*** The North Pinellas 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 North Pinellas Children's Medical Center Brochure.

   _____ _____
   Parent or Representative Signature Date

7. ***Payment for services:*** I am expected to pay for the treatment I receive. North Pinellas Children's Medical Center has the right to revise fees at any time, for any services which have not yet been started. During the course of my 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 North Pinellas 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 and Agreement for Treatment. I am either the parent or have the authority to give consent for the patient. I give consent to North Pinellas 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 and agreement have been answered.

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

_____

_____ _____
Parent or Patient Representative Signature Date

_____ _____
If Patient Representative, Relationship to Patient Witness

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Pharmacy Update

Please help us process your prescriptions properly by updating the information below.

Pharmacy name: _____

Pharmacy telephone number: _____

Pharmacy address: _____

Patient name: _____ Patient date of birth: _____

Patient name: _____ Patient date of birth: _____

Patient name: _____ Patient date of birth: _____

Patient name: _____ Patient date of birth: _____

Patient name: _____ Patient date of birth: _____

Parent / Guardian name: _____

Address: _____

Daytime telephone: _____ / _____

Evening telephone: _____ / _____

Parent / Guardian signature: _____ Date: _____

North Pinellas Children's Medical Center
Patient Appointment Cancellation & No Show Policy

If you need to cancel your appointment, please call us ASAP to enable us to free that time for another patient. If you do not cancel in advance and fail to show for your appointment, it will be considered a No Show and you will be charged a $20 fee. If you incur 3 No Show appointments within a year time period, you may be discharged from our practice.

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