Patient Communication & Consent To Treat

Patient's Name: ___________________________________ Patient's Date of Birth: ______________________

It is the office policy of Professional Park Pediatrics not to release confidential medical information to family members or friends, except for (1) parent/legal guardian request in writing, (2) other authorized persons, (3) as we reasonably infer from the circumstances (ex. If you have a friend/family member accompanying, we assume that they are entitled to receive information regarding treatment, unless there is an objection from the parent/guardian/patient), (4) in the event of an emergency, or (5) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your child's medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below so that we may best serve you.

If you do not want any of your medical information provided to a certain party, or to your family members, please check the "no" box below. By signing below, you authorize the following people to receive information regarding your child's treatment or care. (If you wish to add names later, please confirm this in writing, or call our staff.)

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

Relationship to Patient	Name	Authorized (Yes)	Not Authorized (No)
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

_______________________________________   ______________________

Parent/Guardian Signature   Date (MM/DD/YYYY)

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Parent/Guardian Name (Please Print)

Professional Park Pediatrics: Patient Demographics

Patient Last Name: ______________________________ Patient First Name: ______________________________

Date of Birth: ______/______/______ Preferred Name: ____________________ Gender at Birth (Circle): M F

Address: ____

Primary Language: ______________________ Preferred Pharmacy: ______________________________

Race: ____________________ ***Ethnicity (Circle):*** Hispanic or Latino - Not Hispanic or Latino - Decline to Respond

□ Mom □ Dad □ Legal Guardian	□ Mom □ Dad □ Legal Guardian
Name: ______________________________	Name: ______________________________
DOB: _____/_____/_____ Phone #: ____________________	DOB: _____/_____/_____ Phone #: ____________________

Who is the primary caregiver? □ Mom □ Dad □ Both □ Other ______________________________

Please List All Children's Names & Birth Dates

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New Patient Consent to the Use and Disclosure of Health Information

I understand that as part of my child's health care, Professional Park Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment,
- A means of communication among the many healthcare professionals who contribute to my child's care,
- A source of information for applying my diagnosis and surgical information to my child's bill,
- A means by which a third-party payer can verify that services billed were provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I further understand that Professional Park Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Professional Park Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax (to other physicians ONLY).

______________________________ ____________________

Signature **Date**

Professional Park Pediatrics: Family Medical History

Patient's Name: ______________________ **Patient's Date of Birth:** ______________ **Date Completed:** __________

Please complete to the best of your knowledge. If condition exists, mark **Y** *or answer corresponding question. If the condition does not exist, mark* **N.**

	AGE	CANCER (what type?)	DIABETES (what type?)	HEART ATTACK (what age?)	STROKE	HIGH CHOLESTEROL	BLOOD PRESSURE (high or low?)	EPILEPSY	ASTHMA	OTHER
Patient										
Mom										
Mom's Mom										
Mom's Dad										
Dad										
Dad's Mom										
Dad's Dad										
Patient's Siblings (Circle Below)										
Brother Sister										
Brother Sister										
Brother Sister										
Brother Sister										
Brother Sister										
Brother Sister										
Brother Sister										

Is there any other pertinent medical history you feel that we should know?

Professional Park Pediatrics: Policies and Procedures

Patient's Name: ________________________________ Patient's Date of Birth: ______________________

For our patients to get to know our practice, we have outlined our policies and procedures. We ask that you read and sign below to indicate that you have read and understand the following:

Please initial each section to acknowledge you have read and understand the following policies and procedures.

_____**Our Providers:** Our practice consists of 4 Doctors and 5 Nurse Practitioners. Appointment availability with your primary doctor may vary for urgent or non-urgent visits that need to be scheduled outside of routine well care visits.

_____ **Appointments:** Professional Park Pediatrics operates by appointment only.

_____ **Sick Visits:** Professional Park Pediatrics has triage nurses with 30 years combined pediatric experience and use a telephone triage protocol that is approved by the American Academy of Pediatrics. If you call our office during normal business hours, they will determine whether an appointment is needed or give advice for at home care based on the patient's age, symptoms, and severity of the illness. We schedule same day visits and other non-urgent office visits through our nursing line from 9AM – 1PM and 2PM – 5PM.

_____ **After Hours Care:** If you call our normal office number after hours, we have pediatric nurses available to assist with questions and advice regarding your sick child. For after hours advice, call our office at (850) 402-5454, follow the directions to leave a message, and a nurse will contact you within an hour.

_____ **Late Policy:** At Professional Park Pediatrics, we allow a window of **10 (ten) minutes** to be "late" for an appointment. If you arrive outside of this window, you may be asked to reschedule your appointment.

_____ **No Show Policy:** If you call after our 10 minute window, you are considered a No Show for your appointment. If you do not call our office prior to your scheduled appointment time to cancel or reschedule your appointment, you are considered a No Show. Excessive No Show's in our practice will lead to dismissal. PPP considers 3 (three) or more No Shows within a calendar year for an established patient/family and 2 (two) or more No Shows within a calendar year for a new patient/family to be dismissed from our practice.

_____ **Medical Record Fees:** Requested medical records will be sent with no charge to facilities for referrals, social security, DCF, etc. Excessive requests for medical record copies will result in charges being assessed. Upon the 3rd request for medical records, the fee is $1 per page for the first 25 pages and $0.25 per page in excess of 25 pages.

_____ **Patient Dismissals:** Professional Park Pediatrics believes that the physician/patient relationship must be one based on mutual trust. If there is a breakdown in this relationship, PPP reserves the right to refuse treatment. Reasons for dismissal include, but are not limited to the following:

- Dishonesty.
- Aggressive/inappropriate/threatening behavior (actual OR implied).
- Persistent non-compliance with treatment plans.
- Requests for service beyond our scope of care.
- Excessive No Shows (see above policy).
- Transfer to a local primary physician outside of our practice.
- Profanity usage of ANY sort.
- Refusal to vaccinate.

______________________________________ ______________________________________

Signature of Parent/Guardian Date

Professional Park Pediatrics: Policies and Procedures, Continued

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

_____ **Financial Policy:** As a courtesy, Professional Park Pediatrics will file claims for all services to your health insurance. At registration, you will be asked for your current insurance information. It is solely your responsibility to provide accurate and up-to-date insurance information and to notify us if there are any changes. It is also your responsibility as a parent/guardian to verify if Professional Park Pediatrics is in network with your health insurance company, and to be familiar with your benefits (i.e., copayments, deductibles).

You will be responsible for payments at time of service if:

- ***Copayments are required by your health insurance.***
- ***ANY additional testing is done at a well care/physical appointment due to an illness (i.e., strep test, flu swab, breathing treatment, etc.)***
- ***You have a secondary insurance (as we DO NOT file secondary insurances in our office)***

You will be responsible for a bill if:

- ***Services are not covered by your health insurance.***
- ***Your health insurance requires you to pay deductibles.***
- ***You have a secondary insurance (as we DO NOT file secondary insurances in our office)***

ALL payments are due at the time of service UNLESS a prior arrangement has been made with our office manager. Payment is expected to be made in full. The parent/guardian or person authorized to bring the patient in for the appointment is expected to pay at the time of service.

We accept cash, check, MasterCard, and Visa. If for any reason there is a bounced check, you will be responsible for the fee, and we will no longer accept checks on the account.

_____ **Custody/Divorce Policy:** Our providers believe that custody and divorce matters should not impact a child's medical care. PPP is not a party in custody/divorce matters, YOU ARE. PPP will not be a mediator between separated parents. Co-pays and deductible balances will be collected from the parent attending visits with the child. "Joint Custody" means that each parent has equal access to the child's medical record and patient portal. Without a court order, PPP will not stop either parent from looking at their child's chart, patient portal, or obtaining test results. We will not call the other parent prior to releasing information or for consent prior to treatment. Please note that we encourage both parents to be available for visits, whether in person or via phone. PPP also reserves the right to charge an administrative fee for copying records should the request become excessive. We also reserve the right to request copies of custody/divorce agreements for documentation. If the issues that come between two parents becomes disruptive to our practice and/or interferes with our ability to provide medical care to your child, we will discharge the patient(s) from the practice.

_____ **Vaccinations:** At PPP, our providers and staff strongly believe in the effectiveness of vaccines for prevention of serious illness. Our belief is that children and young adults should be vaccinated according to the guidelines of the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC) for ALL state required vaccines for school and daycare entry starting at birth. We do understand the choice to vaccinate can be emotional for parents/guardians, and our staff will provide education and support regarding the importance of choosing to vaccinate. We ask that you understand it is against our office policy that the providers have set in place if you decide to "delay" or refuse vaccines altogether. Any parent that refuses to adhere to the AAP and CDC recommended vaccine schedule without a documented medical reason to do so will receive a dismissal letter from our practice within 30 days of being informed of your decision. Our providers are always happy to answer questions about vaccinations/vaccinating or to provide educational materials to you as well.

______________________________	______________________________
Signature of Parent/Guardian	Patient's Name
______________________________	______________________________
Date	Patient's Date of Birth

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- A basis for planning my child's care and treatment,
- A means of communication among the many healthcare professionals who contribute to my child's care,
- A source of information for applying my diagnosis and surgical information to my child's bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Professional Park Pediatrics is not required to agree to the restrictions that I request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action.

I further understand that Professional Park Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Professional Park Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions (ex. Parent or Legal Guardian has sole custody, Only Mom/Dad/Legal Guardian can seek medical care) placed on the use or disclosure of my child's health information:

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I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax (to other physicians ONLY).

Written Acknowledgment

I am a parent or legal guardian of ______________________________(Patient Name). I hereby acknowledge receipt of Professional Park Pediatrics' Notice of Privacy Practices and Health Information Disclosure Practices with respect to the patient (my child).

Signature:______________________________ Date:__________________________

Name:_________________________________ Relationship (Circle): Parent Guardian