Countryside Pediatric Care

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

Name _____ Plan Name_____

Policy Holder / Insured_____Relationship to Patient _____

Policy # _____ Group # _____

Co Pay _____ Insurance Effective Date _____

_____ Date _____

Signed

Relationship if other than patient _____

Countryside Pediatric Care

Patient Name: _____ **DOB:** _____

FAMILY HISTORY

Check all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunt's 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 _____

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

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

Countryside Pediatric Care

PATIENT 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 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*

PATIENT 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	_____

Countryside Pediatric Care - Email Consent

Patient Name:_____ DOB: _____

I authorize Countryside Pediatric Care 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

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:

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): _____

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 : _____

Pharmacy Name: _____

Pharmacy Telephone Number: _____

Pharmacy Address: _____

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

Countryside Pediatric Care

Forms Administrative Fees Policy

Countryside Pediatric Care requires payment for the completion of some forms parents ask us to complete on their behalf. We receive many requests which require increased administrative time and financial resources in excess of what is normally needed to complete the medical record.

The following forms will be completed at no charge to the patient:

- School/Sports physical forms
- Return to school forms
- Doctor's certification of sickness to excuse absence from school/sports
- Shot records
- Copies of records sent to other physicians for transfer to another practice or coordination of care

Listed below are services for which we charge an administrative fee. These services are not billed to your insurance company and they are your responsibility.

- FMLA $25 per form
- Home Bound form $25 per form
- Disability $25 per form
- Letter of Explanation of Condition/Treatment, e.g. for attorney $25 per letter
- Misc. Patient requests not covered above or below $25
- Copies of Medical Records to Parent/Guardian/Attorney/Representative other than another healthcare provider $1 per page for the first 25 pages, plus $.25 for each page thereafter (please see separate Medical Record Releases Form on our website for these requests)

Instructions:

- Submit the form completion request to the office well in advance of when it is needed. We will attempt to complete the forms as quickly as possible however, in order to properly address them we need adequate time to review the patient's records.
- Parent/Guardian must complete all of their information on the form prior to giving the forms to us.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.
- If requesting records to be released, the Record Release form must be completed
- Forms/Request for records must be accompanied with any required payment specified above

We will make every effort to complete these forms within 5 business days; however we cannot make any assurance of completion with the patient's time frame(s). Payment is required prior to completion of all forms.

_____	_____	_____	_____
Signature of Parent/Guardian	Name	Relationship to Child	Date

Countryside Pediatric Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First, Mi): _____ DOB: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Countryside Pediatric Care, P.A.
2531 Landmark Dr.,Ste 103
Clearwater FL 33761 Phone: 727-599-0893

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Patient Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ **Date:** _____

COUNTRYSIDE PEDIATRIC CARE

FINANCIAL POLICY 2014

Patient Name:_____ Date of Birth:_____

Countryside Pediatric Care is pleased to welcome you to our practice. Our goal is to provide your child with competent and compassionate health care. In order to serve you better, we want you to understand our financial policy.

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. We will bill most insurance companies for you if proper paperwork is provided to us. Co-payments are due in full at the time of service. If you have an annual deductible on your insurance that has not been met or you are responsible for co-insurance, we will need to collect a retainer on the day of service. When we receive an "explanation of benefits" from your insurance company, we will apply this amount towards your deductible/coinsurance. If the retainer collected is less than what you owe we will send you a statement for the balance. If the amount you owe is less than the retainer collected, the excess amount collected will be refunded to you.

We accept cash and credit cards (MC/Visa/American Express/Discover). Checks are accepted from existing patients towards insurance co-pays and deductibles. Self pay patients are required to pay by cash/credit card.

Your agreement with your insurance carrier is a private one and we are not party to your contract. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If an insurance carrier has not paid within 60 days of billing, the amount due will be your responsibility, and will be payable in full by you. If your insurance carrier changes, you must notify us immediately. If insurance information is not provided within 30 days of office visit, you will be responsible for any visits during that time.

NON COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Periodic preventive health services may or may not be covered under your health insurance policy or may have annual limits. However they may be required by your physician.

STATEMENTS: If you have a balance due on your account, you will receive statements from the office. The letter you receive from your insurance carrier with explanation of benefits will show the amount that is your responsibility. This is considered as your first statement. If no payment is received within 30 days, an additional statement will be mailed. If no payment is received within 30 days, a final bill will be sent to the address on record. Postage and late charges will accrue for additional statements. If payment is not made within 2 weeks of this final notice and no payment arrangements have been made, then the account will be sent to collections. The office will charge a 30 % surcharge to amount due, if the account is sent to collections. The office will charge a fee of $ 30 for bounced/returned checks.

MINOR PATIENTS: The adult signing this policy is responsible for full payment. It is your responsibility to arrange transfer of amount due to the grandparent/guardian/friend who accompanies child to the office. In case of divorced/separated parents, legal payment arrangements must be worked out prior to appointment.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require 24 hours notice to cancel appointments. You will be charged $ 20 for "no-shows". Patients who miss appointments repeatedly without notice may be dismissed.

I have read, understood and agree to the above financial policy for payment of dues.

Signature: _____ Name:_____ Relationship:_____
Date:_____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Countryside Pediatric Care
2531 Landmark Dr.,Ste 103
Clearwater FL 33761

Phone: (727) 599-0893 Fax: (727) 674-2965

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

I hereby authorize you to release medical records of:

My child's name is: _____ _____
(Patient's full name) Date of birth

My child's name is: _____ _____
(Patient's full name) Date of birth

My child's name is: _____ _____
(Patient's full name) Date of birth

My child's name is: _____ _____
(Patient's full name) Date of birth

Please mail medical records to: Countryside Pediatric Care
1840 Mease dr., STE 405
Safety Harbor, FL 34695

Or Fax to: (727) 674-2965

Information Needed:

- ☐ **All Records**
- ☐ **Newborn Discharge**
- ☐ **Hospital Discharge Summary**
- ☐ **Medication List**
- ☐ **Consult Report**
- ☐ **Last Clinic Note**
- ☐ **Radiology**
- ☐ **Laboratory**
- ☐ **Immunizations**

_____ _____ _____ _____
Signature of Patient/Guardian **Patient/Guardian Name** **Relationship to Patient** **Date**

CONFIDENTIALITY NOTICE

The documents accompanying this fax transmission contain confidential information. The information is intended for the use of the individual named above. If you are not the intended recipient, you are notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is not permissible. If you have received this fax in error, please immediately notify us by telephone at **(727) 599-0893** to arrange for the return of the original documents. Thank you for your cooperation.

Race Ethnicity Patient Form

The U.S. government now requires that we ask patients for their race and ethnicity. You have the option to provide this information or to decline by checking the box. All responses will be kept confidential.

1. Patient (Child) Ethnicity?

   ☐ Hispanic

   ☐ Non-Hispanic

   ☐ Declined to specify.

2. Patient (Child) Race?

   Patient Declined to Specify

3. Does the parent/guardian speak a language other than English at home?

   ☐ Yes

   ☐ No

4. If yes to previous question, then What is this language? (For example: Korean, Italian, Spanish, Vietnamese)

5. How well does the parent/guardian speak English?

   ☐ Very Well

   ☐ Well

   ☐ Not well

   ☐ Not at all