Florida Pediatric Group

250 South Wickham Rd
West Melbourne, Fl 32904
Ph (321) 752-5210

Privacy Practices & Patient Rights/Responsibilities Acknowledgement

I hereby acknowledge that I have received a copy of Florida Pediatric Group's Notice of Privacy Practices and patient rights and responsibilities. I understand that I have the right to refuse to sign this acknowledgement if I so choose. This signed acknowledgment will be placed in the child's chart. A copy of these forms are also posted in the office and I may request a copy at any time.

Childs Name: ______________________________________ **Birth Date:** ________________

Parents Name: ____ **Date:** ________________

Email Address: ____

Signature of Parent: ____

We send all prescriptions to your pharmacy via fax or E-Prescriptions. Please list the pharmacy you wish to use.

Pharmacy: ____

Location: ____

PATIENT INFORMATION

Childs Name: ____________________________________ Sex: _______ Birth Date: __________________

Address: ____

City: ____ State: ____________ Zip: _______________

Home Phone #: _______________________ Cell Phone #: _______________________________

In case of an emergency, who should we notify:____

Contact #: ______________________________Relationship: ____________________________________

PATIENT INSURANCE INFORMATION

If you have Medicaid and private insurance, **BY LAW, Medicaid is always secondary. Medicaid **WILL** pay **ALL** fees the private insurance doesn't pay. There will be **NO** out of pocket expense.

**** *IT IS VERY IMPORTANT TO REPORT ALL INSURANCE COVERAGE TO US & YOUR INSURANCE COMPANIES. IF INSURANCE PAYS ON A CLAIM & LATER FINDS OUT THERE'S OTHER INSURANCE (EVEN IF IT'S SECONDARY) YOU WILL BE RESPONSIBLE FOR THOSE CHARGES. THIS HAPPENS ALL THE TIME & IT MAY BE YEARS LATER. AT THAT POINT IT'S TOO LATE TO FILE A CLAIM WITH THE CORRECT INSURANCE. THE INS WILL TAKE THE PYMT BACK, & YOU WILL BE RESPONSIBLE FOR ALL CHARGES.**

Primary Ins. Co: ___________________________Policy Holder: ____________________________

Subscriber/ID #: ____________________________________ Group #: _______________________

Secondary Ins. Co: _____________________________ Policy Holder: ________________________

Subscriber/ID #: ____________________________________ Group #: _______________________

Cell May we leave a message on your home phone?______________ Phone?____________________

I, the undersigned, certify that I or the dependent have insurance coverage with the above named insurance company and assign directly to Maged Farid, MD. All insurance otherwise is payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by my insurance. I hereby authorize the doctor to release information necessary to secure payment of benefits. I authorize the use of this form to be used for insurance submissions. I agree to any and all charges by collections agencies and the amount due to the doctor, should the insurance not pay for any services rendered.

Responsible Party: ______________________________ Date: ________

Relationship to Patient: _______________________________________

PARENT INFORMATION

Childs Name: ____ Birth **Date:** _________________________

Child's Social Security Number: ____

Current School Child Attends:____

Mother's Name: ____ **Birth Date:** _________________________

Mother's Social Security Number: _________________________ **Phone Number:** ______________________

Employer: ____

Occupation: ____

Father's Name: ____ **Birth Date:** _________________________

Father's Social Security Number: _________________________ **Phone Number:** ______________________

Employer: ____

Occupation: ____

Co-Parent Information

Name: ____**Birth Date**: _________________________

Occupation: ____**PhoneNumber**:______________________

Whom may we thank for referring you to us? ____

Child's Name ____ Date of Birth _______________________

CHILD HEALTH HISTORY

Has the child ever suffered with any of the following:

____ Allergies

____ Anemia

____ Paralysis

____ Headaches

____ Convulsions

____ Arthritis

____ Diabetes

____ Hernia

____ Sinusitis

____ Joint Pain

____ Leg Problems

____ Hypertension

____ Neck Problems

____ Backaches

____ Broken Bones

____ Influenza

____ Ear Infections

____ Blood Disorder

____ Colic

____ Growing Pains

____ Orthopedic Problems

____ Constipation

____ Arm Problems

____ Heart Problems

____ Heart Problems

____ Poor Appetite

____ Hyperactivity

____ Rheumatic Fever

____ High Sugar Levels

____ Tuberculosis

____ Walking Problems

____ Muscle Spasms

____ Neuritis

____ Bed Wetting

____ Behavior Problems

____ Strep Throat

____ Acid Reflux

____ Rotavirus

Overall, how would you rate the health of this child since birth: ___________________________________

Is there anything else we should know about your child:____

____

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature: ____ **Date:** ___________________________

Problems	Patient	Family Member's Relationship to Patient
Alcoholism/Drug Abuse		
Asthma/Allergies		
Eczema		
Headache		
Blood Disorder(please name)		
Heart Disorder		
Kidney Disorder		
Thyroid Disease		
Seizures/Epilepsy		
Cancer(please list type)		
Birth Defects		
Miscarriages		
Diabetes(please list type 1 or 2)		
Migraines		
High Blood Pressure		
Stroke before age 60(please list age at time of incident)		
Inherited/Genetic Disease		
Psychiatric Disease		

Date and purpose of last office visit for patient ___

___

___

___

Has the child been treated for emergencies recently? (if yes please tell us the date and facility and details of emergency):

___

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___

___

Please list all surgeries patient has had with dates:

___

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Please list all medications patient is taking with dosage:

___

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___

___

Please list any allergies patient has:

___

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___

___

___

___

___

Florida Pediatric Group, P. A.

250 S Wickham Rd
West Melbourne, FL 32904

PARENTAL CONSENT FOR MEDICAL TREATMENT

Childs Name: ___________________________ **Birth Date**: ___________

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Florida Pediatric Group. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at FPG. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

CAREGIVER INFORMATION:

This information is for anytime you cannot bring your child to the appointment and you would like a friend or a family member to bring the child.

Caregivers Name: ____
Relationship to Child: ___________________ **Phone #:** ____________

Caregivers Name: ____
Relationship to Child: ___________________ **Phone** #: ____________

I authorize the above person(s) to consent for all medical and/or surgical treatment and/or other medical procedures (including admissions, inoculations, diagnostic testing, etc.) for the above named child, which may be required during my absence. If any money is due this person will be asked for payment before services are rendered.

Parent/Guardian: ______________________________ Date: ____________

Florida Pediatric Group, P. A.

Phone: (321) 752-5210 **Fax:** (321) 752-5388

250 S Wickham Rd
West Melbourne, FL 32904

Patient Name: ____DOB:______________________

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION REGARDING YOUR CHILD.

RACE (Please circle one)
American Indian or Alaskan Native
Asian
Other Pacific Islander
African American
White
Native Hawaiian
Refuse to report
Bi-Racial

Ethnicity (Please circle one)
Hispanic or Latino
Not Hispanic or Latino
Refused to report

Language (Please circle one)
English
Spanish
Indian (Includes Hindu and Tamil)
Russian
Arabic
Other _________________________

Parent
Signature:____Date:__________________

Florida Pediatric Group

250 South Wickham Rd.
West Melbourne, FL 32901

25 East Silver Palm Ave
Melbourne, FL 32901

We are now able to send appointment confirmations and reminders, notify you when lab results are available, and send other messages regarding your child's health via e-mail, text message, or voice message. For your convenience, we will be putting in your individual preferences so that you can receive messages in whichever form you prefer. Please fill out this form and return it to us before leaving the office. You may include multiple children on this form!

Please include patient(s) Name and Date of Birth below:

____

____

Which types of reminders would you like to receive? Please circle:

Appointments Lab Results Health Maintenance Rx Confirmation General Notifications
Billing Matters All

***Would you like to receive text messages?** Phone number? ____________________________________

***Would you like to receive phone calls?** Phone number? _____________________________________

Which time would you prefer to receive messages? Morning Afternoon Evening

Would you like to receive e-mails? Email Address:

____

May we contact you at work? Yes_______ No_________ Work Phone: __________________________________

*****Note: it is **your** responsibility to notify us if your number changes to avoid notifications going to the wrong person. If at any time you wish to change your settings, please feel free to hand in a new form with your updated preferences. We thank you for your cooperation in this matter!

Notice of Privacy Practices Acknowledgement Form

The Health Insurance Portability and Accountability Act (HIPPA) are in place to provide a safeguard to your privacy. Implementation of HIPPA requirements official began 04/14/2003. Many of the policies have been our personal practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Personal Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with our services. HIPPA provides certain rights and protections to you as the patient. We balance these needs without goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at: WWW.HHS.GOV.

Florida Pediatric Group has adopted the following policies:

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care is handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and your health insurance.

- It is the policy of Florida Pediatric Group to remind patients of their appointments. We do so by phone, text, email, & U.S. Mail. We may send you other communications informing you of changes to office policy and new technology you may find helpful.
- Florida Pediatric Group utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
- You understand and agree to inspections of the office and the review of documents by government agencies where PHI may be viewed in compliance with HIPPA regulations.
- You agree to bring any concerns or complaints regarding privacy to the attention of our office manager: Brittany Douglas CMA or the proprietor of the practice: Dr. Maged D. Farid.
- Your confidential information will not be used for the purpose of marketing or advertising.
- Florida Pediatric Group agrees to provide patients with access to their records in accordance with state and federal laws.

The undersigned certifies that he/she has fully read and understands the Notice of Privacy Practices.

Patient Financial Responsibility

Thank you for choosing Florida Pediatric Group as your healthcare provider. We are committed to building a successful Physician-Patient relationship with you and your family. The following statement of Financial Responsibility must be signed prior to treatment.

Insurance Claims:

Florida Pediatric Group will file claims with the patient insurance upon the patient's submission of proof of insurance (i.e. Insurance card indication coverage). In the event that the patient has insurance coverage but cannot provide documentation, payment is due at the time of services. Once proof is provided and payment has been received from the insurance company, a refund will be issued to the patient in the form of a check.

Secondary Insurance:

Claims will be filed with secondary insurance if adequate information is received at the time of services. If payment is not received in our office within 45 days of filing, the responsibility will be transferred to the patient and is due upon receipt.

Patient Financial Responsibility:

If no insurance is to be filed, or if we are not a participating provider with your insurance, FULL PAYMENT IS DUE AT TIME OF SERVICE. We are willing to work with you to develop a payment schedule to meet your needs and ours. Co-Payments, Deductibles, Co-Insurance and non-covered services cannot be applied to these payment plans. Payment arrangements will be made with a signed Payment Agreement with the approval of our office manager and billing department.

Minors/Dependants:

Children under the age of 18 will be required to be accompanied by an adult at all times during the visit. Adult party signature is also required on the registration forms.

Methods of Payment:

Cash, Check, Visa, MasterCard, Discover, American Express and Money Order.

Accounts Past Due:

After 90 days, an account will be considered past due. We will attempt to reach you three times. If no contact can be made and the account remains outstanding it will be turned over to collections. This may result in small claims court, credit bureau reporting and discharge from practice. Should the account need to be handled in small claims court the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

Account Consultation

Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you.

Medical Records

If you require us to transfer your medical records to another practice there is no cost. If you would like a copy of your medical records, there will be a fee in the amount of $0.50 per page. This fee must be paid prior to the transfer of the records.

I have received a copy of the Florida Pediatric Group Financial Responsibility Policy and agree to the terms set in the policy.

____ ____________________

Patient Printed Name Date

____

Printed Name of Responsible Person Relationship to Patient

____

Witness Name Witness Signature and Date

Florida Pediatric Group HIPPA Compliant Authorization for the Release of Patient Health Information

To: ____

Name of (Previous) Healthcare Provider/Physician/Facility/Insurance Company

____

Street Address

____

City, State, Zip, Phone Number/Fax Number

From:

Florida Pediatric Group P.A. 250 S. Wickham Rd, West Melbourne, FL 32904 Ph (321) 752-5210 Fax (321) 752-5388

RE: ____

Patient Name **Patient Date of Birth**

I understand that:

1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE

2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

3) I may revoke this authorization at any time by notifying Florida Pediatric Group in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4) Florida Pediatric Group agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

(Please check all the apply)

- ☐ **All medical records. This means every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient records, outpatient records, emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse notes, social worker records, clinical records, treatments plans, care plans, admission records, discharge summaries, test results, statements, questionnaires, histories, photographs, videotapes, telephone messages, and any/all medical records received from other facilities.**
- ☐ **All physical, occupational and rehab requests, consultations, and progress notes**
- ☐ **All disability, Medicaid or Medicare Records, including claim forms and record of denial benefits.**
- ☐ **All autopsy, laboratory, histology, cytology, pathology, immunochemistry, specimens, radiology records, films including MRI, CY, MRA,EMG,EEG, bone scan, myelogram, nerve conduction study, echocardiogram, cardiac catheterization, video's/CD's,/Films,/Reels and reports.**
- ☐ **All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.**
- ☐ **All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payments, denials and benefits.**
- ☐ **All laboratory findings and diagnosis's related to Acquired Immunodeficiency Syndrome(AIDS), Sexually Transmitted Diseases (STD's), and Human Immunodeficiency Virus (HIV)**
- ☐ **All mental health records**

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus(HIV) alcohol and drug abuse. I authorize the release or disclosure of this information.
This protected health information is being disclosed for the following
Purpose: Medical Record.
This authorization is given in compliance with federal consent requirements for release of alcohol or substance abuse of records of 42CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I understand the following: (See CFR 164.508© (2) (i-iii)
Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ____________________

Signature of Patient or Legal Representative **Date**

____

Name and Relationship of Legally Authorized Representative