

# Tampa Pediatric ENT

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_

Race:  African American  Asian  Caucasian  Chinese  Filipino  Hispanic  Japanese  Native American  Native Hawaiian  
 Pacific Islander  Other

Other family members treated here: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pharmacy : \_\_\_\_\_ Pharmacy Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

### PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has legal Custody of the Patient: ( ) Parents ( ) Mother Only ( ) Father Only ( ) Foster Parent ( ) Grandparent ( ) HRS/Other  
**\*\*IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT\*\***

Mother's name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address:  Check here if same as above \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Father's name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address:  Check here if same as above \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### EMERGENCY CONTACTS

#1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

#2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Carrier: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Eligibility Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Co-Payment: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Eligibility Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Co-Payment: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

#### OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Permission to Treat

I, \_\_\_\_\_, authorize Tampa Pediatrics ENT  
(Print name of parent/ legal guardian)  
and its personnel to provide medical services such as medical examination and treatment, as they deem best for the child's physical or mental welfare.

\_\_\_\_\_  
(Print child's name )

\_\_\_\_\_  
(Date of birth)

\_\_\_\_\_  
(Social Security #)

I authorize the following person/people to bring my child in for treatment and to discuss any necessary treatments, medications and to even authorize any tests or labs that are necessary up to and including admission to the hospital.

Name: \_\_\_\_\_ Mother: \_\_\_\_\_

Name: \_\_\_\_\_ Father: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\*\*All of the above will provide identification to be placed in the patients chart.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to biological parents, step parents, referring physicians and other practitioners, and my insurance company.

## **\*\*ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES\*\***

I have been advised and understand the Notice of Privacy Practices of Tampa Pediatric ENT.

\_\_\_\_\_  
*Signature of legal guardian*

\_\_\_\_\_  
*Date*

**Relationship to patient:** \_\_\_\_\_

## FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ INDIVIDUAL REFUSED TO SIGN

\_\_\_\_\_ COMMUNICATION BARRIERS PROHIBITED US FROM OBTAINING

\_\_\_\_\_ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING

\_\_\_\_\_ OTHER (PLEASE SPECIFY) \_\_\_\_\_

## PEDIATRIC HEALTH QUESTIONNAIRE

REASON FOR VISIT: \_\_\_\_\_

OTHER PHYSICIANS (WHO YOU WANT NOTES SENT TO): \_\_\_\_\_

CURRENT MEDICAL PROBLEMS: \_\_\_\_\_

BIRTH HISTORY:    NORMAL        ABNORMAL                    IMMUNIZATIONS UP TO DATE:    YES    NO

NEW BORN HEARING TEST:        PASSED    FAILED

BREAST MILK    REGULAR FORMULA    GENTLEASE    HYPOALLERGENIC    SPECIAL FORMULA \_\_\_\_\_

PARENTS: MARRIED    DIVORCED    SEPARATED    FOSTER CARE

HOSPITAL ADMISSIONS, YEAR AND OPERATION: \_\_\_\_\_

### MEDICAL HISTORY

PLEASE NOTE: IT IS IMPORTANT FOR THIS SECTION TO BE FILLED OUT COMPLETELY BEFORE THE DOCTOR CAN SEE YOU

	YES	NO		YES	NO
<b>CONSTITUTIONAL</b>			<b>GASTROINTESTINAL</b>		
FEEDING DIFFICULTY	_____	_____	REGURGITATION	_____	_____
POOR WEIGHT GAIN	_____	_____	INDIGESTION/HEARTBURN	_____	_____
IRRITABLE	_____	_____	NAUSEA/VOMITING	_____	_____
<b>SKIN</b>			ABDOMEN PAIN	_____	_____
ITCHING	_____	_____	DIARRHEA	_____	_____
RASH	_____	_____	CONSTIPATION	_____	_____
HIVES	_____	_____	BLOODY STOOL	_____	_____
<b>ALLERGIES/IMMUNOLOGY</b>			<b>UROLOGIC</b>		
ASTHMA	_____	_____	BEDWETTING	_____	_____
SEASONAL ALLERGIES	_____	_____	UTI	_____	_____
<b>EARS/NOSE/THROAT/MOUTH</b>			<b>ENDOCRINE</b>		
HEARING LOSS	_____	_____	DIABETES	_____	_____
EAR INFECTIONS	_____	_____	THYROID DISEASE	_____	_____
SINUS INFECTIONS	_____	_____	<b>MUSCULOSKELETAL</b>		
NOSE BLEEDS	_____	_____	JOINT PAIN	_____	_____
RUNNY NOSE	_____	_____	<b>NEUROLOGICAL</b>		
SORE THROATS	_____	_____	SEIZURES	_____	_____
TONSILLITIS	_____	_____	CEREBRAL PALSY	_____	_____
SNORING	_____	_____	INTRAVENTRICULAR HEMORRHAGE	_____	_____
MOUTH BREATHING	_____	_____	<b>PSYCHOLOGICAL</b>		
RESTLESS SLEEP	_____	_____	ANXIOUS	_____	_____
<b>EYES/HEAD</b>			DEPRESSED	_____	_____
VISION LOSS	_____	_____	STRESSED	_____	_____
HEADACHES	_____	_____	HYPERACTIVE	_____	_____
DIZZINESS	_____	_____	<b>HEME/LYMPHATIC</b>		
<b>RESPIRATORY</b>			ANEMIA	_____	_____
WHEEZING	_____	_____	BRUISE EASILY	_____	_____
COUGH	_____	_____	BLEEDING	_____	_____
<b>CV</b>			SWOLLEN GLAND	_____	_____
CHEST PAIN	_____	_____	BLOOD TRANSFUSIONS	_____	_____
SHORT OF BREATH	_____	_____			

**SOCIAL HISTORY**  
 GRADE: \_\_\_\_\_    DAYCARE:    YES    NO  
 ACTIVITIES: \_\_\_\_\_

**FAMILY HISTORY**

	MOTHER SIDE		FATHER SIDE	
	YES	NO	YES	NO
DIABETES	_____	_____	_____	_____
HEARING LOSS	_____	_____	_____	_____
ALLERGIES	_____	_____	_____	_____

DATE				
DR. PATEL REVIEWED				



## **PATIENT RIGHTS & RESPONSIBILITIES**

### **You have a right...**

- ... to be treated with respect in a manner that recognizes your need for privacy and dignity.
- ... to be informed of your diagnosis, prognosis, or treatment options in terms you can understand.
- ... to be informed about recommended treatment and alternative treatments and to be advised of the potential outcomes of each treatment.
- ... to refuse treatment and be advised of the probable consequences of your decision.
- ... to schedule a time to inspect your medical record, and to receive copies of requested pages at a nominal charge for photocopying.
- ... to request that your medical record be corrected or amended. If your doctor believes the record is accurate & complete, you have a right to include a statement of disagreement in your medical record.
- ... to limit access to your medical record without written consent, except to health care providers, payers and law enforcement.
- ... to participate in making decisions about your health care.
- ... to file a grievance with the Department of Health & Human Services.

### **You have a responsibility...**

- ... to provide all medical history, including past care, illnesses, and medications to your doctor, so the best treatment plan can be determined.
- ... to provide accurate health insurance information, and to inform the office of any changes in coverage.
- ... to inform the office if you have more than one insurance coverage.
- ... to know the proper use of your insurance, and how to obtain covered services, and to follow the rules of your plan.
- ... to keep scheduled appointments, or to provide adequate notice to us if you are delayed or need to cancel.
- ... to pay co-payments, deductibles, and non-covered services.
- ... to ask questions about your care until you fully understand.
- ... to follow the advice of your doctor, and to inform the doctor if you refuse to comply with the medical advice given.
- ... to be courteous to other patients, families and office staff.

**Tampa Pediatric ENT**

3450 Fletcher Avenue, Suite 350

Tampa, FL 33613

Office (813)972-3353

Fax (813)978-3667

Florida law provides that State agencies, including Tampa Pediatric ENT, must notify individuals of the circumstances that would require collection of social security numbers.

The following are the general scenarios under which Tampa Pediatric ENT must collect and use social security numbers: insurance and health benefit eligibility; classification of accounts; customer identification and verification; credit worthiness; customer billing and payments; payroll and human resource functions; benefit processing, tax reporting, and any other lawful purpose necessary to conduct Tampa Pediatric ENT business.

Social Security numbers are NOT public records, but may be released to other governmental or commercial entities as required by law in Section 119.071(5), Florida Statutes.

**Tampa Pediatric ENT  
OUR FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to the success of your and/or your child's treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.  
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD/DISCOVER.**

**Regarding Insurance**

Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your first office visit in full. We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

**Surgery**

We will ask you to pay 100% of any outstanding deductible prior to surgery. This is due no later than 3 days prior to surgery. Any refunds due to you will be sent 7-10 days after you have incurred the refund.

We bill secondary insurance carriers as a courtesy to our patients.

**Usual and Customary Charges**

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

**Interest**

We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

**Missed Appointments**

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$30.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

**Returned Checks**

If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged \$25.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

**Billing Questions**

Please address all billing questions to Fountainhead Practice Management Solutions, LLC at 727-456-3288 or toll free 866-343-3288.

**Collections**

You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

TAMPA CHILDREN'S ENT  
A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

**OUR COMMITMENT TO YOUR PRIVACY**

We understand that health information about you and your health care is personal. We create a record of the care and services you receive from Florida Pediatric Associates, LLP (FPA) and are committed to protecting health information about you. We are required by law to 1) Make sure health information that identifies you is kept private; 2) Give you this notice of our privacy practices, and; 3) Follow the terms of the notice that is currently in effect.

**ROUTINE USE AND DISCLOSE YOUR MEDICAL INFORMATION**

The following categories describe the different ways in which we may use and disclose your protected health information (PHI).

- **Treatment.** We may use your PHI to treat you. i.e. laboratory tests, when we order or write a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others outside FPA who are involved in your medical care.
- **Payment.** We may use and disclose your PHI to you, an insurance company or a third party in order to bill and collect payment for the services you receive from us. This may include verifying your health benefits or providing information to obtain prior approval.
- **Health Care Operations.** We may use and disclose your PHI to operate our business, i.e. we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. There are some services we may provide through our business associates.

**OTHER USES**

- **Appointment Reminders.** We may use and disclose your PHI to contact you and remind you of an appointment.
- **Treatment Options.** We may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services.
- **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

**USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

We may use and disclose your PHI without your written permission when we are required to do so by federal, state or local law, such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in an emergency.

**OTHER USES OF HEALTH INFORMATION**

We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

- **Confidential Communications.** You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Medical Information Dept., specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
- **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction you must make your request in writing to Medical Information Department. Your request must describe in a clear and concise fashion 1) the information you wish restricted; 2) whether you are requesting to limit our practice's use, disclosure or both; and 3) to whom you want the limits to apply.
- **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Information Department in order to inspect and/or obtain a copy of your PHI. We may charge a fee for the costs of copying, mailing, and supplies associated with your request. We try to accommodate all reasonable request, however if we deny your request to inspect and/or copy you may request a review of our denial.
- **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made on our form Request for Correction/Amendment and submitted to Medical Information Dept. You must provide us with a reason that supports your request for amendment. We will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that was not created by us, or is not part of the medical information maintained by us, or if the information is accurate and complete. If we deny your request, you can appeal our decision, in writing.
- **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures made. This accounting will not include routine disclosures for treatment, payment or health care operations purposes. In order to obtain an accounting of disclosures, you must submit your request in writing to Medical Information Department. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge. We may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact our Privacy Officer in writing.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer listed below or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**MINORS AND PERSONS WITH GUARDIANS**

Minors and certain disabled adults are entitled to the privacy protection for their health information. Because by law, they cannot make health care decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents or guardians can authorize the use and release of PHI and also hold all rights listed in this notice. Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

**We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.**

Please direct any questions about this notice to our Privacy Officer at (727) 456-4244

Privacy Officer address:  
Florida Pediatric Associates, LLC  
Attn: Privacy Officer  
1033 Dr. Martin Luther King Jr. St. N., Ste 108  
St Petersburg, FL 33701

Medical Information Department address:  
Florida Pediatric Associates, LLC  
Attn: Medical Information Department  
1033 Dr. Martin Luther King Jr. St. N., Ste 108  
St. Petersburg, FL 33701