Pediatrics of South Florida

Patient Forms

Basic Information

Full Name
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth / /

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State Zip

Marital Status

Maiden Last

Driver's License State

Driver's License #

Demographics

Sexual Orientation

Gender Identity

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Address Line 1

Address Line 2

City

State Zip

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact

Full Name
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number**

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Primary Policy Holder

If you are not the primary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** / /

Policy ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name

First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name Pharmacy Address

How did you hear about us?

Pediatrics of South Florida

HIPAA

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

PATIENT NAME: _____

I, _____, have reviewed/received a copy of PEDIATRICS OF SOUTH FLORIDA'S notice of privacy practices and agree to the terms listed.

_____ _____

Signature of Patient/Guardian Print Name

_____

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____ _____ _____

Date Initials Reason

PEDIATRICS OF SOUTH FLORIDA
NOTICE OF PRIVACY PRACTICES

Your Information, Your Rights, Our Responsibilities:
Our Practice is committed to educating our patients about health care issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations. The following categories describe the different ways in which we may use and disclose your Individuality Identifiable health Information (IIHI) or Protected Health Information (PHI)

Our Issues and Disclosures:

- Treatment
- Appointment Reminders
- Payment
- Treatment Options
- Disclosure Required by Law
- Fundraising
- Health Care Operations
- Health Related Benefits and Services
- Provider – Patient Communication
- Release of Information to Authorized Adults and Entities

Our uses and disclosures in unique situations:

- Public Health Risks
- Appointment Reminders
- Payments
- Treatment Options
- Disclosure Required By Law
- Fundraising
- Health Care Operations
- Health Related Benefits and Services
- Provider – Patient Communication
- Release of information to authorized Adults and Entities

Our uses and disclosures only if you provide authorization

- Marketing to Patients
- Communication via Telephone, Text Messaging or E mail
- Pre-Authorization for Billing of non-covered expense
- Psychotherapy notes

You have the right to

- Confidential Communications
- Electronic Access to PHI
- Request Restrictions
- Restrict Disclosures to Health Plans for Treatment Paid out of Pocket in Full
- Copies of your PHI
- Request Modifications to Patient Authorization and other requirements to facilitate research
- Request an amendment of your medical record
- Accounting of disclosures
- Request disclosure of patient immunization to schools
- Enable access to decedent information by family members or others
- File a complaint
- Opt-out of fundraising communications
- Opt-out of provider patient communications regarding appointments or health care reminders
- Opt-out of maintaining payment information on file and re-authorizing payment for non-covered expenses
- Provide an authorization for other uses and disclosures
- Breach notification of unsecure PHI and ePHI

HIPAA PRIVACY FORM A

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: UNDER GOVERNMENT REGULATION WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS. IF WE ARE UNABLE TO APPROVE YOUR REQUEST, WE RESERVE THE RIGHT TO REPLY WITHIN 30 DAYS.

Patient Name: _____ Date of Birth: _____ Account #: _____

Patient Address: _____ City, State, Zip: _____ Phone: _____
Street

I. CHART RESTRICTIONS *(to identify a person/people we should not communicate with)*

Type of Protected Health Information (PHI) to be restricted: (Please check all that apply)

- ☐ Home phone #/Home address
- ☐ Office phone #/ Office address
- ☐ Occupation/Name of employer
- ☐ Spouse name
- ☐ Spouse office phone #
- ☐ Other
- ☐ Patient history
- ☐ Visit notes
- ☐ Hospital notes
- ☐ Prescription Information
- ☐ All Information *(see below)

How would you like your Protected Health Information (PHI) restricted?

_____

_____

I, _____, am requesting that Pediatrics of South Florida communicates with me at the following alternative name and/or location described below regarding my child's or children's health information. Such restriction is necessary to prevent disclosure that could endanger me. **I understand that the Organization may deny this request if it imposes an unreasonable administrative burden.*

Alternative Name: _____
Alternative Location: _____

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____

_____

In order to communicate with you about this visit, we must have a phone number where you can be reached. I request that Pediatrics of South Florida only communicate with me in the following manner and/or at the location described below. I agree that I can be reached at the following PHONE NUMBER if any communication regarding this visit is required:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

III. PROVIDER-PATIENT COMMUNICATIONS-REQUEST TO OPT OUT

I, _____ DO NOT authorize Pediatrics of South Florida to communicate with me via _____ Home Phone _____ Cell Phone/Text, _____ Work Phone, and/or _____ by Email to receive communication regarding appointments or other healthcare reminders (Please check all that apply.)

By signing this form, I am confirming that it is accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

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IV. MAINTAIN PAYMENT INFORMATION ON FILE-REQUEST TO OPT OUT

I, _____ DO NOT authorize Pediatrics of South Florida to maintain my payment (debit card and/or credit card) information on file.

OR

I, _____ DO authorize Pediatrics of South Florida to maintain my payment (debit card and/or credit card) information on file; but I DO NOT pre-authorize payment for non-covered expenses including _____ co payments, _____ deductibles, _____ health forms for school, _____work or athletic teams, and/or _____ fees for missed appointments (Check next to those that apply).

By signing this form, I am confirming that it is accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

FOR INTERNAL PURPOSES ONLY: Name & Title of Staff Receiving Form _____

Date Staff Received Form: _____ **Date Compliance Officer Received Form:** _____

Approval Status: ☐ **Approved as requested** ☐ **Denied & Notified Date:** _____ **Method:** _____

☐ **Approved with modification:** _____

_____

☐ **Highly Restricted with a Password:** _____

☐ **De-activate access to the Patient Portal** ☐ **EHR Support Notified Date** _____

☐ **Alert Info:** _____

_____

Compliance Officer Initials: _____ **Privacy Admin. Initials:** _____