Account#_____

Asthma, Allergy & Immunology

A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

Patient Name: _____ **DOB:**___/___/___ **SS#:**_____-_____-_____**Sex: Male** __ **Female**___

Address:_____ **City:**_____ **State:**_____**Zip:**_____ **Phone#: (**___**)** _____

Race: ☐ **African American/Black** ☐**American Indian or Alaska Native** ☐**Asian**☐ **Native Hawaiian or Other Pacific Islander** ☐**White**

Ethnicity: ☐**Hispanic** ☐**Non-Hispanic** ☐**Declined**

Other family members treated here:_____

Primary Care Physician: _____ **Phone#: (**___**)** _____-_____

Pharmacy :_____ **Pharmacy Phone: (**____**)** _____-_____

Email:_____

Preferred Method of contact: ☐ **Email** ☐ **Mail** ☐ **Home Phone** ☐ **Cell Phone**

Whom may we thank for referring you:_____

PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has legal Custody of the Patient: ( )Parents ( )Mother Only ( )Father Only ( )*Foster Parent ( )Grandparent ( )*HRS/Other
***APPROPRIATE PAPERWORK MUST BE PRESENTED AT TIME OF VISIT**

Mother/Guardian's name: _____ **DOB:** _____/_____/_____ **SS#:** _____-___-___
Address: ☐**Check here if same as above**
_____ **City:** _____ **State:**_____ **Zip:**_____

Home #: (___**)** _____-_____ **Cell#: (**____**)**_____-_____ **Work#: (**___**)**_____-_____

☐ **Check this box if we may use this cell # for text and/or robocall appointment reminders**
Occupation:_____**Employer**_____**Employer Address**_____

Father Guardian's name: _____ **DOB:** _____/_____/_____ **SS#:** _____-___-___

Address: ☐**Check here if same as above**
_____ **City:** _____ **State:**_____ **Zip:**_____

Home #: (___**)** _____-_____ **Cell#: (**____**)**_____-_____ **Work#: (**___**)**_____-_____

☐**Check this box if we may use this cell # for text and/or robocall appointment reminders**
Occupation:_____**Employer**_____**Employer Address**_____

Preferred Language : _____ **Preferred method of contact: Email Phone Cell Phone**

EMERGENCY CONTACTS

#1. Name: _____ **Relationship:** _____ **Phone#: (**____**)** _____-_____

#2. Name: _____ **Relationship:** _____ **Phone#: (**____**)** _____-_____

INSURANCE INFORMATION

Primary Insurance Carrier:_____ **Policy#**_____**Group#**_____

Policyholder's Name: _____ **Date of Birth:** __/____/____

Policyholder's SS#:_____ **Relationship to patient:** _____

Claims Address:_____ **City:**_____ **State:**____**Zip:**_____

Eligibility Phone#(_____) _____-_____

Secondary Insurance Carrier:_____ **Policy#**_____**Group#**_____

Policyholder's Name: _____ **Date of Birth:** _____

Policyholder's SS#:_____ **Relationship to patient:** _____

Claims Address:_____ **City:**_____ **State:**____**Zip:**_____

Eligibility Phone#(_____) _____-_____

ASSIGNMENT OF BENEFITS/ACKNOWLEDGEMENTS

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provide to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier or other medical entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability (HIPPA) to ensure that I have been made aware of my privacy rights.

Parent/Guardian Signature_____ **Date**_____

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 payments 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 individuals' 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 fees.

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

Parent/Guardian Signature_____ **Date**_____

Due to our continuing efforts in meeting the needs of all our patients; we need to make you aware of some of our office policies. **Please initial each policy showing that you have read and understand each policy. Also, please sign and print your name at the bottom of the form.**

RESULTS OF LABS, CT SCAN, MRI:

_____**We require all patients to follow up with our physician to receive results on ordered tests.** This is necessary so that our physician can answer any questions you may have regarding the care of your child as well as discuss any future plan/or treatment options with you. We will not call to give results, unless there is something that requires immediate attention.

NO SHOW POLICY & MISSED APPOINTMENTS:

_____If you have an appointment with our office and are unable to attend, you must give our office 24-hour notice. If we do not receive a call to cancel or reschedule your appointment, you will be responsible for a **$35.00 NO SHOW FEE.** This is not covered by your insurance and must be paid before the next visit. **After the third missed appointment, without notification, we will no longer be able to offer medical care for your child. You will be discharged from our practice!** It is your responsibility to remember and keep your appointments. We do courtesy calls when possible.

MEDICAL RECORDS:

_____**Medical records copied for patients will be charged at $1.00 per page.** You will have to notify the office ahead of time in order to have your records copied. We only handle records on Fridays, so please be aware that we need 5-7 business days to copy records. **We will not mail any records.** They have to be picked up in person. We only fax record to other physicians involved in the care of your child**.**

MEDICATIONS:

_____**You have to keep your follow-up appointments in order to get refills of your medications.**

PATIENT'S NAME: _____

_____ _____ _____

Signature **Print Name** **Date**

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name_____ DOB_____

NOTICE TO PATIENT

Person(s)/Organization(s) authorized to provide the information:

_____

_____

Person(s)/Organization(s) authorized to receive the information:

_____

_____

Specific descriptions of the information that may be used or disclosed; including date span (i.e. office notes for February 1, 2016 through March 3, 2010): **NOTE: Release of "the entire medical record" is rarely necessary and will not be provided unless verified to be necessary.**

_____

_____

_____

Specific descriptions of how the information will be used (i.e. transfer of care, continued treatment, etc.):

_____

_____

_____

This authorization will expire on _____ (**NOTE: If this line is left blank this authorization will automatically expire in one year)**

I understand that I may request a copy of this authorization.

I understand that may revoke or amend this authorization (except to the extent that action was already taken in accordance of this signed authorization) at any time by notifying this office in writing (the appropriate form can be obtained from office staff).

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.

In accordance I may inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by the federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. Additionally, the office noted above as the authorized provider
would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Printed Name Date

OFFICE USE ONLY:
INFORMATION RELEASED BY:_____
DATE RELEASED:_____

Asthma, Allergy & Immunology

A Division of Florida Pediatric Associates, LLC

Authorization for Consent to Medical Treatment of Minors

I, the undersigned parent/guardian of _____,
Hereby grant to the below listed individual(s) the ability to bring my child to their appointment and consent to medical examination, diagnosis and treatment by the providers and staff of Asthma, Allergy & Immunology.

_____

NAME ADDRESS PHONE #:

_____

NAME ADDRESS PHONE #:

_____

NAME ADDRESS PHONE #:

I understand that the above named individuals will be required to present valid photo identification at the time they present to the office with my child and that my child will not be seen without the presentation of such ID.

This authorization will expire on _____ (Note: if left blank this authorization will automatically expire in one year)

I understand that it is my responsibility to cancel this consent - *in writing* – at the time that an individual named above no longer has my permission to consent as described.

Date:_____

_____ _____

NAME RELATIONSHIP

_____

SIGNATURE

RIGHT TO REVOKE:
CONSIDER THIS NOTE TO BE CONFIRMATION THAT I REVOKE MY PERMISSION FOR _____. NAMED ABOVE TO CONSENT TO TREATMENT FOR MY CHILD. THIS IS EFFECTIVE IMMEDIATELY.

_____ _____

SIGNATURE DATE

OFFICE STAFF INITIALS:_____

4503 N. Armenia Ave.
Tampa, FL 33603-2745
Ph. (813) 873-1177
Fax. (813) 873-1166

19039 N. Dale Mabry Hwy
Lutz, FL 33548-4982
Ph. (813) 948-7000
Fax. (813) 948-7008

RELEASE OF RECORDS

ASTHMA, ALLERGY & IMMUNOLOGY OF TAMPA BAY

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

Patient Name:_____
Date of Birth:_____
I hereby authorize:_____
To release information from my medical record as indicated below to:

Dr. Diana P. Martin M.D. Dr. Maliena Longley M.D.

Information to be released:

( ) All Medical Records ( ) Progress Notes
( ) Labs ( ) X-Ray Reports
( ) Vaccines ( ) Other _____

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1) I understand that this authorization will remain in effect for one year; or until I revoke it on writing. I understand that I may revoke this authorization at any time by notifying the office in writing. I further understand that any such revocation does not apply to information already released in response to this authorization.

2) I understand that state law prohibits the re-disclosure of the information disclose to the persons/entities listed above without any further authorization, but the office cannot guarantee that the recipient of the information will not disclose this information contrary to such prohibition.

3) I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

4) I understand that I have a right to inspect and to obtain a copy of any information disclosed.

5) I understand that I may be charged a fee for copy of records. This fee may be waived for copies provided to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by the Florida law.

6) All medical records include mental health, Aids, treatment for alcohol/substance abuse, and genetic counseling.

Signature of Patient/Parent if a minor: _____ Date:_____

For office use only

( ) Date the request was filled