Institute of Pediatric Neurosciences of Florida PLLC
1315 SE 25 Loop, Suite 104. Ocala, FL 34471
Phone: (352) 512-9898 Fax: (855) 889-8577

NEW PATIENT QUESTIONNAIRE

Patient Name:_____ DOB: _____

Allergies: _____

Physicians Involved in Care: _____

Please list past/current medications (prescribed and over the counter)

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History: Please indicate child's past history of any surgical procedures: _____

_____

_____

Presenting Problem/Concerns: _____

_____

Has your child ever had an EEG, MRI, CT scan, etc.? ☐ Yes ☐ No _____

- If yes, why was it done and what were the results? _____

_____

PAST MEDICAL HISTORY: Please indicate any history of any of the following medical conditions

☐ Abdominal Pain	☐ Behavioral Problems	☐ Ear Infection (Chronic)	☐ Hydrocephalus (Congenital)
☐ Acne	☐ Bone Fracture/Broken Bone	☐ Eczema	☐ Hypertension
☐ ADD/ADHD	☐ Chickenpox	☐ Eye/Vision Problems	☐ Kidney Infection
☐ Allergic Rhinitis	☐ Cleft Palate	☐ Gastroesophageal Reflux	☐ Loss of Consciousness
☐ Anemia	☐ Concussion	☐ Headaches	☐ Seizure Disorder
☐ Anxiety	☐ Constipation	☐ Head Injury	☐ Sickle Cell Anemia
☐ Asthma	☐ Convulsions	☐ Hearing Loss	☐ Sleep Disturbance
☐ Autism	☐ Depression	☐ Heart Disease	☐ Thyroid Disorder
☐ Bed Wetting	☐ Diabetes (Type 1)	☐ Hemophilia	☐ Whooping Cough

FAMILY HISTORY: Please indicate any family history of any of the following medical conditions with **M** for Maternal (mother), **P** for Paternal (father) or **B** for Both

☐ ADD/ADHD	☐ Cancer	☐ Drug Abuse	☐ Hypothyroidism
☐ Alcohol Abuse	☐ Chickenpox	☐ Epilepsy	☐ Kidney Disease
☐ Anemia	☐ Cystic Fibrosis	☐ Hearing Loss	☐ Liver Disease
☐ Asthma	☐ Deafness	☐ Heart Disease	☐ Mental Retardation
☐ Autism	☐ Depression/Anxiety	☐ Hemophilia	☐ Migraine Headaches
☐ Bed Wetting	☐ Diabetes (Type 2)	☐ High Blood Pressure	☐ Seizure Disorder
☐ Behavioral Issues	☐ Diabetes (Type 1)	☐ HIV	☐ Sudden Infant Death Syndrome
☐ Blindness	☐ Down Syndrome	☐ Hypertension	☐ Tuberculosis

SOCIAL HISTORY

School Attending: _____ Grade Level: _____

Does the child receive special services? ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Who lives at home with the child? _____

- Parents are ☐ Married ☐ Not Married ☐ Separated ☐ Divorced

Is the child exposed to second-hand smoke? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

As best as you can recall, at what age did your child reach these milestones?

Crawled_____ Walked_____ First Words_____ Rolled Over_____

Sat Up_____ Toilet Trained_____ Stood Up_____ Used Sentences_____

Has your child experienced any regression of these? ☐ Yes ☐ No If yes, explain:_____

_____

Does your child have quality relationships with other children? ☐ Yes ☐ No If no, please explain:_____

_____

Has there been a change in your child's performance at school? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

PREGNANCY/BIRTH HISTORY

Gestational Age:_____ Hospital:_____

Type of Delivery: _____ Weight:_____

Were any of the following a concern during pregnancy?

- ☐ Febrile Illnesses/Fever
- ☐ Abnormal Bleeding
- ☐ High Blood Pressure
- ☐ Early Labor
- ☐ Diabetes
- ☐ Trauma or Accidents
- ☐ Cigarette Use
- ☐ Alcohol or Substance Abuse
- ☐ Concerns about movement in the womb
- ☐ No Problems/Complications

Please list any medications taken during pregnancy:

_____ _____

_____ _____

_____ _____

Did the child need/have any of the following after birth?

- ☐ CPR or Resuscitation
- ☐ Ventilator Use
- ☐ Antibiotics
- ☐ Bleeding in the Brain
- ☐ Jaundice
- ☐ Special Care/Intensive Care Nursery
- ☐ Seizures
- ☐ Surgery

SLEEP PATTERNS

Total hours of sleep per night:_____ Bed-Time_____ Wake-Up Time_____

Does your child take naps in a typical day? ☐ Yes ☐ No

If yes, how many hours in a typical day? _____

Please indicate any of the following concerns:	Current Problem	Change within last 6 months
☐ Difficulty Falling Asleep	Y/N	Y/N
☐ Frequent Awakening	Y/N	Y/N
☐ Snoring	Y/N	Y/N
☐ Restlessness/Movements	Y/N	Y/N
☐ Nightmares	Y/N	Y/N
☐ Not Rested	Y/N	Y/N

Parent/Guardian Signature: _____ Date: _____

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www.pediatricneurologyflorida.com
Email: main@pediatricneurologyflorida.com

Patient Name _____ **DOB** _____

Office Policies

Scheduled Appointments

We make every effort to see our patients promptly, and we ask that you arrive at the appointed time, but we understand that delays can happen. ***If you are more than 15 minutes late to your appointment, the appointment may need to be rescheduled.*** We do not accept patients without appointments. If you believe you have an emergency, please dial 911 or go to the nearest emergency room.

Cancellation/No-Show Fee

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. If you wish to change an appointment, please notify us at least 24 hours in advance. ***Missed and untimely canceled appointments will result in a $50 fee charged to the patient's account.***

Prescription Refills

If your child needs a prescription refill, please contact your pharmacy 3-5 days in advance. If necessary, the pharmacy will contact us directly for authorization to refill the medication. If your insurance requires authorization for a prescription refill, please have your pharmacist call or fax in your request during office hours so we can review your chart.

Insurance/Billing

All co-pays and/or account balances must be paid at the time of service. All medical insurances classified as HMO (i.e. Medicaid, Wellcare, Sunshine) require a referral from your primary care provider. It is your responsibility to obtain the referral or authorization prior to your appointment. You can bring your referral to the office or fax it to (855)889-8577.

Test Results/Returned Calls

We do not contact our patients with normal results or who can wait until their next visit. All messages that are urgent will be returned within 24-48 hours. Non-urgent messages will be answered within 48-72 hours.

Updating Your Information

It is vital that we always have a valid phone number in which we can contact you. It is your responsibility to update your phone number, address, and medical insurance when they are changed. You can call our office or go to our website to actualize this information.

Letters/Forms

Any letter or form that needs to be completed in our office has a $50 fee that will have to be paid before the letter/form is delivered. We require 7-10 business days to complete the letter or form.

Abuse-Free Zone

We reserve the right to terminate our relationship with anyone who is disrespectful or abusive with our staff in the office.

Signature of Legal Guardian _____ Witness (Office Use Only): _____

Name of Legal Guardian _____

PATIENT REGISTRATION FORM

Patient Demographics

Patient Name: _____ DOB: _____ Gender: Male Female

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Would you like to sign up for our Patient Portal? Yes No

Race:

Asian Black/African American White

Native Hawaiian/Other Pacific Other:_____

Ethnicity:

Hispanic or Latin American Non-Hispanic or Latin American Refuse to Report

Guarantor Information

Name:_____ DOB:_____

Phone Number:_____ Relationship to Patient:_____

Insurance

Primary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Secondary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Signature of Parent/Guardian:_____ **Date:**_____

AUTHORIZATION FOR MEDICAL TREATMENT FOR MINORS:

I, _____, the parent(s) or legal guardian of (child's name)_____, hereby authorize Institute of Pediatric Neurosciences of Florida PLLC and its personnel to deliver medical services to my child. The following individuals (must be over the age of 18) are authorized to schedule and/or accompany my child to medical appointments. Please list anyone other than the child's biological mother or biological father who maybe accompanying the child to appointments. I understand that only my child's biological mother and father *and* those listed below will have the authority to authorize treatment. Those listed below are also authorized to receive my child's medical information over the phone. (Please print name and relationship)

_____ _____

_____ _____

_____ _____

*****Please inform the above listed individuals to bring photo ID to appointments *****

PRIVACY STATEMENT ACKNOWLEGEMENT:

I acknowledge Institute of Pediatric Neurosciences has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If revisions are made, I understand it is my responsibility to request a revised copy. I understand the contents of the agreement and I request to following restriction(s), concerning the use of my personal medical information:

_____

_____

Parent/Guardian Signature:_____ Date:_____

AUTHORIZATION TO RECEIVE INFORMATION FOR CONTINUITY OF CARE:

I, _____, the parent(s) or legal guardian of (child's name)_____, authorize Institute of Pediatric Neurosciences of Florida to receive copies of the above identified patient's medical records; including medical, psychiatric, drug and alcohol abuse, and HIV/AIDS/ARC related information for continuity of care.

Parent/Guardian Signature:_____ Date:_____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I, _____, whose signature appears below, authorize Institute of Pediatric Neurosciences of Florida to view my external prescription history via the RxHub service. I understand that prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by my provider and staff at Institute of Pediatric Neurosciences of Florida, and it may include prescriptions dating back several years. ***My signature certifies that I read and understand the scope of my consent and that I authorize access.***

_____ _____

Signature of Parent/Guardian/Personal Representative

Printed Name of Parent/Guardian/Personal Representative

_____

Date

FINANCIAL POLICY:

I hereby authorize payment of insurance benefits to Institute of Pediatric Neurosciences of Florida. I understand that I am financially responsible for all charges, whether they are paid by insurance, for all services rendered on my behalf for my dependents. I authorize the above-named provider of services to release any information to secure the payment of benefits. I authorize the use of the signature on all the insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

Parent/Guardian Signature:_____ Date: _____

Witness (Office Use Only): _____

Pediatric Neurology

AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

I (Parent/Guardian Name) _____, hereby authorize

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To release, receive, and/or discuss the following information:

_____ Complete Medical Records
_____ Labs/Diagnostic Testing
_____ Mental Health Treatment (if applicable)
_____ Other _____

PLEASE PRINT NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN AND/OR FACILITY BELOW
(One form per facility):

_____

_____

_____

Signature: _____ **Date:** _____

Relationship to Patient: _____

I have carefully read and understand the above information and do herein consent to its disclosure. I am aware that information regarding any medical condition(s) will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

- I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.
- I authorize the use of a copy of this form for the disclosure of the information described above.
- I understand this authorization will remain in effect for one year from the date of my signature below unless I have specified a different expiration date. *(Please list desired expiration date of release here:_____)*

JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED

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

If you have any questions about this Notice, please contact the Privacy Office for Institute of Pediatric Neuroscience of Florida at the contact information listed below:
Institute of Pediatric Neuroscience of Florida: 352-512-9898

- OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU
- We understand your health information is personal and we are committed to protecting it. We created a record of the care and services you received at Institute of Pediatric Neuroscience of Florida to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by Institute of Pediatric Neuroscience of Florida whether made by staff of your personal doctor. This notice describes how we may use and disclose your health information and provides examples where necessary. This Notice also describes your rights regarding your health information.
- We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

- CHANGES TO THIS NOTICE
- We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facility.

- NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT
- The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other's behalf. Institute of Pediatric Neuroscience of Florida is separate health care providers, and each is individually responsible for its own activities, including compliance with privacy laws, and all health care services it provides.
- CONSITENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HELATH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

- We may use and disclosed your health information to **provide medical treatment to you and to coordinate or manage your health care and related services.** This may include communication with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.
- We may use and disclose your health information to **bill and receive payment for services rendered.** For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.
- We may use and disclose your health information for **health care operations.** We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other Institute of Pediatric Neuroscience of Florida personnel for review and teaching purposes.
- We may also use and disclose your health information:
- When necessary to **prevent a serious threat to your health and safety** or the health and safety of the public or another person.
- To **organizations that facilitate donation and transplantation** of tissues and/or organs.

- To **authorized officials** when **required by federal, state, or local law.**
- In response to a **subpoena, court, or other administrative order.**
- As required by law, for **public health activities.** For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized **Worker's Compensation activities.**
- To **health oversight agencies.** For example: agencies that enforce compliance with licensure or accreditation requirements.
- To **coroners, medical examiners, or funeral directors** to carry out their duties.
- As required by **military command authorities.** If you are a member of the armed forces.
- To our **business associates** to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For **research or to collect information in databases** to be used later for research. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a **correctional institution having lawful custody of you** as necessary for your
- health and the safety of others.
  - We may also use and disclose your information for **fundraising activities** to raise money for Institute of Pediatric Neuroscience of Florida and it operations. If you do not want to be contacted for fundraising efforts, you must notify the Institute of Pediatric Neuroscience of Florida Privacy Office.

  - SPECIAL CIRCUMSTANCES
  - **Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information** may have special privacy protections. We will not disclose any health information identifying and individual as a patient or provide information

relating to the patient's substance abuse or psychiatric treatment unless:

- You or your personal representative consents in writing;
- A court order requires disclosure;
- Medical personnel need information to treat you in medical emergency;
- Qualified personnel use the information for research or operations activities;
- It is necessary to report a crime or a threat to commit a crime; or
- To report abuse or neglect as required by law.

- YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

- Unless you object, we may use or disclose your health information in the following circumstances:
- **Hospital Directories.** We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you name. We also may share your religious affiliation with clergy.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.
- USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION
- Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reason covered by your revocation. We are unable to take back any disclosures already made with your permission. We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

- YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- You have the following rights regarding health information we maintain about you:
- **Right to See and Obtain Copies of your Health Information:**
  - You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.
  - To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
  - We may deny your request to see and obtain copies or your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**
  - If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:
- The information was not created by us;
- The information is not part of the records used to make decisions about your care;
- We believe the information is correct and complete; or
- You do not have the right to review parts of the medical record under certain circumstances.
  - We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.
  - If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**
  - You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.
  - You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12-month period.