ALL ABOUT KIDS & families MEDICAL CENTER

12086 Ft. Caroline Road, Suite #401, Jacksonville, FL 32225
Phone: (904) 565-1271 Fax: (904) 645-7325

James A. Joyner, IV, MD, Kia M. Mitchell, MD, Thanh Nguyen, MD
Dewey Lee, III, PA, Linda Rowan-Vander Schaaff, ARNP, Meghan Bishop, ARNP, Kaitlin Ray, ARNP,
Hope Gunn, ARNP, Theresa Pye, ARNP, Debra Fisette, ARNP

Immunization History: Please provide a copy of shot records

New Patient Packet for Pediatrics and Adolescent Children

Patient Full Legal Name _____Date_____

Nickname or name patient goes by _____

Address_____ Child's SS# _____

City, State, Zip _____

Phone # _____ Birth Date_____ Sex (circle) Male Female

Hospital of Birth _____City_____State_____

Brother/Sisters we have seen _____

Whom may we thank for referring you to our office? _____

Father's	Mother's
Full Name_____	Full Name _____
Employer_____	Employer _____
Work Phone_____	Work Phone _____
Cell#_____	Cell #_____
Email Address_____	Email Address _____
SS#_____	SS# _____
Father's Date of Birth _____	Mother's Date of Birth _____
Driver's License No._____	Driver's License No._____

Name of the patient's legal guardian(s) (if other than parents) _____

Preferred Pharmacy: _____

Insurance Information (Primary coverage)

Name of Person Holding Policy_____

Relationship to Patient_____

Insurance Co. Name_____ Policy #_____

Address _____Group #_____

Address con't _____ Phone #_____

City, State, Zip_____ Effective date coverage began _____

Insurance Information (Secondary)

Name of Person Holding Policy_____

Relationship to Patient_____

Insurance Co. Name_____ Policy #_____

Address _____ Group #_____

Address con't _____ Phone #_____

City, State, ZIP_____ Effective date coverage began_____

Birth History:

Gestational Age (Weeks of pregnancy)	
Birth Weight	
Birth Length	
Type of Delivery (C/S or Vaginal)	
Hospital Stay (Days or Weeks)	
Complications	

Social History:

Who lives in the home?	
Name of school or day care	
Is patient a smoker? (If yes, how many packs per day)	
Exercise or sport activities	

Family History:

□ Sickle Cell
□ Asthma
□ Diabetes
□ Other (please explain)

Past Medical / Surgical History:

Patient Allergies:

Medications	
Food	
Other	

Medications:	**Dosage:**

I hereby authorize All about Kids & Families Medical Center to render any medical care they deem necessary in the treatment of my child.

Signature of parent/guardian _____Date_____
(*OK to send records requested by specialists for evaluation and treatment of your child)*

Patient Name_____ Date of Birth_____

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EMERGENCY CARE/CONSENT FOR TREATMENT

Patient Name____ Date of Birth ________________

I hereby give permission to all of the providers of All About Kids & Families Medical Center to direct any medical treatment to my children during my absence.

It is understood that they will make every effort to contact me in case of a medical emergency. It is further understood that if they are unable to contact me, I give them this permission with my full consent.

If hospitalization is necessary, I direct the providers of All About Kids & Families Medical Center to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well care, immunizations, minor illnesses, etc.), it is necessary for you to list the individuals to whom you have given permission to bring the child in for care.

Do you consent to Clinical Trials or Research ( ) Yes ( ) No. Please Initial ________________

I authorize the following people to bring my child in for medical care, in my absence. Please check the boxes to give them additional specific authorizations.

Name: ___________________________ ________________________Relationship: _______________________
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: ___________________________ ________________________Relationship: _______________________
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: ___________________________ ________________________Relationship: _______________________
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: ___________________________ ________________________Relationship: _______________________
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: ___________________________ ________________________Relationship: _______________________
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Signature of parent/ guardian____ Date ______________
Witness: ____ (AAKF Staff)

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OUR FINANCIAL POLICY

Your understanding of our FINANCIAL POLICY is important to us. Please let us know if have any questions about our fees, financial policy or your responsibilities.

* CO-PAY, CO-INSURANCE, DEDUCTIBLES AND BALANCES ARE DUE AT THE TIME OF SERVICE

* WE ACCEPT CASH, VISA, MASTERCARD & DISCOVER

* MINORS WHO ARE SEEN IN OUR OFFICE
An adult must accompany all minors and full payment is due at the time of service. If your child is old enough to come to our office on his/her own, they will also be required to pay at the time of service.

* BILLING
All About Kids & Families does not bill or extend credit. You are required to pay your co-pay, deductible, or any balance due at the time of service. We cannot hold checks. If you have an emergency situation or an issue that will prevent you from paying for your service, please contact our billing department in advance and they will discuss arrangements with you.

* INSURANCE
If we accept your insurance, you are responsible for any deductibles, co-insurance or co-pays at the time of service. IF YOUR INSURANCE CARRIER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY US WHEN CHECKING IN. IF YOU FAIL TO DO SO, YOU MAY BECOME RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT. Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account.

* The parent/ guardian who brings the child in for the appointment is responsible for payment.

* I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, not covered by insurance. I have read all of the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Parent/Guardian_____ Date_____

All About Kids & Families Medical Center
Privacy Policy Notification

INTRODUCTION

All About Kids & Families Medical Center is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), All About Kids & Families Medical Center has created a Privacy Policy. The purpose of this notification is to familiarize you with the existence of our policy, as well as give you an overview of its contents. The full written policy is available to you on request.

As a patient you have the right to:

- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

As a patient you have the responsibility to:

- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting unexpected changes in his or her condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For following the treatment plan recommended by the health care provider.
- For keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.

Signed by Patient / Guardian: _____Date:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Patient Name _____ Patient SS# _____ DOB _____

Patient Address_____

I hereby authorize All About Kids and Families Medical Center to (please check one of the following):

□ **Obtain copies of my medical record (s) from:** □ **Release copies of my medical record (s) to**:

Name_____

Address _____

Phone Number _____Fax Number _____

Information as identified below is to be released:*(circle all that apply)*

All Medical Records	Emergency Room Report	Mental/Behavioral Health Notes
Progress Sheets/Clinic Notes	Cardiac Rehab	X-ray Reports
Doctors Orders	Operative Report	Pulmonary Rehab
Lab/Pathology Report	Occupational Health	Immunization Record
PT/OT/ST	Psychological Report	History & Physical
Discharge Summary	Chemical Dependency	Other_____
History & Physical		

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable diseases (*if any such information exists),* may be released unless otherwise specified above.

**This information is needed for the following purpose(s):_____

HIPAA Privacy Rule. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient_____ Date _____

Signature of Parent or Legal Guardian _____ Date _____

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Witness _____(Staff Name) Date _____

NO SHOW POLICY

This policy has been established to help us to serve you better.

Our goal is to provide quality individualized medical care in a timely manner. It is necessary for us to schedule appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient who is in need of medical care.

A "no show" is missing a scheduled appointment without providing our office notice. A "late cancellation" is cancelling an appointment without contacting our office at least 24 hours in advance of a scheduled office visit.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment, due to a seemingly "full" schedule.

If an appointment is not cancelled at least 24 hours in advance:

1st Occurrence: You will be contacted and reminded of our no-show/ cancellation policy.

2nd Occurrence: You will no longer be permitted to schedule follow up appointments/ well visits during our "prime" extended hours of 4:00 - 8:00pm or on weekends.

3rd Occurrence: You may be discharged as a patient from our practice.

For your convenience, our Patient Fusion patient management system allows you to opt-in for appointment reminders via email. We encourage all of our patients to take advantage of this complimentary service.

Patient Name _____ Date _____

Signature of Patient_____

Signature of Parent or Legal Guardian _____