2010 Patient Information

Patient's Full Name: _____ Nickname: _____
DOB: ____/____/_____ M / F Primary Guardian: _____
Parent's marital status: married / divorced / separated / widow
Child Primarily lives with: mom / dad / guardian Visitation agreement:_____
Primary Guardians Address: _____
City: _____ State: _____ Zip: _____
Home PH:_____ Work: _____ Cell: _____
Email Address: _____
Billing address if different from above: _____
City: _____ State: _____ Zip: _____

Insurance Name: _____ Policy Holder: _____
Policy Holder's DOB: ___/___/____ Policy ID:_____ Group #:_____

MOTHER'S INFORMATION	FATHER'S INFORMATION
Name: _____	Name: _____
DOB: ___/___/____ SSN:_____	DOB: ___/___/____ SSN:_____
Marital Status: _____	Marital Status: _____
Partner's Name:_____	Partner's Name:_____
Employer: _____	Employer: _____
Work PH:_____	Work PH:_____

EMERGENCY CONTACT INFORMATION (other than parent)
Name: _____ Phone:_____
Relationship to child: _____ Cell:_____
Authorized to seek medical care for patient: NO / YES

Name: _____ Phone:_____
Relationship to child: _____ Cell:_____
Authorized to seek medical care for patient: NO / YES

SIBLING INFORMATION
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____

Have there been any changes in the child's home or family life in the past year: NO / YES
Is your child enrolled in childcare? NO / YES If Yes, provide name of provider: _____

Financial Policy

We are committed to providing you with the best possible care and we are ready to discuss our professional fess with you at any time. Your understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or what your responsibility is.

- FULL PAYMENT IS DUE AT TIME OF SERVICE

- WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD AND 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.

- REGARDING BILLS

It is the policy of this office not to bill or extend credit. You are required to pay at the time of service. We cannon hold checks. There are a few exceptions such as emergencies that must be discussed prior to treatment. If you have an emergency or a problem paying please call our billing department and they will be happy to discuss arrangements with you.

- REGARDING RETURNED CHECKS

We understand that sometimes people make mistakes. If you have a returned check with us, you have 15 days to make good on that money owed to us. If after 30 days the account has not been cleared, you will be forwarded to a collection agency. There is a $30 service charge for each check that is returned to us. If you have more than two returned checks with us, you account then becomes a cash only account and checks will no longer be accepted.

- REGARDING INSURANCE

If we accept your insurance, YOU are responsible for any deductibles, coinsurance or co pays AT THE TIME OF SERVICE. Insurance polices with required co pays MUST BE PAID at the time of service or we may charge YOU for the full amount of the visit. If you are unable to provide your current insurance card at the time of service, we may require payment in full at the time of service or you may reschedule your appointment. If your insurance carrier changes, IT IS YOUR RESPONSIBILITY to notify us when checking in. If you fail to do so, you may then 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 carrier. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

- The guardian WHO BRING THE CHILD IN is responsible for payment. Divorce settlement / financial responsitlibty for child issues are to be worked out between the parents.

- I understand and agree that regardless of my insurance status, I am responsible for the full balance on my account for any and all professional services rendered not covered by my insurance. I have read al the information on this sheet and understand it to the best of my knowledge. I will notify Oceanside Pediatrics of any and all future changes.

- Starting January 1, 2007 all patients that do not show up for there scheduled appointment without a 24 hour notice will be charged a $25 NO SHOW FEE. If you call prior to the appointment but less than 24 hours before the scheduled appointment, it will be up to Oceanside Pediatrics if you will be required to pay the $25 NO SHOW FEE.

- Our office requires appointments. It is our policy not to accept walk-in or add-on patients to our daily schedule. If Oceanside Pediatrics agrees to allow your child to be seen as a add-on or walk-in patient then I agree to pay the $25 WALK IN FEE.

_____ _____/_____/_____

Signature of patient or parent or legal guardian Date

_____ _____

Name of patient or parent or legal guardian Relationship to patient

Oceanside Pediatrics • 1370 13th Ave. South Suite 216 • Jacksonville Beach, FL 32250 • (904) 246-0644
Dr. Barbara O'Reilly • Dr. Elena Model • Dr. Ann Vonthron • Shannon Frazier Miller, ARNP

Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by OCEANSIDE PEDIATRICS, for the purpose of diagnosing or providing treatment to me or my minor child, obtaining payment for my healthcare bills or to conduct health care operations of OCEANSIDE PEDIATRICS.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. OCEANSIDE PEDIATRICS is not required to agree to the restrictions that I may request. However, OCEANSIDE PEDIATRICS agrees to a restriction that I request, the restriction binding on OCEANSIDE PEDIATRICS, DR. BARBARA O'REILLY, DR. ELENA MODEL, DR. ANN VONTHRON, AND SHANNON FRAZIER MILLER ARNP, I have the right to revoke this consent in writing at any time except to the extent that DR. BARBARA O'REILLY, DR. ELENA MODEL, DR. ANN VONTHRON, AND SHANNON FRAZIER MILLER, ARNP or OCEANSIDE PEDIATRICS have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my provider, another health care provider or hospital (including all departments as such), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

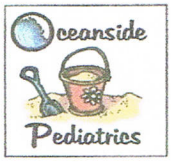
I understand I have a right to review OCEANSIDE PEDIATRICS NOTIC OF PRIVACY PRACTICES prior to signing this document. The OCEANSIDE PEDIATRICS NOTICE OF PRIVACY PRACTICES will be provided to me upon request. It is also posted in the waiting room and exam rooms for my information. The NOTICE OF PRIVACY PRACTICES describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of OCEANSIDE PEDIATRICS. The NOTICE OF PRIVACY PRACTICES also describes my rights and OCEANSIDE PEDIATRICS duties with respect to my protected health information. OCEANSIDE PEDIATRICS reserves the right to change the privacy practices that are described in the notice of privacy practices. I ma obtain a revised NOTICE OF PRIVACY PRACTICES by calling the office and requesting a revised copy.

_____ _____/_____/_____

Signature of patient or parent or legal guardian Date

_____ _____

Name of patient or parent or legal guardian Relation to patient



Signature on File

_____ I authorize use of this form on all my insurance submissions
_____ I authorize release of information to all my Insurance Companies
_____ I understand that I am responsible for my child's bill
_____ I authorize my provider to act as my agent in helping me obtain payment from my Insurance Company.
_____ I authorize payment direct to my provider
_____ I permit a copy of this authorization to be used in place of the original

Parents Name: _____ Child's Name: _____-
_____

Parents Signature: _____ Date: _____/_____/_____

Newborn Patient Questionnaire

Date: _____/_____/_____ Patient Name: _____ DOB: _____/_____/_____

MOTHER

Name: _____
DOB: ___/___/_____ SSN#:_____-_____-_____
Address:_____
City:_____ State:____ Zip:_____
Home ph:_____ Cell:_____
Email:_____
Employer:_____
Employers address:_____
City:_____ State:____ Zip:_____
Work ph:_____
Marital Status: married / divorced / widowed / separated
Who does the child reside primarily with: _____

FATHER

Name: _____
DOB: ___/___/_____ SSN#:_____-_____-_____
Address:_____
City:_____ State:____ Zip:_____
Home ph:_____ Cell:_____
Email:_____
Employer:_____
Employers address:_____
City:_____ State:____ Zip:_____
Work ph:_____---_
Marital Status: married / divorced / widowed / separated
Who does the child reside primarily with: _____

EMERGENCY CONTACT (other than parent)

Name: _____
Relationship to child: _____
Address: _____
City: _____ State: _____ Zip:_____
Home Ph: _____ Cell: _____

INSURANCE POLICY INFORMATION

Company:_____
ID#:_____
Group #:_____
Policyholder:_____
Child covered: yes / no

Name of childcare provider: _____ Ph:_____

PREGNANCY & BIRTH

Mother's age at birth: _____ Father's age: _____
Did mother have any illness during pregnancy: NO / YES
Did she take any meds other than vitamins: NO / YES
How many weeks gestation was the baby: _____
Baby's birth weight: _____ Single or Multiple
Delivery method: Vaginal / C-Section
Did the baby have any trouble starting to breathe: NO / YES
Did the baby have any trouble in the hospital: NO / YES
Describe:_____
Hospital: _____
Discharge Date: ____/____/_____

FAMILY HISTORY

Are the childs parents in good health: NO / YES
Circle any diseases this child's birth parents, grandparents, siblings have had: asthma, anemia, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, inherited illness, venereal disease, cancer, AIDS, other: _____
List age, sex, general health of siblings
_____
_____
_____
_____
Has any of your children ever died: NO / YES

SAFETY & ENVIROMENT

Do you live in a house / apartment / townhouse / mobile home other:_____
Do you know the hottest temperature of the water in your pipes: NO / YES Temp:_____
Is there a working smoke alarm on each floor of the home? NO / YES
Does your child ALWAYS use a car seat NO / YES Type of car seat:_____
Are there any smokers in the household: NO / YES Inside / Outside / Car / Social Only
Are there any problems with the condition of your home? _____

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Newborn Insurance Enrollment Policy

OCEANSIDE PEDIATRICS allows 15 days from the date of birth for parents or guardians to add the newborn to your active health insurance policy. Any newborn not added to a health policy within the 15 day grace period will be SELF PAY for visits.

Please provide us with the below information

Patient Name: _____

Guarantor Name: _____

Insurance Company: _____

Date of Birth: _____

Insurance Policy #:_____

Name of person you spoke with to add child: _____

Reference number from insurance company: _____

I acknowledge by signing as guarantor, if this is not provided to your office I am responsible for full payment at time of service.

_____ _____/_____/_____

Signature of patient or parent or legal guardian Date

_____ _____

Name of patient or parent or legal guardian Relationship to patient