Alliance Pediatrics, P.A.
4627 NW 53rd Ave Gainesville FL 32653

Patient Demographic and Medical History Form/Update Form

The following questionnaire will provide our staff information to best handle your individual billing, communication and health needs.

Please Select Your Primary Care Provider(PCP)

Kathy Sarantos, MD _____ Olga Mas, MD _____ Michelle Massias, MD _____
Stephanie Kirkconnell, MD _____ Ginny Shreve, ARNP _____ Beth Severance, ARNP _____

PATIENT INFORMATION

Patient: Last First Middle (Nickname)

M ( ) F ( )

BIRTH DATE Sex

Child's Social Security # (must be registered for proper filing of insurance(s)

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Race/Ethnicity
❑ American Indian/Alaskan ❑ Asian ❑ African American/Black
❑ Caucasian/White ❑ Hawaiian/Pacific Islander ❑ Other ❑ Decline

Primary Language_____

Does this child live with: Father? ❑ Mother? ❑ Other Adult? ❑

GUARDIAN INFORMATION

Mother: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

Father: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

EMERGENCY CONTACT INFORMATION

Nearest Relative: Last First Relationship

Phone Number (1) Phone Number (2)

PARTY RESPONSIBLE FOR BILLING

(Must be present at this appointment, provide picture ID card and sign bottom of this sheet)

Last First Middle Relationship to Patient
❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Address

City State Zip Code

Home Phone (including area code) Cell Phone

INSURANCE INFORMATION

Subscriber Name L/F/M *(Primary Insurance Holder)* Relationship to Pt.
❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Insurance Company Name Plan Type (PPO,HMO, Options, etc)

Subscriber ID # (Member ID) Group #

Insurance Company Address (Back of Card)

Insurance Company Phone Number (Back of Card)

Employer providing Insurance Phone

FAMILY INFORMATION

Brothers and Sisters DOB Health Issues?

PHARMACY INFORMATION

Pharmacy Name: Location

PRIOR CARE INFORMATION

What Doctor/Clinic has taken care of this child in the past? City Phone

CONTINUED ON BACK ▷▷▷

Alliance Pediatrics, P.A.
4627 NW 53rd Ave Gainesville FL 32653

Medical Information and History Form/Update Form

All responses are kept confidential

Today's Date: _____

_____
Patient Name

_____
Date of Birth **Time of Birth (Newborn)**

1. Were there any problems during the pregnancy or birth of this child?
❑ Yes ❑ No

_____
If Yes, please explain

2. Has your child ever had any significant medical problems (including heart, liver, kidney problems, allergies, asthma, frequent infections, behavioral, growth, or mental or developmental problems?
❑ Yes ❑ No

_____
If Yes, please explain

3. Do any immediate family members have significant medical problems?
❑ Yes ❑ No

_____
If Yes, please explain

4. Is there any family history of the following (please circle):
Heart disease before age 50, Diabetes, Cancer, Tuberculosis, Asthma, Allergies, Inherited Childhood Disease, Sickle Cell Anemia?

5. Does either parent have a total cholesterol over 240?
❑ Yes ❑ No

6. Any hospitalizations, accidents or surgery?
❑ Yes ❑ No

_____
If Yes, please explain

7. Any medication allergies?
❑ Yes ❑ No

_____
If Yes, list and describe

8. Any food or environmental allergies?
❑ Yes ❑ No

_____
If Yes, list and describe

9. Are your child's immunizations up to date? (Please furnish records)
❑ Yes ❑ No

10. Does your child attend daycare? If so, where?
❑ Yes ❑ No

_____
If Yes, please list

11. Does your child have any school or learning problems?
❑ Yes ❑ No

_____
If Yes, please explain

12. Who lives in your home?

_____

13. Are there any serious marital or family problems?
❑ Yes ❑ No

_____
If Yes, please explain

14. Who smokes in the home? _____

Who has Legal Medical Decision Making Rights for this child ?

_____
Name Relation to child

_____
Name Relation to child

15. Do you feel safe at home? ❑ Yes ❑ No

16. Are there pets at home? ❑ Yes ❑ No

17. What is the child's primary source of water?
❑ City ❑ Well ❑ Bottle

18. Is the water fluorinated? ❑ Yes ❑ No

19. Does the entire family wear seat belts in the car?
❑ Yes ❑ No

20. Is the patient taking any OTC/Prescription Medications?

_____

21. Are you seeing a specialist that we have not referred you to?

_____

22. Is there anything we can provide you to help us better care for your child, such as hearing, vision, or reading accommodations?

_____

_____

RISK SCREENINGS

Lead Exposure Risk:

Does your child live in or regularly visit a house built before 1960 with peeling/chipping paint or recent renovation?
❑ Yes ❑ No

Does your child have a sibling, housemate, or playmate with lead poisoning or a high lead level? ❑ Yes ❑ No

Is there an adult at home whose job or hobby involves lead exposure?
❑ Yes ❑ No

Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
❑ Yes ❑ No

TB(Tuberculosis) Risk Assessment:

Are you or the child foreign born?
❑ Yes ❑ No

Do you have a family history of TB? ❑ Yes ❑ No

Is there an adult with HIV infection in or around the family?
❑ Yes ❑ No

Do you have a family member who has been in jail within the past 5 to 10 years? ❑ Yes ❑ No

Do you have or care for foster children who may be at risk for TB or whose medical histories are missing?
❑ Yes ❑ No

Do you live in a high-risk neighborhood or in one with migrant families or homeless? ❑ Yes ❑ No

FOR OFFICE USE ONLY

_____ _____
Initials of Reviewing Provider Date

It is the Guarantor's responsibility to know if Alliance Pediatrics participates in your insurance plan or network. Do this prior to seeing the Physician.

I hereby give annual authorization for payment of insurance benefits to be made directly to Alliance Pediatrics, PA for services rendered. I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all costs of collection and reasonable attorney's fees. I authorize the provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original.

Guarantor's Signature: _____ Date: _____

Alliance Pediatrics, P.A.
Authorization for Alternate Consent

I, _____, the (mother, father, legal guardian) of _____ (child's name). By signing below, I hereby authorize **Alliance Pediatrics, P.A.** to provide medical services to my child as deemed necessary by the physicians at **Alliance Pediatrics, P.A.** upon obtaining the written consent of any one of the following individuals:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

I agree to pay for the charges billed for any and all services provided to my child by **Alliance Pediatrics, P.A.** based upon the consent of any one of the above-named individuals.

I understand and agree that this Authorization will remain in effect until I revoke this Authorization by delivered written notice of such revocation to **Alliance Pediatrics, P.A.**

_____

Signature

_____

Printed Name

_____

Date

_____

Alliance Pediatrics, P.A. Employee
Witness of Signature

Alliance Pediatrics, P.A.
4627 NW 53rd Ave Gainesville FL 32653

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

I authorize and request From: _____
Name of Physician or Medical Facility

_____
Street Address

_____
City State Zip

_____ _____
Facility Phone Number Facility Fax Number

Release Records To: _____
Name of Physicians or Medical Facility

_____
Street Address

_____
City State Zip

_____ _____
Facility Phone Number Facility Fax Number

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition or dates: _____

□ All Heathcare information

□ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ YES □ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

I understand that my medical records of the patient for whom I am signing may include Alcohol/Drug abuse, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. Alliance Pediatrics, PA, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

_____ _____ _____
Patient Signature or Legal Representative Relationship to Patient Date

Alliance Pediatrics, PA

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient Name: _____

DOB: ____/____/____

Today's Date: ____/____/____

By signing below, I have received or have been offered and declined a copy of Alliance Pediatrics ' Notice of Privacy Practices as outlined below.

Parent/Guardian Printed Name: _____ Parent Signature: _____

Updated Notice of Privacy Practices (9/23/13 Revisions) **This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.**

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and Disclosure of Protected Information

Federal law provides that we may use your PHI for your treatment, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to that specialist.

Federal law provides that we may use your medical information **to obtain payment** for our services without further specific notice to you, or written authorization by you For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered Federal law provides that we may use your medical information **for health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us; or to conduct cost-management and business planning activities for our practice.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

Required for public health purposes, or for law enforcement by a law enforcement official; **Required by** law to report child abuse, or by a health oversight agency for oversight activities authorized by law, or by law in judicial or administrative proceedings, or by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official or by a coroner/medical examiner; **Permitted by** law to a funeral director or for organ donation purposes, to avert a serious threat to health or safety; **Permitted by law and required by** military authorities if you are a member of the armed forced of the U.S. ; Permitted by law and required for national security, as authorized by law; or otherwise required or permitted by law.

Certain types of uses and disclosures of protected health information require authorization, these include:

- Uses and disclosures of psychotherapy notes and disclosures of PHI for marketing and disclosures that constitute the sale of PHI. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

State Specific Laws

The State of Florida states the right to privacy in its constitution. FL law is more stringent and will override HIPAA regulations. FL provides additional protection for information regarding HIV/AIDS, mental health, substance abuse and sexually transmitted diseases.

We will also continue to follow considerations of confidentiality under state law for minors when treated for certain conditions (for example, minors do not need parental permission to consent to treatment for sexually transmitted diseases, pregnancy, drug abuse and others. The minor's personal health information is not allowed to be released, except as outlined in this notice, without the written authorization of the minor).

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

Minors

For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the c
that is known to us or unless it is a type of treatment or service where parental rights are restricted.
We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked b
or guardian to take their child to the pediatrician's office may have access to this child's medical information. We prefer to have written authorization from the p
guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.
You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. A separate form is availabl
purpose. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written auth
that you give.

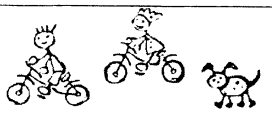
Rights That You Have

- You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictio
- You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and relate
in a particular manner or at a certain location e.g. at home and not at work. Such requests must be made in writing to your physician. Our practice will accom
reasonable requests.
- You have the right to inspect & obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendr
will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you
rights.
- You have the right to request an accounting of any disclosures we make of your medical information An accounting does not have to be made for disclosures
to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 1
for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement off
permitted by law, or disclosures made before April 14, 2003.
- You have the right to restrict certain disclosures of PHI to a health plan, for carrying out payment or health care operations, where you pay out of pocket in ful
healthcare item or service
  - You are required to notify Business Associates of Health Info Exchange of the restriction
  - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time period, which may not be longer than six (6) years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have a right to receive electronic copies of health information.

Obligations That We Have

- We are required by law to maintain the privacy of PHI and to provide individuals with notice of our legal duties and privacy practices. We are required to ab
terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all PHI we maintain. Revised notices will be posted in our office, and copies
available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and H
Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for f
complaint.

Organization Contact Information Alliance Pediatrics, PA*4627 NW 53rd Ave Gainesville FL* (352)335-8888*Contact Person: Carol Ellis, Privacy Officer



Alliance Pediatrics, PA

NEW Vaccine Stance and Policy

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.

We firmly believe that thimerosal, the preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health promoting intervention we perform as health care providers and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

Please recognize that by not vaccinating you are putting your child at unnecessary risk for life threatening illness and disability and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

We would like you to know that those of us in the practice who have children of our own have had them fully vaccinated following the established schedule.

Should you decide that you do not want to vaccinate your children, we regretfully cannot provide care for your family.

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Patient Name: _____ **DOB**: _____

Parent Signature: _____ **Date**: _____

Please be advised that our office does not participate in the VFC Medicaid Program and all Medicaid patients must go to the Health Department to receive their vaccinations.

Alliance Pediatrics, P.A.

Patient Name: _____ Patient's DOB: _____

Office Policies

- If you are unable to keep your appointment, it is important to notify us 24hrs. prior to your appointment time. If you do not call to cancel your appointment, you will be charged a **$20.00 NO SHOW FEE**. If it is a Monday appointment, then the morning of appointment is sufficient. In special circumstances an appeal can be submitted for a "one-time" removal of a "no-show" per account if an appeal is approved. Patients who do not show up for a scheduled appointment 3 times within a 12 month period and fail to notify us prior to the appointment, will be discharged from the practice.
- If you walk-in without an appointment, you may be subject to wait until the first opening is available or be referred to the nearest urgent care facility.
- If you come in early for an appointment, please remain seated in the waiting area.
- Once you are taken back into the exam rooms, please remain in the room until the provider sees you.
- Any records request, immunizations records, and or physical forms have a 3 day turn around and should be requested ahead of the date needed.
- Please notify the front desk staff if your insurance, address, or telephone information has changed.
- Please provide the office with any information regarding custody, guarantor, or family changes.
- You will be asked, on a yearly basis, to complete a new demographics form. Please fill it out as accurately as possible to ensure proper billing and contact information.

Financial Policies

- It is the guarantor's responsibility to know if Alliance Pediatrics (APPA) participates in the patient's insurance plan/network and should be confirmed prior to seeing the Provider.
- The guarantor is financially responsible for all charges whether or not they are covered by the insurance.
- The guarantor authorizes the provider to release all information necessary to secure payment of benefits.
- Payment is expected at the time of service. This includes all co-pays, co-insurances, and deductibles.
- A $10.00 processing fee will appear on your statement for any co-pays not paid on the date of service.
- Our staff has the right to ask you for any past due balances, as well as your portion of the payment for today's services. Failure to meet your financial obligations within a timely manner may result in discharge from the practice. If you have an outstanding balance, we reserve the right not to schedule yearly well visits until the balance is paid.
- Some insurance companies require that labs be performed in a different location other than the physician's office. If you choose to have the test performed at our office, you will be expected to pay the fee for this service. Your insurance company will not be billed for these services. Similarly, if your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will need to pay for those services upfront. Your insurance cannot be billed for these services.
- We reserve the right to charge an "extended/prolonged provider visit fee" along with your regular office visit fee while in the office and under the care of a physician/ARNP, for a period of time greater than or beyond your regularly scheduled office appointment.
- If you are being seen for an annual well check and have additional services outside of your insurances' "well check guidelines" that result in a written prescription, a referral being sent to an outside provider or a procedure being done along with the well exam, we reserve the right to charge a regular office fee along with a well exam fee. Any co-pays, co-insurances or deductibles that would accompany the regular office visit would apply and the guarantor would be responsible for those fees.
- If provided with a primary and a secondary insurance, we will bill charges in accordance to that order. Once claims have been processed by both insurances and a balance still remains, the guarantor will be responsible for payment of the balance.

_____ _____

Signature of Guarantor Date Revised: June 2015