



Space Coast Pediatrics
8045 Spyglass Hill Road Ste 105
Melbourne, FL 32940

PARENTAL CONSENT FOR MEDICAL TREATMENT

Childs Name: _____ **Birth Date:** _____

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Space Coast Pediatrics. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at SCP. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

CAREGIVER INFORMATION:

This information is for anytime you cannot bring your child to the appointment and you would like a friend or a family member to bring the child.

Caregivers Name: _____

Relationship to Child: _____ **Phone #:** _____

Caregivers Name: _____

Relationship to Child: _____ **Phone #:** _____

I authorize the above person(s) to consent for all medical and/or surgical treatment and/or other medical procedures (including admissions, inoculations, diagnostic testing, etc.) for the above named child, which may be required during my absence. If any money is due this person will be asked for payment before services are rendered.

Parent/Guardian: _____ **Date:** _____

Notice of Privacy Practices Acknowledgement Form

The Health Insurance Portability and Accountability Act (HIPPA) are in place to provide a safeguard to your privacy. Implementation of HIPPA requirements official began 04/14/2003. Many of the policies have been our personal practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Personal Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with our services. HIPPA provides certain rights and protections to you as the patient. We balance these needs without goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at: WWW.HHS.GOV.

Space Coast Pediatrics has adopted the following policies:

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care is handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and your health insurance.

- It is the policy of Space Coast Pediatrics to remind patients of their appointments. We do so by phone, text, email, & U.S. Mail. We may send you other communications informing you of changes to office policy and new technology you may find helpful.
- Space Coast Pediatrics utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
- You understand and agree to inspections of the office and the review of documents by government agencies where PHI may be viewed in compliance with HIPPA regulations.
- You agree to bring any concerns or complaints regarding privacy to the attention of our office manager: Jose Candelario or the proprietor of the practice: Arlene Sepulveda MD
- Your confidential information will not be used for the purpose of marketing or advertising.
- Space Coast Pediatrics agrees to provide patients with access to their records in accordance with state and federal laws.

The undersigned certifies that he/she has fully read and understands the Notice of Privacy Practices.

Patient Financial Responsibility

Thank you for choosing Space Coast Pediatrics as your healthcare provider. We are committed to building a successful Physician-Patient relationship with you and your family. The following statement of Financial Responsibility must be signed prior to treatment.

Insurance Claims:

Space Coast Pediatrics will file claims with the patient insurance upon the patient's submission of proof of insurance (i.e. Insurance card indication coverage). In the event that the patient has insurance coverage but cannot provide documentation, payment is due at the time of services. Once proof is provided and payment has been received from the insurance company, a refund will be issued to the patient in the form of a check.

Secondary Insurance:

Claims will be filed with secondary insurance if adequate information is received at the time of services. If payment is not received in our office within 45 days of filing, the responsibility will be transferred to the patient and is due upon receipt.

Patient Financial Responsibility:

If no insurance is to be filed, or if we are not a participating provider with your insurance, FULL PAYMENT IS DUE AT TIME OF SERVICE. We are willing to work with you to develop a payment schedule to meet your needs and ours. Co-Payments, Deductibles, Co-Insurance and non-covered services cannot be applied to these payment plans. Payment arrangements will be made with a signed Payment Agreement with the approval of our office manager and billing department.

Minors/Dependants:

Children under the age of 18 will be required to be accompanied by an adult at all times during the visit. Adult party signature is also required on the registration forms.

Methods of Payment:

Cash, Check, Visa, MasterCard, Discover, American Express and Money Order.

Accounts Past Due:

After 90 days, an account will be considered past due. We will attempt to reach you three times. If no contact can be made and the account remains outstanding it will be turned over to collections. This may result in small claims court, credit bureau reporting and discharge from practice. Should the account need to be handled in small claims court the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

Account Consultation

Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you.

Medical Records

If you require us to transfer your medical records to another practice there is no cost. If you would like a copy of your medical records, there will be a fee in the amount of \$0.50 per page. This fee must be paid prior to the transfer of the records.

I have received a copy of the Space Coast Pediatrics Financial Responsibility Policy and agree to the terms set in the policy.

Patient Printed Name

Date

Printed Name of Responsible Person

Relationship to Patient

Witness Name

Witness Signature and Date



Space Coast Pediatrics HIPPA Compliant Authorization for the Release of Patient Health Information

To: _____

Name of (Previous) Healthcare Provider/Physician/Facility/Insurance Company

Street Address

City, State, Zip, Phone Number/Fax Number

From:

Space Coast Pediatrics 8045 Spyglass Hill Road Ste 105, Melbourne, FL 32940 Ph (772) 269-1904 Fax (321) 326-1136

RE: _____

Patient Name

Patient Date of Birth

I understand that:

1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE

2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

3) I may revoke this authorization at any time by notifying Florida Pediatric Group in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4) Space Coast Pediatrics agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

(Please check all the apply)

- ☐ All medical records. This means every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient records, outpatient records, emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse notes, social worker records, clinical records, treatments plans, care plans, admission records, discharge summaries, test results, statements, questionnaires, histories, photographs, videotapes, telephone messages, and any/all medical records received from other facilities.
- ☐ All physical, occupational and rehab requests, consultations, and progress notes
- ☐ All disability, Medicaid or Medicare Records, including claim forms and record of denial benefits.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunochemistry, specimens, radiology records, films including MRI, CY, MRA, EMG, EEG, bone scan, myelogram, nerve conduction study, echocardiogram, cardiac catheterization, video's/CD's,/Films,/Reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payments, denials and benefits.
- ☐ All laboratory findings and diagnosis's related to Acquired Immunodeficiency Syndrome(AIDS), Sexually Transmitted Diseases (STD's), and Human Immunodeficiency Virus (HIV)
- ☐ All mental health records

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus(HIV) alcohol and drug abuse. I authorize the release or disclosure of this information.

This protected health information is being disclosed for the following

Purpose: Medical Record.

This authorization is given in compliance with federal consent requirements for release of alcohol or substance abuse of records of 42CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I understand the following: (See CFR 164.508© (2) (i-iii)

Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legal Representative

Date

Name and Relationship of Legally Authorized Representative