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NEW PATIENT INFORMATION

36468 Emerald Coast Parkway Unit 2101
Destin, FL 32451
(850) 659-6556

Today's Date

PATIENT

Last _____ First _____ Middle _____

☐ Male ☐ Female Date of Birth _____/_____/_____ Social Security _____-_____-_____

Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (_____) _____

Current Pediatrician _____ School _____

Preferred Pharmacy _____ Location_____ Phone _____

PARENT/GUARDIAN

Name _____ Relationship to Patient _____

Email _____ Date of Birth _____/_____ /_____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (_____) _____

Social Security _____ - _____ - _____ Employer _____

ADDITIONAL PARENT/GUARDIAN

Name _____ Relationship to Patient _____

Email _____ Date of Birth _____/_____ /_____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (_____) _____

Social Security _____ - _____ - _____ Employer _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (_____) _____

Primary Insurance_____Policy Holder Name _____

Policy Holder Sex ☐ F ☐ M Policy Holder DOB_____/_____/_____

Policy Holder SSN #_____-_____-_____ Policy Holder Relationship to Patient _____

ID#_____Group # _____

Secondary Insurance_____Policy Holder Name _____

Policy Holder Sex ☐ F ☐ M Policy Holder DOB_____/_____/_____

Policy Holder SSN #_____-_____-_____ Policy Holder Relationship to Patient _____

ID#_____Group # _____

_____ _____

Patient or Guardian Signature Relationship to Patient Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:_____ DOB:_____ Phone #: _____

Street Address:_____ City, State, Zip: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone: Fax:

PLEASE **SEND** INFORMATION **TO**:

Coastal Pediatric Group, LLC
Name of Provider/Clinic/Organization

Emerald Coast Parkway Unit 2101
Street Address

Destin, FL 32451
City, State, Zip Code

(850) 659-6556 (850) 249-1309
Phone: Fax:

I AUTHORIZE the following information to be disclosed: (Please mark all that apply)

- ☒ Complete Health Records
- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Well Child Visits
- ☐ Progress Notes
- ☐ Consult Notes
- ☐ Medication History
- ☐ Date(s)_____
- ☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ADDITIONAL PATIENT INFORMATION:
If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Guardian Date Signature of Witness Date

_____
Name of Patient or Guardian Relationship

☐ Pick-Up Records ☐ Mail Records ☒ FAX Records

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AUTHORIZATION TO PROVIDE MEDICAL CARE

I, _____, being the parent/guardian of _____, authorize the following list of individuals to consent for treatment of my above mentioned child. I understand that by providing the following information about the individuals, I am allowing Coastal Pediatric Group to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of my child, I may do so by requesting a new form, filling it out, and signing again. I also understand that if there is any necessary treatment that requires a major decision be made, Coastal Pediatric Group will make every effort to contact me first. However, if no contact can be made with a parent, and I have authorized the individual to consent for treatment, the individuals listed below have my permission to make decisions for my child's medical care. This authorization will be indefinite and will only expire if I fill out a new form. All individuals listed below will be required to provide at least one form of identification that must include a photograph as well as the information provided below for verification purposes. I understand that this is being done to protect my child's well-being.

The following individuals are authorized by me to consent for treatment:

Name of Individual	Relationship to Patient	Date of Birth

Signature of Parent **Name of Parent** **Date**

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with your state 's laws and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Coastal Pediatric Group uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Coastal Pediatric Group.

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Coastal Pediatric Group

3. I have the right to revoke this authorization at any time by writing to Coastal Pediatric Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

6. This authorization expires one year from the date of my signature below.

7. THIS AUTHORIZATION DOES NOT AUTHORIZE COASTAL PEDIATRIC GROUP TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____ _____

Signature of Patient or representative authorized by law Date

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PARENT'S ACCEPTANCE OF POLICIES

Patient Name: _____

Patient Privacy Practices

By signing here, I am acknowledging that I have received a copy of Coastal Pediatric Group's Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. I understand that my medical information may be viewed or shared amongst the staff of Coastal Pediatric Group and that every effort will be made by Coastal Pediatric Group to protect my health information as is required by HIPAA regulations. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____

Parent or Patient Signature Date

Patients' Bill of Rights

By signing here, I am acknowledging that I have received a copy of Coastal Pediatric Group' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____

Parent or Patient Signature Date

Patient Responsibilities

By signing here, I am acknowledging that I have received a copy of Coastal Pediatric Group's Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____

Parent or Patient Signature Date

Financial Responsibilities

I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Coastal Pediatric Group will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Coastal Pediatric Group permission to bill my or my child's insurance company on my behalf. I hereby assign all medical benefit to which I am entitled to Coastal Pediatric Group. I hereby authorize and direct my insurance carrier to issue payment check(s) directly to Coastal Pediatric Group for medical services rendered to my dependents. I understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

_____ _____

Parent or Patient Signature Date

Permission to Release Medical Information

By signing here, I authorize Coastal Pediatric Group to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to Coastal Pediatric Group until written notice revoking this authorization is provided by the patient or patient's legal representative.**

_____ _____

Parent or Patient Signature Date

If you are signing for the patient, please indicate your relationship here: _____

Relationship to Patient

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Coastal Pediatric Group (the "Practice")

NOTICE OF PRIVACY PRACTICES:

The privacy of your personal and health information is important.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
No action on your part is required, unless you have a request or complaint.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. You may call the office and request that a revised copy be sent to you in the mail or request a current copy at the time of your next appointment.

I. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. Uses and Disclosures for Treatment, Payment and Health Care Operations: We collect health information from you and store it in an electronic chart. This is your medical record. The medical record is the property of the practice, but the information in the medical record belongs to you. We protect the privacy of your health information. The law permits us to use or disclose your health information for the purposes of treatment, payment and health care operations. Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make:

Treatment. We may use or disclose your PHI to physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment. We may use or disclose your PHI to obtain payment for your health care services. For example, obtaining approval for services may require that your PHI be disclosed to your health plan.

Health Care Operations. We may use or disclose your PHI or a limited data set in order to operate our practice. For example, we may use your PHI in order to evaluate the quality of health care services that you receive or to evaluate the performance of those who provide health care services to you. We may also provide your PHI to consultants in order to make sure we are complying with the laws that affect us. We may ask you to sign in at our front desk, and also call you by name when your physician is ready to see you.

B. Others Involved In Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

C. Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

D. Other Permitted and Required Uses and Disclosures that may be made without your authorization or opportunity to object: We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required by law, legal proceedings, or law enforcement. We make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered in a judicial or administrative proceeding.

Public Health. As required by law, we may release PHI or a limited data set to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. We are required to report all births and deaths to the office of vital statistics for certificate purposes.

Health Oversight Activities. We may disclose your health information to assist the government when it conducts an investigation or inspection of a health care provider or organization. We are required to disclose PHI, upon request, to the Secretary of the Department of Health & Human Services so they can determine our compliance with privacy laws.

Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or Privacy Board.

Public Safety. We may disclose your health information or limited data set to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specific Government Functions. We may disclose your health information for military, national security, and prisoner purposes.

Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or to give information about other treatments or health-related benefits

and services that may be of interest to you. For example, your name and address may be used to send you a newsletter.

Florida State Specific Requirements. When Florida's laws are more stringent than federal privacy laws, the state law preempts the federal law.

Diagnostic and therapeutic information regarding psychiatric, drug/alcohol abuse or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required by law.

II. WHEN WE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If we obtain an authorization from you to use or disclose your health information for other purposes, you may revoke your authorization in writing at any time except to the extent that your physician or your physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

III. YOUR HEALTH INFORMATION RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Your request for a copy must be in writing and you may be assessed a charge to cover the expenses related to providing the information.

You have the right to request restriction on certain uses and disclosures of your protected health information. We will consider your request, but are not required to accept it. These requests must be in writing.

You have the right to obtain a paper copy of this notice from us, upon request.

You have the right to choose how you receive your health information. You have the right to ask that we send information to you at an alternative address (for example e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. These requests must be in writing. You may be assessed a charge for this accommodation.

You have a right to request that we correct or update information that is incorrect or incomplete. We are not required to change your health information. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial. These requests must be in writing.

You have a right to receive a list of disclosures we have made, such as disclosures required by law, disclosures to government officials, and disclosures for workers' compensation. This request must be in writing and must state the time period. The time period requested may not be longer than six years. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

IV. QUESTIONS

If you have questions about any part of this notice, or if you want more information about our privacy practices, please contact the office manager at Coastal Pediatric Group.

V. INCIDENTAL DISCLOSURES

We make reasonable efforts to avoid incidental disclosures of your protected health information. An example of an incidental disclosure is conversations that may be overheard between you and our team members.

V. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the President/ Vice President of Coastal Pediatric Group. To file a complaint with us, contact our office at (850) 659-6556, or info@coastalpediatricgroup.com. **You will not be penalized for filing a complaint.**

VI. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to change this Notice of Privacy Practices at any time in the future. We reserve the right to make the changed notice effective for health information we already have about you as well as any we receive in the future. We will post a current copy of the Notice. In addition, you may obtain

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I. Information Disclosure
You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed health care decisions.

II. Choice of Providers and Plans
You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

III. Access to Emergency Services
If you have severe pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions
You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination
You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.

VI. Confidentiality of Health Information
You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals
You have the right to a fair, fast, and objective review of any compliant you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.

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A patient is responsible for:

- Providing to your healthcare provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his health;
- Reporting unexpected changes in your condition to his healthcare provider;
- Reporting to your healthcare provider whether he comprehends a contemplated course of action and what is expected of your;
- Following the treatment plan recommended by your health care provider;
- Keeping appointments and, when you are unable to do so for any reason, for notifying the healthcare provider or healthcare facility;
- Assuring that the financial obligations of your healthcare are fulfilled as promptly as possible;
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow your healthcare provider's instructions.
- Following healthcare facility rules and regulations affecting patient care and conduct.

You may request a copy of this law from your health care provider.

Print Form to Bring to Appointment