7504 McElvey Drive
Panama City Beach, FL 32408
Phone: 850-481-1101 Fax: 850-441-3748

Office visit date: _____

PATIENT INFORMATION

Patient Full Name: _____**Date of Birth:** _____ **Child SSN:** _____

Address: _____**SEX:** Male Female
STREET ADDRESS, CITY, STATE, ZIP CODE

Home Phone: _____ ____ **Cell Phone:** _____ **SMS/Text ok?** Y { } N { }

Email Address: _____ **Would you like online access to the patient portal?** Y { } N { }

Mother's Name: _____ DOB: _____ SSN: _____Employer/Ph #_____
Father's Name: _____ DOB: _____ SSN: _____Employer/Ph #_____
Legal Guardian's Name: _____ DOB: _____ SSN: _____Employer/Ph #_____
(If other than parent)
Race: Asian / Native Hawaiian-Pacific / Black –African American/ White / Hispanic/ Other race/Decline to Report
Ethnicity: Hispanic – Latino/Not Hispanic / Decline to report

How did you hear about us? _____

Do you have insurance? Yes No If yes, please complete the following:

INSURANCE INFORMATION:

1. **PRIMARY:** _____ POLICY NUMBER:_____
_____
(address)
Policyholder Name: _____ Policyholder DOB: _____

2. **SECONDARY:**_____POLICY NUMBER: _____
_____
(address)
Policyholder Name: _____ Policyholder DOB:_____

FINANCIAL RESPONSIBILITY

Responsible Party (guarantor): _____ Relation to patient: _____

Address: _____ DOB: _____

_____Phone Number: _____

AUTHORIZATION TO FILE INSURANCE

Patient Name: _____

MEDICARE/TRICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorized any holder of medical information to include psychiatric and or psychological, HIV/AIDS, or other information about me to release these to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician (s) to submit a claim to the carrier for payment. I understand that I am personally responsible for my medical bills and will pay my deductible and or co-pays.

_____

PRINTED PARENT/GUARDIAN NAME SIGNATURE OF PARENT/GUARDIAN OF MINOR DATE

INSURANCE LIFETIME AUTHORIZATION

I authorize any holder of medical information to include psychiatry, HIV/AIDS, or other information about me to release same to any insurance carrier for the purpose of obtaining payment of services rendered by the physician (s) of this medical group practice. This includes but is not limited to hospital or medical services companies, insurance companies, workman's compensation carriers, veteran's administration or welfare. I understand that I am financially responsible for my medical bills regardless of insurance coverage. Any insurance coverage that has not been paid within 45 days will become my responsibility to pay.

_____

PRINTED PARENT/GUARDIAN NAME SIGNATURE OF PARENT/GUARDIAN OF MINOR DATE

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to benefits of any type arising out of any insurance insuring the patient or any other party liable to patient, such benefits are hereby assigned to Nation's Best Family Health Care for application to the patient's bill. The undersigned and or patient are responsible for charges not covered by this assignment.

_____

PRINTED PARENT/GUARDIAN NAME SIGNATURE OF PARENT/GUARDIAN OF MINOR DATE

PAYMENT POLICY

Payment Policy
Thank you for choosing Nation's Best Family Health Care as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request. **PLEASE INITITAL EACH NUMBER.**

1. **Insurance.** We accept most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. _____
2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit._____
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit._____
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license, social security number and current valid insurance to provide proof of insurance. If you choose not to provide us with any of these, we are not obligated to file your insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. _____
5. **Claims submission.** Our billing department will submit your claims and assist you in any way they reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. _____
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. _____
7. **Nonpayment.** If your account is over 45 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. _____
8. **Missed appointments.** If you need to change your appointment, please call our office within 24 hours of your scheduled appointment. Our policy is to excuse the first missed appointment. The second missed appointment will be charged $50. These charges will be your responsibility and billed directly to you. If you cancel your appointment the same day of your appointment you will be charged $25. Please help us to serve you better by keeping your regularly scheduled appointment. If you miss more than two appointments in a row, this is grounds for dismissal from our practice. _____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____
Signature of patient or responsible party Date

PATIENT CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I understand that as part of my healthcare, Nation's Best Family Health Care, originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information and uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Nation's Best Family Health Care is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Personally, I wish to be contacted in the following manner (List / circle all that apply and please number the order of your preference 1-3)

_____Home Phone/Cell phone _____ Can/Cannot leave message

_____Text Message/Email _____

_____Work Number _____ Can/Cannot leave message

Written Communication to: Home address /Email/ Fax to: _____

I authorize Nation's Best Family Health Care to give personal information to the following people: Please list name/relationship to the patient and phone number:

_____

_____

_____ _____

Patient's Signature Date

_____ _____

Witness Date

Would you like a copy of this form? Please initial _____ yes _____no

Prescription History Consent

I give my consent to Nation's Best Family Health Care to obtain my prescription history from external sources.

Patient of Authorized Person's Signature: _____Date: _____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has 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.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to 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.

A patient has the right 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.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right 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.

A patient has the right 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.

A patient is responsible 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.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible 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.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible 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.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

History.—s. 1, ch. 91-127; s. 65, ch. 92-289; s. 656, ch. 95-148; s. 21, ch. 98-89; s. 178, ch. 98-166; s. 64, ch. 99-397; s. 7, ch. 2001-53; s. 2, ch. 2001-116; s. 3, ch. 2004-297; s. 12, ch. 2006-261; s. 3, ch. 2008-47; s. 2, ch. 2011-112; s. 1, ch. 2011-122.

[1]Note.—The word "of" was substituted for the "or" by the editors.

For more information on the Florida Patient Bill of Rights: http://www.flsenate.gov/laws/statutes/2011/381.026

Would you like a copy of the Florida bill of rights? YES NO

Please sign below acknowledging you have been offered a copy of the Florida Patient's Bill of Rights.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Name:_____ **D.O.B:** _____ **Date:** _____

INITIAL PATIENT INTAKE FORM:

Briefly describe what brings you to our clinic today?

_____

_____

Pregnancy and Birth

Mother's age at pregnancy: _____ Any illness during pregnancy? Y { } N { } Medication during pregnancy ? Y { } N { }
Smoking, alcohol, street drugs during pregnancy? Y { } N { } Was baby early, late, on time? _____
Complications? _____ **Type of delivery:** Vaginal C-section **Birth weight**:_____ **Length**: _____
Any problems soon after birth @ nursery or home? _____

Past Medical History of Patient

Allergic reactions: Y { } N { } Food: Y { } N { } Animals: Y { } N { } Insect Bites: Y { } N { } Explain: _____
_____

Immunizations up to date? Y { } N { } Do you have a copy of shot record? Y { } N { }

PRIOR IMMUNIZATIONS

□ Flu	□ Hepatitis A	□ MMR	□ PPD (Tuberculosis screen)
□ Pneumonia	□ Hepatitis B	□ Shingles	□ Gardasil (HPV)
□ Tetanus	□ Tetanus w/ pertussis		

Hospitalizations? Y { } N { } If yes, please list: _____
Serious Injuries? Y { } N { } If yes, please list: _____

Please list any medications taken regularly:

NAME OF MEDICATION	DOSE	FREQUENCY	PRESCRIBER	PHARMACY

******Allergies******

History of skin or adverse reaction to: (Please circle/list)
Are you sensitive or allergic to foods, drugs, or environmental substances? (Rash, anaphylaxis, etc.)

ANTIBIOTICS: _____

PAIN MEDICATION: _____

ANTISEPTICS (Iodine, etc.): _____

TAPE/SUBSTANCE (latex, silk tape, etc.): _____

IMMUNIZATIONS: _____

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: Dust, Mold, Other: _____

Has patient had any of the following conditions?

Red Measles	Y { } N { }	Vision Problems	Y { } N { }	Rheumatic Fever	Y { } N { }
Chicken Pox	Y { } N { }	Blood Transfusions	Y { } N { }	Bleeding Tendency	Y { } N { }
Scarlet Fever	Y { } N { }	Anemia	Y { } N { }	Hearing Problems	Y { } N { }
Asthma/Wheezing	Y { } N { }	Joint Problems	Y { } N { }	Urinary Infections	Y { } N { }
Strep Throat	Y { } N { }	Hepatitis	Y { } N { }	German Measles	Y { } N { }
Mumps	Y { } N { }	Seizures	Y { } N { }	Eczema/Hives	Y { } N { }
Whooping Cough	Y { } N { }	Ear Infections	Y { } N { }		

Feeding and Nutrition

Food allergies Y { } N { }List if any _____**Normal Appetite?** Y { } N { } **Vitamins/Supplements?** Y { } N { }
Breast Fed? Y { } N { } # of months_____ **Formula?** Y { } N { } **Current Brand**: _____
Colic or feeding problems during first 3 months? Y { } N { } **Special Diet?** Y { } N { } **Fluoride?** Y { } N { }

Family Profile:

Parents are: Married { } Separated { } Divorced { } Unknown { }
Father's age: _____ Highest grade school completed: _____ Health: _____
Mother's age: _____ Highest grade school completed: _____ Health:_____

Please list child's siblings and their ages: _____

FAMILY MEDICAL HISTORY: List all blood relatives of the child who have the following conditions. Use abbreviations {F} father, {M} Mother, {B} Brother, {S} Sister, {M} Mother's Mother, {MF} Mother's Father, {FM} Father's mother, {FF} Father's Father, {A} Aunt, {U} Uncle, {C} Cousin

□ Alcoholism/substance abuse	□ Epilepsy/Seizures	□ Obstructive Sleep Apnea
□ Allergies/Chronic Sinusitis	□ Fibromyalgia	□ Osteoporosis / Osteopenia
□ Anemia/blood disorder	□ Glaucoma	□ Psoriasis/Eczema
□ Asthma	□ Headaches/Migraines	□ Psychosis/Schizophrenia
□ Arthritis / Joint Pain	□ Heart Disease/Prior Heart Attack	□ Rheumatoid Disease
□ Bipolar Disorder	□ Hemorrhoids	□ Shingles
□ Bladder infections	□ Hepatitis	□ Stroke
□ Birth Defects	□ Hiatal Hernia/GERD	□ Sudden Infant Death
□ Cancer	□ High Blood Pressure	□ Tuberculosis
□ Crohn's disease / Ulcerative Colitis	□ High Cholesterol	□ Thyroid disease
□ COPD/chronic bronchitis	□ HIV/AIDS	□ Other Medical Conditions:
□ Cystic Fibrosis	□ Kidney Disease	
□ Depression / Anxiety	□ Lupus/Autoimmune disease	
□ Diabetes	□ Mental Retardation	
□ Early Deafness	□ Migraines	
□ Emphysema	□ Muscular Dystrophy	

Development and Behavior

At what age did the child: Sit alone _____ Walk _____ Use sentences _____ Toilet trained _____ Bicycled _____
Grade in school: ____ Problems in school? Y { } N { } Learning problems? Y { } N { } Getting along with other kids Y { } N { }
Behavior concerns: Y { } N { } Bad Habits? Y { } N { } Bedwetting Y { } N { } Nail biting Y { } N { } Use of illegal drugs Y { } N { }
Hobbies: Y { } N { } Sports Y { } N { }

Parent/Guardian Signature: _____ Date: _____

Do you have any significant cultural or religious beliefs pertaining to your health care? □ Yes □ No

Please select and complete ONE of the following options (only option A or only B).
Please be sure to inform anyone listed below that they will be required to present a **photo ID**

Patient Name: _____ Patient DOB: _____

OPTION A – Authorization of Other Persons for Patient Transport

A) _____ I, _____ authorize the following person/persons to bring my child to his or her appointment in case of my absence:
(name of parent/guardian)

_____ _____
Name **Relationship to child**

_____ _____
Name **Relationship to child**

_____ _____
Name **Relationship to child**

_____ _____
Signature or parent/legal guardian **Date**

/OR/

OPTION B – Authorization of Parent/Guardian ONLY for Patient Transport

B) _____ I, _____ authorize NO ONE to bring my child to his/her
(please initial) (name of parent/guardian)
to his/her appointment, only MYSELF.

_____ _____
Signature of Parent/Guardian Date

OFFICE POLICIES

1. ***Same Day Appointments:*** Same day appointments are available if your child is sick. Please call the office to schedule a same day appointment. Same day appointments are reserved for sick patients only.
2. ***Missed/Late Appointments:*** If you need to change your appointment, please call our office within 24 hours of your scheduled appointment. Our policy is to excuse the first missed appointment. The second missed appointment will be charged $50. These charges will be your responsibility and billed directly to you. If you cancel your appointment the same day of your appointment you will be charged $25. Please help us to serve you better by keeping your regularly scheduled appointment. If you miss more than two appointments in a row, this is grounds for dismissal from our practice.
3. ***NO SMOKING*** **–** Please review the accompanying No Smoking Policy for further information
4. ***Cell phones -*** Cell phones need to be muted or turned off.
5. ***Any damage to Nation's Best property or property of its employees may result in immediate dismissal as a patient from our practice.*** Additionally, ***Food and Drinks are not permitted in the waiting area or exam rooms***. .
6. ***Shot Records & Administration Documentation*** **–** We require 72 hour notice for any shot record/immunization history reports, as well as other documents requiring a provider's signature.
7. ***Changing Tables*** **–** For your convenience, we supply our patients with a changing table in the patient restroom. This is the ONLY place you should dispose of soiled diapers.
8. ***Medical Records –*** Medical records will be released to another provider after we have received a signed medical records request. If you require a hard copy of the records, there will be a fee of $1 per page for the first 25, then 25 cents per page for each additional page.
9. ***Lab Draws –*** At times we may need to draw lab work on your child. If so, we will send to the lab of our choice unless you specifically request another lab in writing. _____
10. ***Medication Refills –*** Medication refills require a 72 hour notice to be reviewed by the provider. ADHD medication will not be called in. The patient must be seen in the office to receive a RX for these medications.

By signing below, I certify that I have read and understand the office policies.

_____ _____ _____

Parent/Guardian name (print) Parent/Guardian signature Date

NO SMOKING POLICY

Nation's Best Family Health Care/ Pediatrics is a non- smoking facility.

We do not allow smoking on our premises, to include the sidewalk near the building nor the parking lot. This is to protect our patients and our staff.

We ask that you refrain from smoking on the way to your appointment, as the smoke scent that stays on your clothes may flare up allergy or asthma symptoms in a patient with the condition.

_____ _____

Signature of Parent/ Guardian Date