Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Parkway, Suite300
Gulf Breeze, FL 32561
Phone: (850) 932-5055

J. Ben Renfroe, M.D. Weldon A. Mauney, M.D. Sara A. Winchester, M.D.
Genei Bougher, ARNP Tracy Ezelle, ARNP Mailande Dedeaux, P.A.

# DOCTOR-PATIENT SERVICES AGREEMENT

Welcome to our office. Your child's appointment is on _____

at_____.

Neurology Treatment: We specialize in the care of infants, children and, adolescents with neurological disorders. We also treat adults for some specific disorders.

Appointments: We have a late policy. Patients arriving 15 minutes after the designated appointment time will need to be rescheduled. Please note that a 24-hour notice is required to cancel an appointment.

Insurance Authorizations: It is the responsibility of the patient to ensure prior insurance authorization for follow-up appointments and procedures. Please contact our office prior to the appointment to verify that we have received the appropriate insurance authorization.

Professional Fees: Payment in full is due at the time of service unless prior arrangements have been made. Payment of insurance deductibles and insurance co-pays are due at the time of service. As a courtesy, we will continue to file for all insurance companies. Payment is due in full by the 30th of the month. Please contact our billing office at 850-932-5055 option 7 for questions regarding your bill.

Contacting the Office: Phone calls are answered from 8:00 am 4:00 pm, Monday through Friday.

Emergencies: For medical emergencies, call 911 or go to your local emergency room.

Consent: I authorize my insurance benefits to be paid directly to Child Neurology Center; realizing I am responsible for non-covered services. I authorize the release of pertinent medical information to insurance carriers.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Responsible Party Patient Name Patient DOB

# Child Neurology Center of NW FL

## PATIENT INFORMATION

**Please review and update**

Name: _____ Patient#: _____

Address: _____ Social Security #: _____ Sex: _____

_____ Date of Birth: _____ Age: _____

Home Phone#: _____ Race: _____

Work Phone#: _____ Ethnicity: _____

Cell Phone#: _____ Language: _____

Emergency Contact: _____ Emergency Phone#: _____

Emergency Relationship: _____

## GUARANTOR INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security#: _____

_____

Home Phone#: _____ Cell Phone#: _____

Work Phone#: _____

## REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ Phone#: _____

Address: _____

## INSURANCE INFORMATION

Primary Insurance: _____

Certificate#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____

Certificate#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

**Authorization To Pay Benefits To Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Child Neurology Center of Northwest Florida when they accept assignment.

**Authorization To Release Medical Information.** I hereby authorize my Provider, Child Neurology Center of NW FL, to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

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# Pediatric Patient History

Name of Child: _____ SSN: _____
Last First Middle

Date of Birth: ____/____/____ Place of Birth: Hospital: _____
City/State: _____

Child's Address: _____
Street Apt. City State Zip

Home Phone Number: (___)_____ Cell Phone Number: (___)_____

Work Phone Number: (___)_____ To Leave Messages: (___)_____
What is this person's name? _____

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Please complete this section for all people who live in the same home as the child.

| Full Name | How Related | Age | Work | Education |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Who has legal custody of the child? _____ Relationship _____

Who is the child's primary doctor? _____
Name Phone

Do other doctors also see the child? If so, please list them.

| Name of Doctor | Address | Phone Number | Why does child see this doctor? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What pharmacy do you usually use? _____ ( ) _____
Name Location Phone

Why are we seeing your child today? _____

Please provide us with some information about your child's history.

Biological Mother's Pregnancy History:

1. **Pregnancy:** Total number of pregnancies:_____ This was pregnancy number: _____
   Did mom have any miscarriages? _____ How many? _____

2. **Please check the box if any of the following problems occurred during the pregnancy of the child we are seeing today.**

| | | |
|---|---|---|
| Unusual swelling | Unusual weight gain | High blood pressure |
| Infection | Unusual vomiting | Bleeding |
| Alcohol use | Tobacco use | Drug use |

Child's History:

3. **Birth:** Was this child born: early? _____ late? _____ on time? _____
   Was labor induced? _____ Why? _____
   Did mom need to have a Cesarean Section? _____
   Why? _____
   Birth weight: _____ Apgar scores (if known): _____
   Please describe any problems the baby had right after birth: _____
   _____

4. **Please check the box if your baby had any of these problems during the first year of life.**

| | | |
|---|---|---|
| Problems sucking | Choking | Lots of spitting/vomiting |
| Poor eating | Seemed stiff | Seemed limp |
| Cried a lot | Seemed too quiet | Didn't gain enough weight |

**Any other problems during the first year?** _____
_____
_____

5. **At what age did your child first do each of these things?**

| | | |
|---|---|---|
| Hold head up | Roll over | Sit alone |
| Crawl | Pull up | Walk |
| Feed self | Speak first word | Use sentences |
| Dress self | Have bladder control | Have bowel control |

**Did your child ever lose any developmental milestones? When?** _____
_____

6. **Behavior: Describe any behavioral concerns or problems with your child:** _____
_____
_____
_____

7. Please tell us about all the medicines your child takes at this time.

| Name of medicine | Amount taken | How often | What for |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

8. Please tell us about any hospital stays or surgeries your child has had.

| Date of stay/surgery | Name of hospital | Reason for hospital stay | Surgery performed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

9. Does your child have any other medical problems? If so, please describe them here.

| System | Type of problem (s) |
|---|---|
| Breathing | |
| Heart | |
| Skin | |
| Psychiatric/emotional | |
| Eyes/ears/nose/throat | |
| Stomach/intestines | |
| Kidneys/bladder | |
| Blood | |
| Immune system/infections | |
| Muscles/bones | |
| Seizures/head injury | |

10. Are immunizations up to date? Yes _____ No _____

11. Does your child have any allergies? If so, to what and what kind of a reaction is there?

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

12. Please tell us about all the medicines your child has taken in the past.

| Medicine name | Why taken | When started/stopped | Why stopped |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

13. Please check the box and write who if anyone on either mom or dad's side of the family has these problems.

| | | |
|---|---|---|
| Headaches | Cerebral Palsy | Mental Retardation or slow development |
| Weak muscles | Miscarriages or baby who died at a young age | Tics |
| ADHD/ADD | Psychiatric problems | Seizures |

14. Please tell us about your child's school or day care.

| | |
|---|---|
| Name and city where located. | |
| Grade or program child is in. | |
| Receiving any special services? What type? | |
| Results of any special testing done. | |

*Please attach a recent photograph of your child, if one is available.*

Parent/Legal Guardian Signature: _____ Date: _____

How are you related: _____

MD/ARNP Signature: _____ Date: _____

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From the west (Mobile):

1. Take I-10 east toward Pensacola.
2. From I-10 take Exit 12 (which merges onto I-110 south) toward Pensacola/Pensacola Beach.
3. Go approximately 7 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Walmart Neighborhood Market shopping center. Continue across the parking lot to the Regions Bank.
7. Child Neurology Center is INSIDE the Regions Bank building. Enter the door by Starbucks.
8. Take the elevator to the 3rd floor, Suite 300.

From the East (Milton, Crestview, Defuniak Springs)

1. Take I-10 west until you reach Pensacola.
2. From I-10 take Exit 12 (which merges onto I-110 south) toward Pensacola/Pensacola Beach.
3. Go approximately 5.5 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Walmart Neighborhood Market shopping center. Continue across the parking lot to the Regions Bank.
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From the South (Gulf Breeze, Fort Walton Beach, Destin)

1. Take US Highway 98 West to Gulf Breeze.
2. Continue through Gulf Breeze. You will pass Gulf Breeze Elementary, Middle, and High Schools on your left. The football stadium is on your right.
3. Go 1 block past the football stadium. Turn right into the Starbucks entrance, then into the Regions Bank parking lot. (WalMart Neighborhood Market is in the same complex).
4. **Do NOT cross the 3-Mile Bridge into Pensacola!**
5. Child Neurology Center is INSIDE the Regions Bank building. Enter the door by Starbucks.
6. Take the elevator to the 3rd floor, Suite 300.

From the North (Cantonment, Century)

1. Take US Highway 29 toward Pensacola.
2. Merge onto I-10 east via the ramp to Tallahassee.
3. Go approximately 7 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Walmart Neighborhood Market shopping center. Continue across the parking lot to the Regions Bank.
7. Child Neurology Center is INSIDE the Regions Bank building. Enter the door by Starbucks.
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# HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Parkway; Suite 300, Gulf Breeze, FL 32561
850-932-5055

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information 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:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

Genei Bougher/Suzanne Barker 850-932-5055; suzanne.barker@cneurology.com

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

# HIPAA Notice of Privacy Practices

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400 Gulf Breeze Pkwy, Suite 300
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850-932-5055
850-932-1404 fax

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Your signature below is only acknowledgement that you have received this notice of our privacy practices.

Patient Name _____ Patient's Date of Birth _____

Parent/Guardian Name _____ Parent/Guardian Signature _____

Date Signed _____

# STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Pkwy, Suite 300
Gulf Breeze, FL 32561
Phone 850-932-5055 Fax 850-932-1404

Information to be Used or Disclosed
The information covered by this authorization includes:

1) Neurology Office Notes
2) EEG Reports
3) Neuroimaging Reports (i.e. MRI, CT Scan)
4) Laboratory Results
5) Other: _____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Child Neurology Center of Northwest Florida

Persons to Whom Information may be Disclosed
Information described above may be disclosed to:

1) _____ Name of person or organization

2) _____ Name of person or organization

3) _____ Name of person or organization

4) _____ Name of person or organization

Expiration Date of Authorization
This authorization is effective while under the care of Child Neurology Center unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Child Neurology Center of Northwest Florida. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ Name of patient (print) Date of Birth

_____ Signature of patient Date signed

_____ Signature of patient representative Relationship to Patient Date signed