Account Number: _____

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Preferred Spoken Language: ☐ English ☐ Spanish ☐ Other _____

Preferred Method of Communication: ☐ Spoken ☐ Written

*How would you best describe this child's **Ethnic** origin?*

NOTE: Answer Ethnicity about Hispanic origin and not Race. For this question, Hispanic origins are not races.

☐ Not of Hispanic, Latino, or Spanish origin
☐ Mexican or Mexican American
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino, or Spanish origin – Print Origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.

*How would you best describe this child's **Race**?* Mark all that apply.

☐ White, Caucasian
☐ Black, African American
☐ Asian Indian
☐ American Indian or Alaska Native
☐ Chinese
☐ Native Hawaiian
☐ Filipino
☐ Other Asian – Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.
☐ Samoan
☐ Japanese
☐ Korean
☐ Other Pacific Islander - Fijian, Tongan, and so on.
☐ Vietnamese
☐ Pakistani, Cambodian
☐ Guamanian or Chamorro
☐ I wish not to provide this information
☐ Some other race_____

_____ _____
Signature Date

_____ _____
Completed by: Relationship to patient

Comprehensive Childcare Associates

Patient Questionnaire

Patient Name _____ **Account #** _____

1 Any on-going health concerns?

_____

_____

2 Any past medical problems?

_____

_____

3 Any hospitalization or surgeries?

_____

_____

4 Does your child see other physician's or mental health care workers?

_____

5 Any allergies?

_____

6 Who is living with you and your child?

_____

7 Any OTC or prescription medicines?

_____

8 Any vaccines due?

_____

9 What questions do you have for the doctor today?

_____

_____

_____

Notes:

_____

_____

_____

Form completed by: _____

Information entered into patients EMR/dashboard: **Date:** _____

Document scanned and placed in folder: **Date:** _____

Rev 6/16

PINK

Account Number: _____

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

FAMILY MEDICAL HISTORY

Disease			If yes, please indicate which relative
Allergies	NO ☐	YES ☐	_____
Asthma	NO ☐	YES ☐	_____
Autoimmune disorder	NO ☐	YES ☐	Type: _____
Blood disorder	NO ☐	YES ☐	_____
Brain disorder	NO ☐	YES ☐	_____
Cancer	NO ☐	YES ☐	Type: _____
Cystic fibrosis	NO ☐	YES ☐	_____
Deafness	NO ☐	YES ☐	Age of onset: _____
Diabetes	NO ☐	YES ☐	Type 1 ☐ Type 2 ☐
Gastrointestinal disorder	NO ☐	YES ☐	Type: _____
Genetic disorder	NO ☐	YES ☐	Type: _____
Headaches or Migraines	NO ☐	YES ☐	_____
Heart disease	NO ☐	YES ☐	Death before age 50 YES ☐ NO ☐
High blood pressure	NO ☐	YES ☐	_____
High cholesterol	NO ☐	YES ☐	_____
Immunologic disorder	NO ☐	YES ☐	Type: _____
Intellectual or learning disability	NO ☐	YES ☐	_____
Kidney disease	NO ☐	YES ☐	Type: _____
Mental illness/ Substance abuse	NO ☐	YES ☐	Specify: _____
Seizures	NO ☐	YES ☐	_____
Sickle cell disease	NO ☐	YES ☐	_____
Tuberculosis	NO ☐	YES ☐	_____

Completed by: _____ Relationship **to patient:** _____

Signature: _____ **Date:** ____/____/____

Account Number _____

Patient Name: _____ _____ **DOB:** ____/____/____
(First name) (Last name)

Gender: ☐ Male ☐ Female

BIRTH HISTORY

Birth Weight _____ **(pounds) Length:** _____**(inches) Place of Birth:** _____

☐ **Preterm (** _____**weeks) (OR)** ☐ **Full Term** ☐ **Vaginal (OR)** ☐ **C-Section**

PAST MEDICAL HISTORY

Has the child ever had any problem with the following? If yes, please explain.

Disease			If yes, please explain
ADHD	☐ NO	☐ YES	_____
Asthma	☐ NO	☐ YES	_____
Allergies (food/environmental)	☐ NO	☐ YES	_____
Allergies to medications	☐ NO	☐ YES	
Anemia/Blood Disorders	☐ NO	☐ YES	_____
Bones/Joints	☐ NO	☐ YES	_____
Diabetes	☐ NO	☐ YES	_____
Ears (multiple infections)/Hearing	☐ NO	☐ YES	_____
Eyes/Vision	☐ NO	☐ YES	_____
Constipation	☐ NO	☐ YES	_____
Diarrhea	☐ NO	☐ YES	_____
Reflux	☐ NO	☐ YES	_____
Gastrointestinal disorder	☐ NO	☐ YES	_____
Heart	☐ NO	☐ YES	_____
Repeated Infections	☐ NO	☐ YES	_____
Headaches	☐ NO	☐ YES	_____
Seizures	☐ NO	☐ YES	_____
Mental health/ Substance abuse	☐ NO	☐ YES	_____
Skin (eczema)	☐ NO	☐ YES	_____
Urine/Kidneys	☐ NO	☐ YES	_____
Tuberculosis	☐ NO	☐ YES	_____
Other			_____

Are the child's immunizations up to date: ☐ Yes ☐ No

Does your child use any tobacco products: ☐ Yes ☐ No

Does your child have any medication, food, or environmental allergies: ☐ Yes ☐ No
If yes, please list:

Allergy: Reaction:

_____ _____

_____ _____

Please list medications your child is currently taking and reason for taking. Please include over-the-counter medications:

Medication Name:	Dose:	Reason:
_____	_____	_____
_____	_____	_____

Please list any hospitalizations, operations, serious illness or injuries:

_____ **Date:** ____/____/____

_____ **Date:** ____/____/____

Please list any developmental problems /delays and when they occurred:

_____ **Date:** ____/____/____

_____ **Date:** ____/____/____

Please list other health care providers involved in patient's care:

_____ **Phone:** _____

_____ **Phone:** _____

_____ **Phone:** _____

SOCIAL HISTORY

Lives with: _____

If 2 households, Custody status: _____

Attends school/daycare at: _____ Grade: _____

Exposure to:

Smoking ☐ Yes ☐ No

Lead Paint ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Drugs ☐ Yes ☐ No

Pets ☐ Yes ☐ No

Other: _____

Has your family experienced any recent deaths within the family? ☐ Yes ☐ No

If yes, relationship to child, date, and cause of death:

_____

_____ _____

Signature Date

_____ _____

Completed by: Relationship to patient

Account #_____

Original HIPAA date: ____/____/____

Mother's Information:

Name: _____

DOB: ____/____/____ **Social Security #:** ____/____/____

Mailing Address: _____

_____

Email Address: _____

Employer & Occupation: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Father's Information:

Name: _____

DOB: ____/____/____ **Social Security #:** ____/____/____

Mailing Address: _____

_____

Email Address: _____

Employer & Occupation: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Children:

Name:_____ **DOB:** ____/____/____ **Gender: M ☐ F ☐**

Insurance: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F ☐**

Insurance: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F☐**

Insurance: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F☐**

Which physician would you prefer to see? ☐ Featherman ☐ Carroll ☐ Minella ☐ Murphy ☐ Fernandez ☐ Patterson

Signature: _____

Relationship to patient: _____ **Date:** ____/____/____

Disclosure to Others

I give my permission for the person(s) listed below to obtain and discuss with Comprehensive Childcare Associates, and/or members of the medical staff, my child's medical information. This may include, but not be limited to, making appointments, discussing appointments, bringing my child(children) to appointments, and obtaining lab, pathology, and radiology results.

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Printed name: _____

Relationship to patient: _____

Signature: _____ **Date:** ____/____/____

Comprehensive Childcare Associates is proud to be recognized by the NCQA as a Patient-Centered Medical Home. Only about 10% of primary care practices in the U.S. have achieved this recognition.

The Patient-Centered Medical Home model:

- ✓ **Comprehensive care** by a team of professionals working together
- ✓ **Patient-centered**, respecting the importance of patient and family needs and preferences
- ✓ **Coordinated care** to assist with referrals and help ensure needs are met in a timely manner
- ✓ **Accessible**, with extended office hours and availability both via the telephone and secure electronic messaging
- ✓ **Quality and safety,** with our clinicians working hard to stay current on the most recent evidence-based guidelines

We request that you:

- ✓ Bring your insurance card to every visit
- ✓ Bring a list of the medications your child is taking (prescription, over-the-counter, and herbals)
- ✓ Let us know about any recent visits to emergency departments or other health care providers

_____
(please initial acknowledgement)

Notice of Privacy Practices and Financial Policy available upon request

Comprehensive Childcare Associates
FINANCIAL POLICY

Thank you for Choosing Comprehensive Childcare Associates for your family's pediatric care. The following is a statement of our financial policies. All patients must accept our FINANCIAL POLICY before receiving treatment.

Financial Policies are not created or enforced to create tension or ill will between patients, families and Comprehensive Childcare Associates physicians or staff. Treating your child's health is very important to us. Unfortunately there will be times when unpleasant situations will arise and the parents/guarantors will be asked to contact their insurance companies or pay an outstanding balance. Comprehensive Childcare Associates staff will make every effort to assist parents/guarantors through these times.

METHOD OF PAYMENT: We accept cash, check, Visa, MasterCard, Discover, American Express and Health Savings Plan credit cards. Payment plans may be available on an individual basis.

INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company for payment. Any balance after the processing of your claim by your carrier is your responsibility. Your policy is a contract between you and your insurance company. In order to correctly submit your claim and receive payment from your insurance company we will need your most current and up to date insurance card and information. Parents must be responsible for understanding their insurance plan and benefits, especially when pertaining to which providers, radiology groups and labs are within your policy's network. Your particular plan may not cover all of the services provided for your child. Therefore, any services or amounts not covered by your insurance company could become the responsibility of the guarantor even if the insurance company states that the services were bundled or experimental.

INSURANCE CARDS ARE REQUIRED AT EVERY VISIT

Your child can still be seen without an insurance card, as long as we have a valid copy on file and the coverage can be verified. However, the appointment will be treated as Self-Pay and the claim/charges will not be submitted to your insurance carrier until the insurance card has been presented. Please note: Submitting claims/charges to your insurance carrier is time sensitive.

CO-PAYMENT: All co-payments are due prior to treatment and at the time, you check in. Should your insurance card not indicate a specific co-payment amount on the card, a minimum of $25.00 maybe collected at the time of check-in.

REFERRALS/AUTHORIZATIONS: If your insurance requires a referral or authorization, we will do all we can to help you. However, it is the parent's responsibility to obtain a referral or authorization for your appointment with a specialist. Referrals or authorizations may take up to 72 hours to obtain and your patience is appreciated.

DEDUCTIBLE: A deductible is an annual dollar amount established by your insurance plan. This amount is your obligation and may be collected prior to your visit with the physician. All efforts will be made to verify your deductible amount due at check-in for your current visit. If an actual amount cannot be verified by your insurance company, 70% of the estimated office visit will be collected at check-in.

COINSURANCE: An insurance policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula. This amount is your obligation and may be collected prior to your visit with the physician.

RETURNED CHECKS: A service fee will be added to your account for a check payment returned to the office for any reason. Some examples are: Non-Sufficient Funds (NSF), Return to Maker, Account Frozen or Closed and Stop Payment.

CHANGE OF ADDRESS/DEMOGRAPHICS/RETURNED MAIL: Every effort will be made to communicate to you through the information provided to Comprehensive Childcare Associates. Account statements or mail returned to Comprehensive Childcare Associates by the US Postal Service may incur a Bad Address Fee to cover postage and administrative costs.

NO SHOW POLICY – CANCEL LESS THAN 24 HOUR NOTICE: Unfortunately, appointments resulting in a no show or cancellation without giving a 24-hour notice maybe subject to fees. Excessive missed appointments may result in dismissal from the practice.

PAYMENT POLICY: Statements will be mailed monthly and balances are due upon receipt. Payment of any outstanding balance is due at the time of check-in. Outstanding balances that are 30 days or older may incur a late fee. Accounts with balances over 90 days may be turned over to our collection agency. Any fees, costs or balance percentage add on assessed by the collection agency may be added to the outstanding balance. An account turned over to the collection agency that is not paid maybe reported to the credit bureaus. Please note that Comprehensive Childcare Associates cannot control the delivery of your statement or correspondence through the US Postal Service.

APPOINTMENT COURTESY CALLS: Please understand that we will try to call you with a reminder of your appointment if time permits to the telephone number you have provided. This is not always possible and is done as a courtesy only. Your appointment time is your time and no one else's with the Physician. Should you not be able to keep your appointment, a 24-hour cancellation notice is required. Appointments resulting in a no show or cancellation without given 24-hour notice maybe subject to fees. Families who continually cancel or miss appointments may be dismissed from the practice.

PHONE CALL CHARGES: Telephone calls between parents/guardians and a physician during or after business hours to discuss symptoms or treatment may result in a consultation fee. Any amount not covered by insurance will become the responsibility of the parent or guardian. The amount charged depends on the complexity of the treatment or advice and the time involved.

MISCELLANEOUS CHARGES: Fees are assessed to services requested by parents or guardians and payment is due prior to the completion of the request. Examples, but not limited to, copies of medical records, additional copies of vaccine or physical forms, itemized statements, copy of super bills, researching account activity, etcetera.

PLEASE BE NICE! We understand that everyone has a bad day every once in a while. However, it is not appropriate to yell, or use bad language when addressing anyone of our staff. Please do not make us ask you to leave our practice for bad behavior.

I UNDERSTAND AND ACCEPT THE TERMS OF THIS FINANCIAL POLICY

X _____ DATE _____/_____/_____
SIGNATURE OF GUARANTOR

Terms and Conditions Subject to Change – Updated Policies Available Upon Request

ccapeds.com

****The attached documents are also located on our website****

Please make sure that you have completed the attached documents and have signed each page.

Thank you,

The Staff at Comprehensive Childcare Associates

Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.
- At Comprehensive Childcare Associates, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. Or, information may be disclosed to public state health agencies as required by law for certain communicable diseases.
- We may release to state authorities all reasonable suspicion of sexual or physical abuse, neglect or domestic violence to the proper authorities. We may disclose personal health information about your child to governmental authorities including social services or protective services agencies authorized by law to receive reports of such abuse, neglect, or domestic violence.
- We may disclose personal health information to state recognized health oversight agency with the responsibility for ensuring compliance with the rules of governmental health programs such as Medicaid or the CMS Watch program.
- We may disclose personal health information to a coroner or medical examiner as authorized by law.
- We may disclose personal health information to prevent or lessen a serious and imminent threat to a person's or public's health or safety.
- We may use statistical information for services your child may have received to support budgeting, financial reporting and activities to evaluate and promote quality of care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.
- You should take note that under Florida State law certain portions of your child's records when they are 18-years of age will not be available to you without their written permission.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.
- You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

- You have the right to see and receive a copy of your health information. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.
- You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a report to whom we disclose information.
- If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.
- Please contact our Security Officer, Dede Perry, at (941) 955-5191 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of Comprehensive Childcare Associates Notice of Privacy Practices.

Printed name: _____

Relationship to patient: _____

Signature: _____ **Date:** ____/____/____

If signing as a parent or guardian, please list your child(ren) below:

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F ☐**

Last 4 digits Social Security #: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F☐**

Last 4 digits Social Security #: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F☐**

Last 4 digits Social Security #: _____

Name: _____ **DOB:** ____/____/____ **Gender: M ☐ F☐**

Last 4 digits Social Security #: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Comprehensive Childcare Associates – 2020 Cattlemen Road Suite 600 – Sarasota, Florida 34232
Office (941)955-5191 – Fax (941)366-7582 – www.ccapeds.com

Please provide thorough and accurate information when filing out this form. Comprehensive Childcare Associates will only process valid and complete Authorization forms.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Social Security Number: _____ Daytime Phone Number: _____

RELEASE INFORMATION *FROM*:

☐ Comprehensive Childcare Associates

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone (required) _____

Fax _____

RELEASE INFORMATION *TO*:

☐ Comprehensive Childcare Associates

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone (required) _____

Fax _____

TYPE OF INFORMATION TO BE RELEASED (I may be charged a fee for the cost of copying and postage)

☐ **All Health Information**

☐ Health Information related to the following treatment(s) or conditions _____

☐ Laboratory/Diagnostic Tests _____

☐ Other _____

The release of sensitive health information requires specific patient consent. If you would like to release this type of information, please initial the following item(s):

_____ *Drug*/Alcohol Abuse _____ Sexually Transmitted Diseases (including AIDS and HIV)

_____ Mental Health (including pain management or psychiatry records)

Purpose or Need for this Information: ☐*Transfer of Care* ☐*Copies for Own Use* ☐ *Other* _____

* I permit the information to be released for the specific purpose stated above. Any other use of this information without my written consent is prohibited.
* I recognize that health information pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
* I realize that I have a right to a copy of this Authorization.
* I am aware that the Authorization will expire in 90 days unless otherwise specified: _____ (date/event).
* I understand that I may revoke or modify this Authorization at any time in writing, except to the extent that action has already been taken to comply with it.
* I voluntarily sign the Authorization and understand that my health care will not be affected if I do not sign it.

By signing this document, I acknowledge that I have read and agreed to the Authorization's terms.

_____ _____ _____

Date ***Signature of Patient or Legally Responsible Party*** ***Authority to sign, if not Patient***

Comprehensive Childcare Associates
Board Certified Pediatricians
2020 Cattlemen Road, Suite 600
Sarasota, Florida 34232
Phone: (941) 955-5191, Fax: (941) 366-7582
www.ccapeds.com

Medical Records Copying and Shipping Policy

In accordance with Rule 64B8-10.003, Florida Administrative Code all Pediatric Health Care Alliance Offices assess charges for reproducing patient medical records, as follows:

- *$1.00 per page for paper records for the first 25 pages*
- *$0.25 per page for paper records thereafter*

In addition, actual cost to retrieve medical chart from offsite storage, actual cost of postage to mail medical records and actual cost of reproducing x-rays, overhead and labor costs to reproduce the medical records being requested.

Records will not be released until charges are paid in full

Name of Person/Organization Requesting Information: _____

Daytime phone number: _____

Medical Information Requested for: _____

Release Medical Information to: _____

_____
Signature of Patient or Legally Responsible Party ***Date***

Item	*Quantity*	*Each*	*Amount Due*
Paper Copies (1st 25 pages)		*$1.00*	*$*
Paper Copies (over 25 pages)		*$0.25*	*$*
Retrieve From Storage		*$28.00*	*$*
Postage		*Actual Cost*	*$*
Total Amount Due			*$*

Florida Administrative Code
Rule: 64B8-10.003

Cost of Reproducing Medical Records

(1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.

(2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following:

a. For the first 25 pages, the cost shall be $1.00 per page

b. For each page in excess of 25 pages, the cost shall be .25 cents

(3) Reasonable costs of reproducing x-rays and such other special kind of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record as well as the labor costs and overhead costs associated with such duplication, in addition to the actual cost of retrieving the medical records from offsite storage.

(4) Specific Authority 458.309 FS. Law Implemented 456.061, 456.058, 458.331 (1) FS. History – New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003.

HIPPA Authorization
45 CFR 164.508