Orange Park Pediatrics

Baptist Primary Care

Charles T. Dellinger, M.D., F.A.A.P. Dan R. Spearman, M.D., F.A.A.P.
Richard G. Gehret, M.D., F.A.A.P. Rhonda L. Woolwine, M.D. F.A.A.P.
Shiree Sauer, M.D., F.A.A.P. Mark Bedard, D.O., F.A.A.P.
Tracy Tyson, M.D., F.A.A.P.

Marianne M. Davenport, ARNP, MPH Mekal Faciane, P.A.-C

2140 Smith Street
Orange Park, FL 32073
(904) 269-2140
FAX (904) 264-3018

6353 Argyle Forest Blvd, Ste. #4
Jacksonville, FL 32244
(904) 908-0200
FAX (904) 908-3915

1747 Baptist Clay Drive, Ste. #110
Fleming Island, FL 32003
(904) 520-6620
FAX (904) 215-2981

EMAIL ADDRESS FOR PRACTICE: OPPA@bmcjax.com

Below is a list of items that should be brought to your visit to the office.

- Drivers License
- Insurance Card
- Previous Records including Immunization Record
- Discharge Paperwork if the patient is a newborn or was seen in the ER or Urgent Care Center
- If the patient is being seen for a Behavioral Conference:
  - Behavioral Conference Forms (Available at OrangeParkPediatrics.com)
  - Any previous evaluations

Please plan to arrive at least 15 minutes early to allow us time to process your paperwork.

Orange Park Pediatrics

Baptist Primary Care

Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Drug / Medication Allergies: _____

Current Medications: _____

Past Medical History: *(Please describe any major medical problems and their dates)*

_____

_____

_____

Hospitalizations / Operations (with dates): _____

_____

Family History:

ADD/ADHD	NO	YES	PATIENT	FAMILY
Arthritis	NO	YES	PATIENT	FAMILY
Asperger's Syndrome	NO	YES	PATIENT	FAMILY
Asthma	NO	YES	PATIENT	FAMILY
Autism	NO	YES	PATIENT	FAMILY
Bleeding Disorder	NO	YES	PATIENT	FAMILY
Cancer_____	NO	YES	PATIENT	FAMILY
Developmental Delay	NO	YES	PATIENT	FAMILY
Diabetes Type I / II	NO	YES	PATIENT	FAMILY
Hepatitis B / C	NO	YES	PATIENT	FAMILY
Thyroid Disorder	NO	YES	PATIENT	FAMILY
Mental Illness / Depression	NO	YES	PATIENT	FAMILY
Migraine	NO	YES	PATIENT	FAMILY
Seizure Disorder	NO	YES	PATIENT	FAMILY
Skin Problems	NO	YES	PATIENT	FAMILY
Hypertension	NO	YES	PATIENT	FAMILY
Heart Disease	NO	YES	PATIENT	FAMILY
Genetic Disease_____	NO	YES	PATIENT	FAMILY
Kidney Disease	NO	YES	PATIENT	FAMILY
High Cholesterol	NO	YES	PATIENT	FAMILY
Tuberculosis	NO	YES	PATIENT	FAMILY
Anemia	NO	YES	PATIENT	FAMILY
Auto Immune Disorder	NO	YES	PATIENT	FAMILY
Other_____	NO	YES	PATIENT	FAMILY

Social History:

Birthplace: _____ Birth Weight: _____ Vaginal / C-Section

Members of Immediate Family:

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Is the child SENSITIVE / INTOLERANT / ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Say Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries

Other: _____

Please list any other allergies your child has been diagnosed with or that you suspect:

_____

Does anyone in the home smoke? No Yes Type: Cigarettes Cigars Pipes Other _____

Number/day: _____

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Orange Park Pediatrics

Baptist Primary Care

PARENTAL AUTHORIZATION FOR MEDICAL CARE

For families who are ongoing patients of ORANGE PARK PEDIATRICS it may be more convenient to have prior authorization
for medical care delivered to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you wish to authorize treatment in advance.

I/we request and authorize Orange Park Pediatrics and its personnel to deliver medical care to my/our child/children listed below:

PLEASE PRINT CHILD/CHILDREN'S NAME

NAME _____ DOB _____

NAME _____ DOB _____

NAME _____ DOB _____

I/we authorize the following people to bring in my child/children for treatment:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

Please try to contact me/us regarding the health care of my/our child/children at the following phone numbers:

PARENTS NAME _____

PHONE _____

PARENTS NAME _____

PHONE _____

OTHER NAME _____ RELATIONSHIP _____

PHONE _____

SIGNATURE _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/ guardianship with non-parent, etc.), please explain in space below.

_____

_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____ Written Communication

☐ O.K. to leave message with detailed information
☐ Leave message with callback number only

☐ O.K. to mail to home address
☐ O.K. to mail to work/office address
☐ O.K. to fax to this number

_____

Work Telephone _____

☐ O.K. to leave message with detailed information
☐ Leave message with callback number only

☐ Other _____

Patient Name: _____ Birthdate _____

Parent Signature _____ Date _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI, to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

FOR OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax #	Description & Purpose of Disclosure	By Whom Disclosed

Orange Park Pediatrics

Baptist Primary Care

MEDICAL RECORDS RELEASE TO ORANGE PARK PEDIATRICS

Records to be sent to the following address:

NAME: **Orange Park Pediatrics, Baptist Primary Care**
(Please check below the correct address for your selected location.)

	Address				Phone	FAX
O	2140 Smith Street	Orange Park	FL	32073	904/269-2140	904/264-3018
O	6353 Argyle Forest Blvd., #4	Jacksonville	FL	32244	904/908-0200	904/908-3915
O	1747 Baptist Clay Dr., #110	Fleming Island	FL	32003	904/520-6620	904/215-2981

****PLEASE MAIL ALL RECORDS TO ABOVE CHECKED ADDRESS AND FAX IMMUNIZATION TO ASSOCIATED FAX NUMBER.**

Reason for Release of Records: _____

Records to be received from:

Physician/facility: _____

Address: _____

Phone: _____ **Fax:**_____

Release from my medical records the following information for the following dates:

From: _____ **To:** _____

As part of the medical record, the following information will be released unless stricken:

SEXUAL ABUSE INFORMATION, DRUG & ALCOHOL ABUSE INFORMATION, CHILD ABUSE & NEGLECT INFORMATION, PSYCHIATRIC INFORMATION, AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by Federal law. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: _____ Date:_____

Patient Name: _____ DOB: _____ SS#:_____

Witness: _____ Date: _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.

BAPTIST Primary Care

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____

Patient Information

Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email _____

Date of Birth _____ Sex _____ Marital Status _____

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native
❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not-Hispanic or Latino ❑ Unknown ❑ Declined

Primary Language _____

Social Security Number _____

(If a minor): Mother's Name _____ Home Phone # _____

Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____

Relationship to Patient _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Referred by _____

BAPTIST Primary Care

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance Information

- If you are covered by Medicare,Tricare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, Mastercard and Discover.**
- All self-pay patients are expected to pay for services in full at the time that services are rendered.
- We will file with all insurance plans for our professional fees for any hospital admissions.
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Completion of Forms

Baptist Health reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Treatment and Payment

I consent to examination,diagnosis and general medical care and treatment to be performed by office personnel, including physicians, nurses and assistants.

I hereby authorize Baptist Health to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

_____ _____

Responsible Party Signature | Date

_____ _____

Patient's Name (Please Print)) | Date of Birth

Notice of Privacy Practices

I acknowledge receipt of a copy of the Baptist Health Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at Baptist Health, I authorize Baptist Health to use and disclose information from and release copies of my (the patient's) medical records in accordance with Baptist Health's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

_____ _____

Patient or Parent (Guardian) | Date