New Patient Information Sheet

Village Pediatrics, LLC

Today's Date: ________________ Gender: ____________________

Patient Information: ____ Date of Birth: ______________________________

Last First Middle

SS# ______________________________

Address: ____ Primary Phone: (____) ___________________

Street; Apt#

____

City State Zip

Parent(s)/Guardian(s) Information:

(1) ____ Relationship to Patient: ______________________

Last First Middle SS#_______________________________________

Email Address: ____

Address: ____ Cell Phone: (____) _________________

Occupation: ____Work Phone: (____) _________________

Work Address: ____

(2) ____ Relationship to Patient: ______________________

Last First Middle SS#_______________________________________

Email Address: ____

Address: ____ Cell Phone: (____) _________________

Occupation: ____Work Phone: (____) _________________

Work Address: ____

In case of Emergency, please provide a name of a friend or relative:

____ Phone: (____) _____________ Relationship to Patient: _______________

Last First

Health Information:

Primary Insurance

Company Name: _________________________

ID# _________________________

Group: _________________________

Address: _________________________

Subscriber's Name: ______________________

Subscriber's DOB: ______________________

Subscriber's SS# ________________________

Copay: _________________________

Secondary Insurance

Company Name: _________________________

ID# _________________________

Group: _________________________

Address: _________________________

Subscriber's Name: _______________________

Subscriber's DOB: ________________________

Subscriber's SS# _________________________

Copay: __________________________

Office Policy

I authorize Village Pediatrics, LLC to treat my child. I understand that payment is expected in full at time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, a non-covered service(s), co-pay, and/or deductibles will be collected at time of visit. Arrangements for anything other than full payments at time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services in full. I understand that I am financially responsible for any balance not covered by my insurance carrier, I have read and understand the office policy for payment and agree to the terms stated.

Parent/Guardian Signature: ____ Date: _____________________________________

Village Pediatrics, LLC: *New Patient Questionnaire*

Date: ________________

Patients Name: ____________________________________ ***DOB:*** ________________

Newborn/Neonatal History: (Please Check/fill in appropriate information)

Adopted: (Yes__/No__)
Any known history: (Yes__/No__) If so please fill in the following.

Pregnancy:

Normal (Yes__/No__) Number of week gestation__________________________
Complications: Premature Labor ___ Preeclampsia ___ Infection ___ Other __________________________
Alcohol (Yes__/No__) Smoking (Yes__/No__) Substance use (Yes__/No__) ________________________
Medications/Vitamins ____

Birth History:

Home Birth (____) Birthing Center (____) Hospital (____)
Name of facility and Doctor/Midwife/Practitioner: ____
Delivery Type: Normal Vaginal (____) Forceps (____) Suction (____) VBAC (____)
C-Section Routine/Scheduled (____) Emergency (____) Please Explain: ____________________
Birth Weight: _________ Discharge Weight: _________
Hepatitis B Vaccine given at birth (Yes__/No__) Vitamin K (Yes__/No__) Eye Ointment (Yes__/No__)
Blood Type: Mother _____ Baby _____ Coombs: Positive _____ Negative _____
Newborn Nursery (____) Neonatal Unit (____) Length of stay ____
Breastfed (____) Formula: which kind ____
Feeding Problems ____
Jaundice/Hyperbilirubinemia (____) Phototherapy # day's ____
Respiratory: TNN (____) Pneumonia (____) Ventilator (____) CPAP (____) O2 (____)
Infection: Group B Strep (____) R/O Sepsis (____) Antibiotics (____) # of day's ______________________
Anemia (____) Transfusions (____) Newborn Screening Performed (Yes__/No__)
Circumcision (Yes__/No__) Planning but not performed yet (____) Hearing Screening (Pass__/Fail __)
Other Important information: ____

Has your child had any of the following? (Please Check/fill in appropriate information)

ENT: Ear Infections (____) Hearing Loss (Left____) (Right____) Other ear issues ______________________
Throat Infections (____) Strep (____) other throat issues____
Nose bleeds (____) Allergic Rhinitis (____) Chronic Sinus Infections (____) Sleep Apnea (____)
Other Nose Issues ____
Cardiac: Heart Defect (____) Type ______________ Heart Murmur (____) Type ______________________
Arrhythmia (____) Other Heart/Cardiac Issues ____
Respiratory: RSV (____) Bronchitis/Bronchiolitis (____) Asthma (____) Cystic Fibrosis (____) Pneumothorax (____) Pneumonia (____)
Type ______________ Required Hospital Stay(Yes__/No__)
Other Respiratory Issues ____
Gastrointestinal: GERD (____) Constipation (____) Chronic Diarrhea (____) Other ____________________
Genitourinary: Hernia (____) Hydrocele (____) Bedwetting (____) UTI (____)
VCUG/Ultrasound/Renal Scan (Yes__/No__) Results/Procedures ______________________________
Dermatological: Skin Infections (____) Eczema (____) Acne (____) Other______________________________
Allergies: Medication (____) Environmental (____) Food (____) Specify________________________________
Endocrine: Diabetes: (____) Type I (____) Type II (____) Age of Diagnosis ______________________________
Hypothyroidism (____) Hyperthyroidism (____) Other____
Hematology/Oncology: Anemia (____), Bleeding Disorders (____) Type ___________________________ Cancer (____)
Type__________________________ Other ______________________________________
Neurology/Psychology/Developmental: Seizures (____) Type ________________ Low Tone (____)
Hyper Tone(____)OCD(____) Cerebral palsy (____) Autism(____) Asperger Syndrome(____) ADD/ADHD (____) Bipolar
Disorder(____)Anxiety (____) Delayed(____) Speech/Language (____) Behavioral Issues (____)
Other ____
Genetic Disorders: Specify ____

(Over)

Surgery: (List dates/hospital/type)

____

____

Hospitalizations: (List dates/hospital/reason)

____

____

Injuries/Fractures: (Date/Treatment)

____

____

Medications/Supplements:
Past____
Present ____

Immunizations: Up to Date (Yes__/No__) Delayed (Yes__/No__) Religious Exempt (Yes__/No__)

Education: Grade _____ School _________________________ Performance _______________________________
Additional Assistance _____________________________ Sports/Activities ________________________________

Pets: (Yes__/No__) Type ____

Does anyone in the Family smoke? (Yes__/No__) Who? ____
Inside or Outside? ____

Social: Parents: Married (____) Together (____) Separate (____) Divorced (____) Blended family (____)
Child (children) live with ____

Family History:
List significant history and whether or not relative is on maternal (M) or paternal (P) side.
Mother adopted (____) Father adopted (____)

Heart Attack (____) (____) Stroke (____)(____) High Blood Pressure (____) (____) High Cholesterol (____) (____) Aneurysm (____)(____) Blood Disorders (____)(____) Diabetes (____)(____) Type: Juvenile/ Adult
Obesity (____) (____) Alcoholism (____) (____) Other substance abuse (____) (____)
Mental Illness: specify (____) (____) Other problems: ____

List immediate family members, age and whether or not they have health issues:

____

____

____

Any other information you would like to share?

____

____

I have had the opportunity to review the Notice of Privacy and have no other questions.

Signature ____ Date ______________________________

Witness ____ Date ______________________________

Village Pediatrics of St Augustine, LLC

WGV 319 West Town Place, Suite 1, St. Augustine, FL 32092
Main Tel: (904) 940-1577 Fax: (904) 940-1916

PALENCIA 290 Paseo Reyes Dr., St. Augustine, FL 32095
Tel: (904) 217-8461 Fax: (904) 814-8693

Patricia Elvir, MD, FAAP, ABIHM
Naela Osman MD, FAAP
Hillary Hooser, MSN, ARNP
Trudy English,MSN ARNP

Welcome to Village Pediatrics!

Thank you for choosing Village Pediatrics as your child's primary care provider. We are committed to partnering with you and delivering the highest quality of pediatric care. We desire to provide you and your family with information and choices which will enhance your lifestyle and promote both physical and spiritual well being. Please take a moment to carefully review our office and financial policies.

OFFICE HOURS:

WGV: Monday & Tuesday 9am to 6pm (last appt at 5:30 pm) Closed 1-2 for lunch
Wednesday and Thursday 9am to 5pm, Closed 1-2 for lunch
Friday 9am to 4pm Closed 1-1:30 for lunch
Palencia: Tuesday, Wednesday, and Thursday 9am to 5pm, Closed 1-2 for lunch
We close on Federal Holidays.

PROVIDERS and MEDICAL STAFF:

Drs. Elvir and Osman are board certified with the American Board of Pediatrics and are Fellows with the American Academy of Pediatrics. Dr. Elvir is also board certified with the American Board of Integrative and Holistic Medicine. Nurse Practitioners Hillary Hooser and Trudy English are both certified with the Pediatric Nursing Certification Board.

Our medical staff (Medical assistants/RN's) are able to offer advice and answer most common questions during regular office hours. However, if you have many questions or complex concerns, you will be asked to make an appointment.

HOSPITAL:

In the event of an emergency please call 911. If you are able to transport your child we recommend you take your child to the emergency department at Wolfson's children's hospital (WCH) where board certified pediatricians are on staff to attend to your child. ED locations are downtown Jax and at the Town Center off I-295. Should your child need to be hospitalized, they will be cared for by hospitalists (pediatricians who specialize in inpatient care). Newborns will be attended by neonatologists (pediatricians who specialize in newborn care) at the hospital where you deliver and will attend to your newborn until discharge. Typically we see newborns after 48 hours of discharge. (For home births, it is essential to see baby in the first 48 hours)

Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal.

Please read each section carefully and initial. Each section needs to be signed and cannot be altered in any way. If you have any questions, do not hesitate to ask a member of our staff.

Active status:

1) To remain an active patient in our practice and in order for your child to receive the best care, we require that you adhere to the AAP (American Academy of Pediatrics) recommended Well Child schedule which includes yearly Well Child visits after the age of 3 years. We are unable to complete any medical forms on patients (3yrs+) whom we have not seen for a Well Child visit in over a year. (For your convenience we have magnets with the AAP schedule for placement on your refrigerator).
2) If you choose an alternative vaccination schedule, you will be asked to sign an agreement which outlines future visits and potential additional costs.
3) If you choose not to vaccinate your child we still require that you abide by the AAP recommended Well Child visit schedule to remain active in our practice. Well child visits are not just about vaccinating, they are about monitoring growth, development, nutrition and identifying problems in a timely fashion so that appropriate recommendations, treatments and interventions can be made.

Initial: ________

Appointments:

We value the time we have set aside to see and treat your child and appreciate your promptness. Broken appointments represent a cost to you and is an inconvenience to other patients who otherwise could have been seen in that time set aside for you. We do not double book appointments.

1) MISSED APPOINTMENTS: There is a $25 charge for missed SICK appointments and $50 charge for missed WELL CHILD appointments. Multiple missed appointments (3) will result in our inability to schedule further appointments for your child(ren) and a request to transfer your records to another physician.
2) TARDINESS: If you are late for your appointment (>5 minutes) we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) WELL CHILD VISITS : We request that you arrive 10-15 minutes PRIOR to your WELL CHILD VISIT appointment time. If you are unable to keep an appointment we would appreciate 24 hour notice so that we may accommodate other patients. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy (well child) visit. Some plans require a year + 1 day while others allow 1 per calendar year.
4) EXTENUATING CIRCUMSTANCES: Prior to making your appointment (Sick or Well) please let us know if there any **extenuating circumstances** that require more time. We allot a certain amount of time for Well/Sick visits. Should the number of concerns you have require more time than the allotted time, you may be asked to return for an additional appointment or billed an extended fee. This charge may go to your deductible and may require a co-pay according to your insurance plan of which you will be responsible.

Office Policies

5) WAIT TIME: We strive to minimize any wait time, however emergencies and extenuating circumstances do occur. As such, they will take priority over a scheduled visit. We appreciate your understanding in the event of delays in your appointment and will do our best to communicate any unforeseen wait times.
6)WALK INS: Unfortunately, we are unable to accommodate walk in appointments. Please call the office and we will schedule a visit for your child. Patients with appointments are given priority. If there is an emergency call 911 or take your child to the nearest emergency room. For patients who walk in and insist on being seen, we cannot guarantee you will be see. In the event that we can accommodate you there will more than likely be a wait and an additional **$60 walk-in fee** which is not covered by Insurance.

Initial: __________

Referrals:

1) Advance notice is needed for all non-emergent referrals, typically 3-5 days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) It is your responsibility to know if a written referral or authorization is required to see specialists, whether or not preauthorization is required prior to a procedure, and what services are covered.

Initial: __________

Forms:

1) There is no charge for immunization or physical forms given at the time of your WELL Child's visit as this is considered part of the visit. **However**, should you need replacement forms there is a $5 charge per form.
2) There is no charge for school medication sheets **if** you fill them out completely so that they only require a signature. The fee is $5 if the sheet needs to be filled out by the provider or our staff.
3) Any additional school, camp, or sport forms are subject to a $5 per form fee at the time of visit and $10 outside of the office visit.
4) FMLA forms are complex and specific to the needs of each family. Payment is due when the forms are dropped off. We require a 3 day turnaround time.
    a. For first time forms, we require an office visit so that the provider can fill out the form correctly and to accommodate your needs. An office visit will be billed to your insurance, a co-pay may be required or the visit may go towards your deductible/co-insurance/out of pocket expenses.
    b. If you are unable to come into the office, a phone consultation will be necessary and there will be a $50 fee which will NOT be billed through insurance.
    c. For repeat/updated FMLA forms which require no change, the fee is $25.
5) Letters to schools, attorneys, etc are $25-$100 depending on the complexity of the correspondence.

Initial: __________

Office Policies

Telephone fees and policies:

1) Our After hours call service is for **URGENT OR EMERGENCIES ONLY**. There will be a **$25 fee** for calls that come in after hours and do not result in a referral to the emergency room.
   a) Calls after hours will be routed to our answering service. Please use the main number. Calls will be returned within the hour. If you do not receive a call back, please call the service back.If you cannot wait for our return call, call 911 or take your child to the emergency room.
2) If you have a routine question, we ask that you call us during regular office hours. You may also avail yourself of the nursing "hotline" offered by your insurance company. Our website also provides dosing information for common over the counter medications.
3) As always, if your child is in need of a prescription medication (i.e. antibiotic) after hours, we prefer that you be evaluated at a local urgent care clinic or ER. However, if after a phone assessment or an email assessment of a photo we deem it reasonable to call in an RX, there will be a **$35 fee.**

Initial: _________

Prescription refills:

1) For monthly medications refills we require 48 hours notice and requests need to be made during regular office hours. Please plan accordingly. After hour refills called into a pharmacy will be subject to a $35 fee. Prescriptions for controlled substances need to be picked up at the office.
2) Patients on certain medications require regular office visits. Please plan accordingly and make your appointments in advance. Waiting until the last minute to make your appointment may mean that your child could go without his/her medication.

Initial: __________

Transfer of records:

1) If you transfer to another physician we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours notice. Your child's chart will then be deactivated within our practice.
2) A copy of your complete record is available for a $1 per page fee.
3) We provide records for visits (not including consults from specialists) rendered here at Village Pediatrics only. For copies of consults and any previous records, you must request them directly from your previous doctor(s) and specialist(s).
4) All balances need to be paid before records are transferred.

Initial: __________

Financial Policies

Financial Responsibility & Insurance:

PAYMENT IN FULL IS DUE AND EXPECTED AT THE TIME OF SERVICE
(For those that are not aware. Village Pediatrics is a private entity. We do not receive government subsidy. We depend on your financial responsibility to cover expenses and staff salaries)

1) **PAYMENT:** We accept cash, credit cards: Visa, Mastercard, Amex, Discover, debit cards and checks. (A $25 fee will be charged for any checks returned for insufficient funds).
2) **INSURANCE:** As a courtesy to our patients we will file claims to any insurance carrier with whom we are participating providers. (If you have insurance which we do not participate with , payment in full is expected from you at the time of the visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.)
    a) It is your responsibility to keep us updated with your correct insurance information.Please notify the office ASAP of all insurance and address changes. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and be responsible for submitting charges to the correct plan for reimbursement.**
    b) As your Primary Care Physician, our name or phone number should appear on your card. Please take a moment to verify this. If your insurance company has not yet been informed that we are your primary care physician you will be financially responsible for your current visit.
    c) It is ***your responsibility*** to understand your benefit plan in regards to covered services such as participating laboratory, etc. For example: Not all plans cover annual healthy (well) physicals, sports physicals, or hearing, vision & developmental screenings or in house labs. If these are not covered, you will be responsible for payment.
    d) For children less than 2 years of age there is a limit to the number of allowable Well Child visits per year. If the number of visits is exceeded, your insurance company will not pay; therefore you will be responsible for payment.

3) **UNINSURED:** (including those that participate in cost sharing policies). IF you do not have insurance, come prepared to pay for your service in full. We offer a **20% prompt-pay discount** for your visit and some services if payment is made in full at the time of the visit. If your balance cannot be paid in full at the time of service we can create a payment plan that needs to be paid within 90 days.

4) **RESPONSIBILITY:** According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. You agree to pay any portion not covered by your insurance. If your insurance company does not process and pay the claim within a timely manner or denies the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for treatment.

5) **CO-PAYMENTS** are due at the time of service. A **$10 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.

6) **HIGH DEDUCTIBLE PLANS:** If you participate in a high deductible plan we reserve the right to request payment in full or in part for charges incurred at the time of service as allowable by yourinsurance carrier. We also require a copy of either a health savings account debit/credit card or a copy of a personal credit card to remain on file for use as balances occur.

Financial Policies

7) **DIVORCE:** In the case of divorce or separation, the parent authorizing treatment for the child(ren) will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the **AUTHORIZING PARENT'S** responsibility to collect from the other parent or have the responsible party's credit card information on file for use at the time of the visit or as balances incur.

8) **OUTSTANDING BALANCES:** Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB). Your remittance is due within **10** business days of your receipt of the bill. If previous arrangements have *not* been made with our finance office, any account balance outstanding greater than 28 days will be charged a **$10 re-bill** fee for each 28 day cycle. **Any balance over 90 days will be forwarded to a collection agency.** For scheduled appointments, prior balances must be paid **prior to** the visit.

9) **PAYMENT PLAN:** Village Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy we offer a payment plan to be paid within 90 days. In order for services to be rendered, patients must be in full compliance with all conditions of the agreement. Failure to make scheduled payments on the plan or not paying off a balance in full will result in your account being turned over to a collection agency.

10) **WAIVER OF CONFIDENTIALITY**: I understand that if my account is submitted to a collection agency or if a past due status is reported to a credit reporting agency, information of my receiving treatment at Village Pediatrics may become a matter of public record.

Initial: __________

I have read and understand this office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously. Knowing this I request that services be performed.

Patient Name(s) ____

Responsible party member's name ______________________________Relationship_____________________

Responsible party member's signature_______________________________Date________________________

Upon Completion we will provide you with a copy for your records

"It takes a village to raise a child"- Old African Proverb

Village Pediatrics, LLC
319 West Town Place, Suite 1
St. Augustine, FL 32092
Tel: (904) 940-1577 Fax: (904) 940-1916

Palencia location -
290 Paseo Reyes Dr., St. Augustine, FL 32095
Tel: (904) 217-8461/ Fax (904) 814-8693

Authorization to Release Medical Records

Patients Name: ____
Date of Birth: ________________________ SS#: __________________________________
Address: ____
City: ________________________________State:______________Zip:_______________
Telephone Number: ____________________ Date of Treatment: _______________________

I, the undersigned, hereby authorize: (your former Pediatrician)
Name: ______________________________ Location: ____________________________
Address: ____
City: ________________________________ State: _____________ Zip: ______________
Telephone: ___________________________ Fax: _________________________________

The specific information to be used or disclosed is as follows:

Complete Health Record _______ Operative Reports __________ Pathology Reports _________
Laboratory Reports ________ Radiology Reports ___________ Cardiology Reports __________
Other Testing Results ______________ Emergency Room Discharge Summary______________

I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that I have the right to inspect and copy the information to be used or disclose is pursuant to this authorization. I understand that once this information is received by the authorized person or organization then may be subject to redisclosure and may no longer be protected by federal privacy laws.

I hereby authorize the above use and disclosure.

Signature of Parent or Legally Authorized representative: ______________________________

Date: ____________________

Village Pediatrics, LLC

Credit Card Authorization

I, ____________________________, hereby authorize Village Pediatrics, LLC, to charge my credit card the balance of payment due Village Pediatrics, LLC after receiving notice from my insurance company. The amount charged is not to exceed the amount due. I also understand that I am responsible for payment of services should credit card be declined for any reason.

Village Pediatrics, LLC will send a receipt of the charges along with an explanation of benefits. These documents are to be used should the insurance company audit any claims filed by Village Pediatrics, LLC.

Name(s) of patients____

Date of service____

Name of cardholder____

Cardholder signature____

Credit card number____

Expiration date________________

Security number (3digit code on back of card)_____________

Should you decline to provide credit card information, payment in full is expected at the time of service.

Village Pediatrics, LLC (witness)____

Signature____