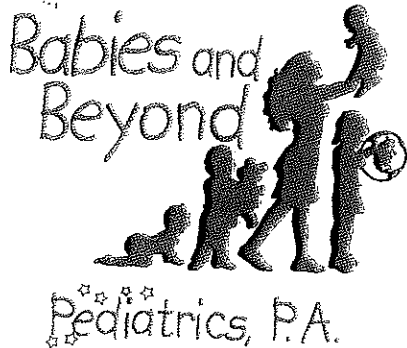

Date: ____________________

Russell T. Bain, M.D., F.A.A.P.
James M. Davis, M.D., F.A.A.P.
Norman Becker, M.D., F.A.A.P.

Dear ____:

Thank you for your interest in Babies and Beyond Pediatrics, P.A.

Please find enclosed:

(1) Brochures (Babies and Beyond, Stay Fit Kidz and Adult, Hormone Replacement Therapy) and Business Card
****(2) Personal Information Form**
****(3) Authorization/Emergency Contact Form**
****(4) New Patient Intake History Form**
(5) Important Office Policies
(6) Unique Services Offered
****(7) Financial Policy**
****(8) Authorization for Medical Records Release**
(9) Insurance's we accept (contracted with)
****(10) HIPAA form**

We would appreciate your completing and returning ****(2)Personal Information Form, **(3)Authorization/Emergency Contact Form, **(4)New Patient Intake History Form, **(7)Financial Policy, **(8)Authorization for Medical Records Release and **(10) HIPAA form** as soon as possible.

Please complete and send the **Medical Records Release Form** to your children's previous Doctor. Once this information is received, we will review your child(ren)'s records and contact you to schedule their initial office visit. **Please note: We need to receive these records in their entirety before a *well* exam can be scheduled. ** If your child is acutely ill, we can see him/her without previous records. ****

Furthermore, please read our **Babies and Beyond Brochure** and **Unique Services Offered. These documents contain important information that our doctors want you to read in order to assist you in making informed decisions when bringing your family to our office.**

Please keep all of these documents in a safe place, as you may want to refer to them again in the future.

Should you have any questions or concerns regarding the enclosed information, please contact our office. Our staff will be happy to assist you. We look forward to meeting you and you family and providing the highest quality of pediatric care.

Welcome to our Pediatric Family

Russell T. Bain M.D., FAAP

224 Mariner Boulevard
Spring Hill, FL 34609
(352) 686-9779
(352) 686-5998 Fax
www.thebabiesandbeyondpeds.com

2. ADULT PERSONAL INFORMATION FORM

PATIENT INFORMATION:
ACCOUNT# ____________

CLIENT'S FIRST NAME: ____________ MIDDLE INITIAL ____________

ADDRESS: ____________

CITY: ____________ STATE: ____________

SS#: ____________ DOB: ____________ GEND ____________

PHONE NUMBER (PLEASE CIRCLE PREFERRED CONTACT#)

HOME: ____________ OFFICE: ____________ ____________

CONFIDENTIAL EMAIL (TO SEND YOU CONFIDENTIAL MEDICAL INI ...ION): ____________

this is the only diff betw new pt pkg

CONFIDENTIAL FAX (TO SEND YOU CONFIDENTIAL MEDICAL INFORMATION): ____________

PERSONAL PHYSICIAN'S NAME: ____________ PHONE #: ____________

NAME OF EMPLOYER: ____________ OCCUPATION: ____________

MARITAL STATUS: ________ IF MARRIED SPOUSE'SNAME: ____________ PH#: ____________

COPY OF DRIVER'S LICENSE GIVEN: ☐ YES ☐ NO

EMERGENCY CONTACT **YOUR RELATIONSHIP TO PATIENT:** ____________

FIRST NAME: ____________ MIDDLE INITIAL: ________ LAST NAME: ____________

ADDRESS: ____________
(IF DIFFERENT FROM ABOVE)

CITY: ____________ STATE: ____________ ZIP CODE: ____________

HOME TELE: (______) ____________ DOB: ____________

EMPLOYER: ____________ OCCUPATION: ____________

WORK #: (______) ____________ EXT: ____________ CELL #: (______) ____________

I AUTHORIZE DR. RUSSELL BAIN AND BABIES AND BEYOND PEDICATRICS TO **SHARE** MY MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

NAME ____________ PHONE # ____________ RELATIONSHIP ____________
NAME ____________ PHONE # ____________ RELATIONSHIP ____________
NAME ____________ PHONE # ____________ RELATIONSHIP ____________
NAME ____________ PHONE # ____________ RELATIONSHIP ____________

____________ ____________
Signature of Patient **Today's date**

FOR OFFICE USE ONLY

ENTERED IN COMPUTER BY: ____________ DATE: ____________
(PRINT NAME RECEPT)
FORMS REVIEWED BY: CHECK-IN RECEPTIONIST ____________ DATE: ____________
(PRINT NAME RECEPT)

OVER FOR COPY OF DRIVER'S LICENSE

Revised 6/11/13

BABIES AND BEYOND PEDIATRICS, P.A.
Russell T. Bain, MD, FAAP and Associates

2. PERSONAL INFORMATION FORM

PATIENT INFORMATION:
ACCOUNT# ____________ PATIENT SS# ____________
FIRST NAME: ____________ MIDDLE INITIAL: ______ LAST NAME: ____________
ADDRESS: ____________
CITY: ____________ STATE: ______ ZIP CODE: ______
HOME TELE: (_____) ____________ DOB: ____________ GENDER: _____MALE _____FEMALE
PARENT'S EMAIL ADDRESS (MUST ENTER): ____________
MEDICAID LETTER GIVEN BY/DATE: ____________

MOTHER'S INFORMATION (OR GUARDIAN) **YOUR RELATIONSHIP TO PATIENT:** ____________
FIRST NAME: ____________ MIDDLE INITIAL: ______ LAST NAME: ____________
ADDRESS: ____________
(IF DIFFERENT FROM ABOVE)
CITY: ____________ STATE: ______ ZIP CODE: ______
HOME TELE: (_____) ____________ DOB: ____________ SPOUSES NAME: ____________ *(IF DIFFERENT FROM FATHER)*
EMPLOYER: ____________ OCCUPATION: ____________
WORK #: (_____) ____________ EXT: ______ CELL #: (_____) ____________
SS# ____________ MARITAL STATUS: ______ COPY OF DRIVERS LICENSE ☐ INITIAL ____

FATHER'S INFORMATION (OR GUARDIAN) **YOUR RELATIONSHIP TO PATIENT:** ____________
FIRST NAME: ____________ MIDDLE INITIAL: ______ LAST NAME: ____________
ADDRESS: ____________
(IF DIFFERENT FROM ABOVE)
CITY: ____________ STATE: ______ ZIP CODE: ______
HOME TELE: (_____) ____________ DOB: ____________ SPOUSES NAME: ____________ *(IF DIFFERENT FROM MOTHER)*
EMPLOYER: ____________ OCCUPATION: ____________
WORK #: (_____) ____________ EXT: ______ CELL #: (_____) ____________
SS# ____________ MARITAL STATUS: ______ COPY OF DRIVERS LICENSE ☐ INITIAL ____

EMERGENCY CONTACT (DIFFERENT FROM ABOVE) **YOUR RELATIONSHIP TO PATIENT:** ____________
FIRST NAME: ____________ MIDDLE INITIAL: ______ LAST NAME: ____________
ADDRESS: ____________
CITY: ____________ STATE: ____ ZIP CODE: ______ **CELL#:** (_____) ____________

CHILD(RENS) NAME(S)
____________ DOB ______ ____________ DOB ______
____________ DOB ______ ____________ DOB ______

MAY WE LEAVE A MESSAGE REGARDING APPT. ON ANSWERING MACHINE? Y__ N__ IF NO THEN WHERE
____

WHOM MAY WE THANK FOR YOUR REFERRAL?
PRINT FULL NAME: ____________ **SOURCE:** ____________
(i.e. another physician, friend, insurance, yellow pages, etc.)
ARE THEY A PATIENT HERE? ☐ YES ☐ NO

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D. F.A.A.P., and Associates

3. AUTHORIZATION CONTACT FORM

1) I (we) AUTHORIZE the following people to BRING my child(ren) into your office for treatment:

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

2) I (we) authorize Babies and Beyond, Pediatrics, P.A. to SPEAK to the following people regarding my health or child's health (i.e. spouse, child, etc. including phone number). Relationship (i.e. parent, guardian, grandparent).

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

3) 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:

____

____

____

____

______________________________ ______________

Parent/Guardian Sign Date

Note: If more than one child, make copies of this document and put it in the other children's chart.

"Committed to Providing Compassionate and Quality Care for Babies, Toddlers, & Teens"

224 Mariner Blvd. Spring Hill, FL 34609
Phone (352) 686-9779 Fax (352) 686-5998

Babies and Beyond Pediatrics, P.A.

Primary Language spoken in home: (✓ one)
❑ English ❑ Spanish
❑ Other: ________________

4. New Patient Intake History Form

Pt. Name: ______________________________ DOB: ________________
Patient resides with: __________________ Legal Guardian is: __________________ Relationship to Child: __________
Marital Status of Child's Parents: ❑ Married ❑Divorced ❑Single—Never Married

Birth History

Hospital born at: __________________ Obstetrician: ________________ Pediatrician in Nursery: ______________
Type of delivery (✓ one): ❑ Vaginal Delivery ❑C-Section Delivery Age: ❑ Preterm (# 37 wks) ________wks
If C-Section delivery, why? ______________________________ ❑ Fullterm (∃ 38 wks)
Birth Weight: _______ Birth Length: ________ Discharge Weight: __________
Did the baby have any problems at or immediately after birth? ____

List age: Held up Head: ________ Cooed or laughed: ________ Sat up: ________ First Word: ________ Walked: ________

Patient Health History

Child's Previous Pediatrician: ____________________ City/State: __________________ Phone #: ______________
Date of last exam: ____________________ Results: ______________________________________
Any serious short or long-term illness? ❑ No ❑ Yes If yes, what and when? ______________________________

Any operations or hospitalizations? ❑ No ❑ Yes If yes, what and when? ______________________________

Does any family member smoke? ❑ No ❑ Yes If yes, who? ____________________ In the home? ❑No ❑Yes
Are immunizations up to date? ❑ No ❑ Yes
Any medication allergies? ❑ No ❑ Yes If yes, what med and what was the reaction? ____________________

HAS THE CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWNG: (CIRCLE YES OR NO)

Yes No AIDS/HIV	Yes No Chicken Pox	Yes No Hearing Problems	Yes No Pneumonia
Yes No Anemia	Yes No Constipation	Yes No Heart Problems	Yes No Rheumatic fever
Yes No Asthma	Yes No Convulsions	Yes No Hepatitis	Yes No Sinus problem
Yes No Bed Wetting	Yes No Diabetes	Yes No Kidney Disease	Yes No Speech Problem
Yes No Birth Defects	Yes No Diarrhea	Yes No Lead Poisoning	Yes No Thyroid Disease
Yes No Bladder problems	Yes No Drug/Alcohol abuse	Yes No Liver Disease	Yes No Tuberculosis
Yes No Bleeding Excessive	Yes No Ear Infections	Yes No Measles	Yes No Urinary Disease
Yes No Cancer	Yes No Epilepsy	Yes No Mononucleosis	Yes No Vision Problems
Yes No Cerebral Palsy	Yes No Fainting		

Family History

Has any member of the family or close relative had any of the following? Please circle yes or no. If yes, indicate which family member and age if asked.

Yes No Arthritis __________	Yes No Hyperactivity __________	Yes No Seizure __________
Yes No Asthma __________	Yes No Hemophilia __________	Yes No Substance Abuse ______
Yes No Cancer __________	Yes No High Blood Pressure ______	Yes No Stroke __________
Yes No Diabetes __________	Yes No Immuno suppressed ______	Yes No TB __________
Yes No Heart Problems __________ Age ______	Yes No Kidney Disease __________	Yes No Migraine ______
Yes No High Cholesterol __________	Yes No Mental Disorder __________	Yes No Other __________

Name of person completing form: ____________________ Relationship to patient: ________________ Date: __________

Reviewed by Doctor: ______________________________ Date: ____________________

J:\forms\New Patient Forms\new patient intake history.doc

Babies & Beyond Pediatrics

5. OFFICE POLICIES

- Please notify us of any changes to your **INSURANCE STATUS, PHONE NUMBER** and/or **ADDRESS.**

- **CANCELLATIONS** must be made **24 hours** in advance of appointment to avoid a No-Show charge.

- All payments are expected at time of service.

- Please allow **72 HOURS** for school forms, sport forms and/or referrals to be completed.

- A doctor is always available 24 hours a day 7 days a week for all emergencies.

(PLEASE CALL OUR OFFICE BEFORE GOING TO AN AFTER HOURS FACILITY OR EMERGENCY ROOM, UNLESS IT IS A LIFE THREATENING SITUATION).

- **SATURDAY HOURS** are available from 8:45 a.m. to 12:00 noon.

- Some **PRESCRIPTIONS** can be filled in our office.

- Patient will be seen by their **APPOINTMENT TIME NOT BY WHEN THEY ARRIVE.**

- As a courtesy, our nurses can perform **LAB WORK** but your **CO-PAY /%** will apply.

6. UNIQUE SERVICES OFFERED AT BABIES AND BEYOND PEDIATRICS

On Call Program

If you need to speak to one of our doctors, please call the office phone number which will connect you to our answering service. The service is instructed to take a brief history and get an accurate phone number and spelling of the patient and callers name. If the Doctor /Nurse has not called you back within 20 minutes please call the service again and re-verify the phone number that you gave them. The answering service are non- medical professionals who are instructed not to give any advice. When a parent or guardian leaves a message with our answering service, the service immediately contacts the On – Call Doctor/Nurse by sending an electronic message. A Doctor/Nurse from our group is always on-call and available to speak with you 24 hours a day, 7 days a week, 365 days a year no matter what time it is!!!

Stay Fit Kidz Weight Loss/Gain Program

A comprehensive program to fight obesity, while creating healthier children and teens. An extensive Medical/Nutritional/Psychological Assessment by a Board Certified Pediatrician. A small group exercise program (lose body fat, add strength and muscle mass). One on one nutritional counseling and impletation. Clinically proven vitamins and weight loss/gain supplements for children and teens.

Stay Fit Adult Weight Loss Program

HCG: If you are unfamiliar with the HCG diet, HCG (Human Chorionic Gonadatropin), is a hormone produced during pregnancy. The purpose of the HCG hormone is to rally the metabolism of systemic fat. Typically, as a species, the human body is pre-disposed to retain calories in the form of fat reserves as a survival mechanism for long winters or famine; conditions that rarely exist today. This is why dieting is such an uphill battle; not only are we struggling our own poor eating habits, but a genetic predisposition to retain fat. HCG is the solution. When a women becomes pregnant, the growing baby requires a 24/7 calorie source. In response, the placenta of the mother begins to produce HCG, which "unlocks" her stored fat to provide the calories necessary for proper development of her unborn child. If the HCG hormone is supplemented in the absence of a pregnancy, the dieter can sustain themselves on their own stored fat, resulting in healthy weight loss.

Naturalistic: This a 3 month (90) day comprehensive Medical/Holistic approach to weight loss (17 years & up). It combines Medication(s), Natural Weight Loss Supplements, Nutrition and Exercise. During this 90 day program you will start eating every 2-3 hours throughout the day. It is important to maintain a certain amount of calories to adequately burn fat and not lose lean muscle. Eating your meals in a 5-6 meal per day format will help balance your insulin response and improve metabolism.

Stay Fit Adult Hormone Replacement Therapy

Testosterone is much more than a sex hormone. There are testosterone receptor sites in cells throughout the body, most notably in the brain and heart. Youthful protein synthesis for maintaining muscle mass and bone formation requires testosterone. Testosterone improves oxygen uptake throughout the body, helps control blood sugar, regulates cholesterol and maintains immune surveillance. The body requires testosterone to maintain youthful cardiac output and neurological function. Testosterone is also a critical hormone in the maintenance of healthy bone density, muscle mass and red blood cell production. If you feel based on your symptoms that you may have low testosterone or you want to decrease your body fat and increase your muscle tone then ask our office for a patient medical questionnaire, consent and HIPAA forms and a 4-day food log and set up an appointment to draw your labs at our office.

Expertise in Child and Adult Mental Health Disorders: i.e. Depression, Bipolar, ADHD, OCD

Also expertise in: Autism, Asthma, Allergies, Sleep Disorder, Acne and Obesity.

In Office

EKG, Pulmonary Function Test, Skin Testing and Sinus Endoscopy (scope into nose to diagnose Sinus Infections, No need for X-rays or CT Scans). Available for purchase: Vitamins, Protein Shakes, Fish Oil etc.

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D., FAAP and Associates

8. AUTHORIZATION TO RELEASE MEDICAL RECORDS (SEND TO)

♦ Date of Request: / /

Your previous physician's name, practice's name or name of ER/Hospital recently visited:

City: State: Zip:

Phone: ( ) Fax: ( )

Dear Doctor/Hospital: ______________________ **Attn: Medical Records Dept.**

The following ♦ ______ has asked that medical records be released and forwarded to our office as soon as possible. *Parent/legal guardian*

Patient Name(s): ♦ ♦ Date of Birth:

♦ ♦ Date of Birth:

♦ ♦ Date of Birth:

In order for us to fully evaluate this patient's health and make informed decisions, the parent has approved our request for copies of all relevant records in your file. Please be sure to include radiology reports, lab results, consultation reports, emergency room reports and any hospitalizations from the time they have been a patient in your practice or at your hospital.

Thank you for expediting this request.

Please send the records to our office at the address below:

224 Mariner Blvd.
Spring Hill, FL 34609

Ph: 352-686-9779
Fax: 352-686-5998

♦ ____ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
(Initial)

I hereby authorize the release of all necessary medical records to Babies and Beyond Pediatrics for as long as I remain a patient there. I wish them to be forwarded as soon as possible. I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time upon written notice except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". This form must be received within 90 days of signing and is valid for 90 days after receipt.

♦ Parent/Legal Guardian (*Signature if patient is a minor*) ♦ Print Name ♦Relationship to patient: ✓ **one**

☐ Parent ☐ Legal Guardian
☐ Grandparent ☐ Other

♦ Name of Insurance: ♦Name of Ins. Policy Holder:

♦ Ins. Policy Holder SSN: ♦Ins. Policy Holder DOB:

♦Patient's address: ♦City

♦State ♦Zip ♦Phone:

NOTE: keep original in chart

SIGNATURE OF WITNESS: ______________________

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D., FAAP and Associates

8. AUTHORIZATION TO RELEASE MEDICAL RECORDS (KEEP IN CHART)

PLEASE FILL OUT HIGHLIGHTED AREAS ONLY

♦ Date of Request: /   /

Your previous physician's name, practice's name or name of ER/Hospital recently visited:

City: State: Zip:

Phone: ( ) Fax: ( )

Dear Doctor/Hospital: ____________________ **Attn: Medical Records Dept.**

The following ♦ ______ has asked that medical records be released and forwarded to our office as soon as possible. *Parent/legal guardian*

Patient Name(s): ♦ ♦ Date of Birth:

♦ ♦ Date of Birth:

♦ ♦ Date of Birth:

In order for us to fully evaluate this patient's health and make informed decisions, the parent has approved our request for copies of all relevant records in your file. Please be sure to include radiology reports, lab results, consultation reports, emergency room reports and any hospitalizations from the time they have been a patient in your practice or at your hospital.

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(Initial)

I hereby authorize the release of all necessary medical records to Babies and Beyond Pediatrics for as long as I remain a patient there. I wish them to be forwarded as soon as possible. I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time upon written notice except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". This form must be received within 90 days of signing and is valid for 90 days after receipt.

♦ Parent/Legal Guardian (*Signature if patient is a minor)*

♦ Print Name

♦Relationship to patient: ✓ **one**

☐ Parent ☐ Legal Guardian
☐ Grandparent ☐ Other

♦ Name of Insurance: ♦Name of Ins. Policy Holder:

♦ Ins. Policy Holder SSN: ♦Ins. Policy Holder DOB:

♦Patient's address: ♦City

♦State ♦Zip ♦Phone:

NOTE: keep original in chart

SIGNATURE OF WITNESS: ____________________

Babies and Beyond Pediatrics, P.A.
Russell T. Bain, M.D., F.A.A.P. and Associates

9. Insurance Companies We Are Contracted With

Aetna - HMO, PPO, MC, Traditional and Indemnity
Amerigroup
Amerigroup Healthy Kids
Avmed
Baycare
Beechstreet
Cigna - HMO, PPO & POS
CMS
CMS Healthy Kids
Coventry (Formerly First Health and Southcare)
Evolutions
Florida Blue (BCBS) - (PPO, HMO, Traditional, Network Blue and Blue Options)
Humana - HMO, PPO & POS
Medicaid
Medipass
Multiplan (Formerly PHCS)
Pedicare
Pedicare Healthy Kids
Prestige Medicaid
Simply Healthcare
Staywell Medicaid
Sunshine Healthcare
United Healthcare - HMO, PPO & POS
United Healthcare Medicaid
United Healthcare Healthy Kids
Universal Healthcare
Tricare Standard (Not Prime)

NOTE: If insurance is not listed on here it may be affiliated with one of the above networks. Please call the insurance company if you are not sure.

Babies and Beyond Pediatrics, P.A.

7. Financial policy: Patients with contracted insurance or with no insurance (self pay)

We are totally committed to providing you and your family with the highest quality pediatric care while at the same time making sure you receive your maximum allowable benefits according to your insurance plan. In order for this to occur, we need your assistance and complete understanding of your insurance benefits and our financial policy.

Payments:
Payment is due at the time service is rendered. We accept cash, checks or major credit cards (Visa, Master Card, Discover and American Express). If circumstances arise that cause a parent to be unable to pay, please notify the receptionist **before** your visit. We do not have the ability to do payment plans.
NOTE: We encourage all routine well physicals to be rescheduled until the visit can be paid in full.

Return Check Policy:
There is between a $25.00 bounced check fee for returned checks, depending on the face value of the check. We can not accept another check until the bounced check and bounced check fee is paid in full. If more than one check is returned, we will no longer be able to accept any further checks.

Our Fees:
Our charges are generally considered to fall within the acceptable ranges by ***most*** insurance companies….and will be covered up to the *maximum allowance* determined by your insurance carrier.

Patient Balances:
In some instances we cannot be certain of the exact amount allowed by a particular insurance company for each visit, thus resulting in a refund to you or money owed to us. Refunds and statements are sent out on a monthly basis. If you do not understand your statement, please call our billing department at 352-684-8112. Patient balances > 30 days may be subject to collections and small claims court fees.

Insurance Coverage:

I. *General Information*:

A. In order to accept and file your insurance the following must occur.

1. We need you to provide us with your child's insurance information and card.
2. We must be able to verify that your child is enrolled in the policy and what your benefits are. If we cannot verify your insurance benefits before your visit then we cannot accept your insurance for that visit. We will extend to you a discount off the total charges and give you a copy of your bill for you to send in for reimbursement.
3. It is your responsibility to provide us with **up to date** **and** **accurate** insurance information. Failure to do so may result in your being held responsible for all charges plus any additional fees associated with insurance filing.

B. If you do not understand the details of your insurance coverage [i.e.: the amount of / or what visits your co-pay applies to, if all ages are covered in full for well care (some are not), what your deductible is and when does it apply (sick and/or well visits, labs or procedures)], please ask us to explain your benefits *before* your initial visit.

II. ***Deductibles:***
If your deductible has not been met, you will pay what your insurances contracted allowable fee is for each charge. Once your deductible is met you will be required to pay a **percentage off of your insurances contracted allowable fees**.

OVER

III. *Percentages*:
If you have an insurance policy that states you pay a percentage, this will be **off your insurances contracted allowable fees**.

IV. *PPO Patient only*:
We will file your insurance claim. If payment is not received within 60-90 days you will receive a statement advising you to contact your insurance company to help get the claim paid, otherwise the balance will become your responsibility.

V. *No Insurance Coverage*:
If you have no insurance for your child or one that we do not accept, our policy is to extend a discount off our standard charges **only if** the entire visit is paid in full at the time services are rendered.

VI. *No Show Policy:*
We understand that there are times when emergencies may arise and you are unable to give proper notice, we would sincerely appreciate when possible, that all future appointments requiring cancellation be done at least 24 hours in advance of said appointment so we may utilize this time for other ill patients.

☐ **Same day sick appointment** was missed thus a $50.00 no show charge will be assessed.
☐ First no show without 24 hr cancellation. (no charge)
☐ First no show, **if confirmed by speaking to parent or guardian** and NO 24 hour cancellation, a $25.00 no show charge will be assessed.
☐ Second no show without 24 hr cancellation, thus a $75.00 no show charge will be assessed.
☐ Third no show without 24 hr cancellation, a $100.00 no show charge will be assessed and possible termination from the practice.

INFORMED CONSENT

1. My signature below indicates my consent to any and all of the medical services provided to my child(ren) by the office/doctors of Babies & Beyond Pediatrics, P.A.
2. I authorize my insurance company to pay Babies and Beyond Pediatrics P.A. directly for all services rendered.
3. I have read and understand the financial policy of this office and agree that I am responsible for any balances that result from services rendered for my child(ren) by Babies and Beyond Pediatrics, P.A.
4. In addition, I also understand that whomever brings my child(ren) to this office is responsible for payment in full at time services are rendered.
5. I authorize the release of any medical information necessary for the care of my child(ren) and to process the claim.

______________________	______________________	______________________	______________________
Name of Responsible Party	**Signature of Responsible Party**	**Relationship to Patient**	**Today's Date**

______________________	______________________
Witness sign (receptionist)	**Today's Date**

PS: If you have any questions about the information you have just read or any uncertainty regarding your insurance coverage please do not hesitate to ask us.

Note: If more than one child, make copies of this document and put it in the other children's chart.

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D. F.A.A.P., and Associates

10. HIPAA Notice of Privacy Practices

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 describes how we 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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities, employee review activities, training of medical students, licensing, 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.

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 and Organ Donation, Research, Criminal Activity, Military Activity and National Security: Workers' Compensation, Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

224 Mariner Blvd. Spring Hill, FL 34609
Phone (352) 686-9779 Fax (352) 686-5998

You may revoke this 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, **you may not inspect or copy the following records: psychotherapy notes or any other physician notes outside this practice**, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 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 of 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 a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to have your physician amend 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 we have made, if any, of your protected health information. We reserve the right to change the terms of this notice. The policy in force will be posted in the office and a copy made available to you. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **December 1, 2004.**

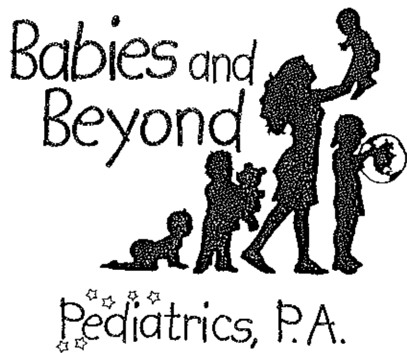
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any issues related to our privacy policies, please ask to speak with our **HIPAA Compliance Officer, Tonya Croghan**, in person or by phone at (352) 686-9779.

I have read and understand the above.

________________	________________	________________	________
Signature	Print Name	Relationship to patient	Date

________________	__________
Witness (**receptionist**) signature	Date

Note: If more than one child, make copies of this document and put it in the other children's chart.



October 30, 2014

Russell T. Bain, M.D., F.A.A.P.
James M. Davis, M.D., F.A.A.P.
Norman Becker, M.D., F.A.A.P.

To: Parents of Babies and Beyond Pediatrics
From: Dr. Russell Bain

We need your help!!!

We do our best to get our patients in the same day when they are sick and try to call 48 hours before to remind our patients of their upcoming appointments. We are having a major problem with people not showing up for their appointments and not calling especially the parents who made a sick appointment that day. We need our patients to call before and cancel their appointment. We understand occasionally emergencies happen but this has not been the case. When we call we get responses like I got busy or oh well. The doctor's time has to be respected.

Effective immediately if a patient **no shows the same day** they make an appointment and don't respectfully call to cancel there will be a $50 mandatory no show charge. If a patient no shows for an upcoming appointment there will be a $50 mandatory no show charge. **We can't possibly call all of our patients and remind them of their upcoming appointments. Please write down your appointment time.**

Respectfully,

The Doctors & Staff of Babies and Beyond Pediatrics

Print Parent/Guardian Name	Sign	Date

224 Mariner Boulevard
Spring Hill, FL 34609
(352) 686-9779
(352) 686-5998 Fax

www.thebabiesandbeyondpeds.com

Babies & Beyond Pediatrics Allergy Screening Form

Patient: ______________________ Date of Birth: ____________ Today's Date: ____________

Does the patient experience any of these symptoms?

	Yes	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often does the patient experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year
- ☐ Other: ______________________

Does the patient take prescription or over-the-counter (OTC) medications for the management of his/her allergy symptoms? ☐ Yes ☐ No

If yes, name of medication and last date taken: ______________________

Please indicate below symptoms/conditions the patient experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, Headaches, sinusitis **MORE THAN 3 X YEAR**)
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Re-occurring Seasonal Colds
- ☐ Consistent or Re-occurring coughing
- ☐ Chronic colds **(LASTING LONGER THAN 2 MONTHS)**
- ☐ Chronic/Intermittent fatigue, irritability & restlessness
- ☐ Chronic/Intermittent Headaches
- ☐ Asthma
- ☐ Chronic/Intermittent Skin Conditions (dry and/or itchy skin, etc.)

Parent Name (Print): ______________________ Phone: ______________

Parent Signature: ______________________ Date: ______________

Recommendations: ______________________

____

______________________ ______________________

Dr Sign Date Reviewed