The Wolff Center for Child & Adolescent Health

Intake History

Who referred you to our clinic:_____ Previous Physician:_____

Name - First: _____ Middle Initial: _____ Last: _____

DOB:_____ **Gender**: Male / Female **Primary Language**: _____

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Race : _____ Asian, _____Black or African American, _____ Native Hawaiian or Other Pacific Islander,

_____ White, _____ Other race not listed:_____

Mother's Name: _____ **SS#**: _____ **DOB**: _____

Email: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Lives with: Y / N **Home#**:_____ **Work#**: _____ **Cell #**:_____

Father's Name: _____ **SS#**: _____ **DOB**: _____

Email: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Lives with: Y / N **Home#**:_____ **Work#**: _____ **Cell #**:_____

Custody (if applicable): Joint custody or Is the Primary Custodial Parent Mom or Dad (above)

Step-parent Name & #'s: _____ **Lives with**: Y / N

Step-parent Name & #'s: _____ **Lives with**: Y / N

Emergency Contact, if parent can't be reached: _____

Phone #'s:_____ **Relationship to patient**:_____

Primary Insurance: _____ **Policy Holder Name**: _____

Policy Holder Relationship to Patient: _____ **DOB**: _____

Secondary Insurance: _____ **Policy Holder Name**: _____

Policy Holder Relationship to Patient: _____ **DOB**: _____

_____ (intial) Please note, we do not file any Medicaid product, including Humana Medicaid as a Secondary policy. Any state funded insurance plan is always your secondary policy, i.e: Medicaid, Tricare, CMS.

_____ (intial) Most insurance companies use the "Birthday Rule" to determine primary and secondary policies, in most instances unless a court order states otherwise, which ever parents birthday come 1st within the calendar year is considered the primary insurance plan. However, there are circumstances that would change that rule. Please let us know if there are any special circumstances with your insurance plans.

_____ _____ _____

(Parent/Guardian Name Print) (Signature) (Date)

The Wolff Center for Child & Adolescent Health

Patient Name: _____ DOB: _____ Gender: M / F

Birth History

Hospital: _____ Birth Weight: _____ Delivery: □C-Section □Vaginal □Full Term □Premature
Use during pregnancy: □Alcohol, □Cigarette smoking, □Illegal drugs, □Medications:_____
Any pregnancy complications: □Infection, □High blood pressure, □Anemia, □Diabetes, □Bleeding, □Other:___
Any problems in the newborn nursery: □Jaundice, □Infection, □Breathing problems, □Feeding problems,
□Other:_____

Medical History

Medication Allergies: _____ Other Allergies: _____

Surgery/Procedures:	Approximate age of child in reference to procedure:
____ Circumcision	_____
____ Ear surgery _____(specify type)	_____
____ Tonsillectomy	_____
____ Adenoidectomy	_____
____ Hernia _____ (specify type)	_____
____ Appendectomy	_____
____ Other _____	_____

Hospitalizations for illness (excluding surgeries already listed):	Approximate age of child for hospitalization:
_____	_____
_____	_____

Family History

Have any relatives had any of the following: (check and indicate what relative.) □ Other:_____
□Allergies/hay fever_____ □Blood disorders_____ □Heart disease_____ □Kidney disease_____
□Anemia_____ □Cancer/Leukemia_____ □Hepatitis_____ □Seizures_____
□Asthma_____ □Brain damage/retardation___□High blood pressure__□Sickle cell trait/disease__
□Birth defects_____ □Diabetes_____ □HIV/AIDS_____ □TB_____

Social History

List other children in the family (full name & date of birth):

_____ _____ _____
_____ _____ _____

Type of home: □Apartment □Trailer □House □Other_____ Who else lives in household:_____
Any smokers in the household? Y / N Any guns kept in the home? Y / N Pets: _____
Daycare/School attends:_____ Grade:_____ Sports:_____

Teens

Favorite class in school:_____ Hobbies/Interests:_____ Job:_____
Do you use: □Cigarettes □Alcohol □Drugs Sexually Active? Y / N
For Girls: have you had your first menstrual period: Y / N If yes, What age? _____ Date of LMP?_____

_____ _____ _____
(Parent/Guardian Name Print) (Signature) (Date)

The Wolff Center for Child & Adolescent Health, P.L.L.C.
Notice of Privacy Practice

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 to carry out treatment, payment and health care operations and for the 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, which may identify you and that which relates to your past, present or future physical health and/or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices. You may call our office and request that a revised copy is sent to you by mail or by asking for a copy at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information based upon your written Consent.

You will be asked by our office staff to sign an Acknowledgment of receipt. By signing this form you are acknowledging that you have received this notice and understand your rights. Your protected health information may also be used and disclosed to pay your health care bills and to support the operations of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office according to the HIPAA Law.

Treatment: To provide, coordinate, and/or manage your health care and any related services. This includes the coordination and management of your health care with a third party that has already obtained your permission to have access to your protected health information.

Example:

1. To a home health agency that provides care to you.
2. To other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.
3. To a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.
4. To another physician or health care provider (e.g., a specialist or laboratory) who, at the request of our physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: As needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Example:

1. Obtaining approval for a hospital stay may require that our relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: In order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

Example:

1. To medical school students who may observe treatment of patients in our office.
2. Calling you by name in the waiting room when the physician is ready to see you.
3. Contacting you to remind you of your appointment. (This includes identifying our office by name to the person answering the call)
4. Third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

2. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

3. Other Permitted and Required Uses and Disclosures that may be made with your Consent, Authorization or Opportunity to Object.

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Health care: Unless you object, we may disclose to a family member, a relative, a close friend or any other person you identify on this consent, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: In emergency treatment situations, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable due to conditions and circumstances, he may still use or disclosure your protected health information to treat you.

Communication Barriers: If your physician attempts to obtain a consent form from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

4. Other Permitted and Required Uses of Disclosure that may be made without Your Consent, Authorization or Opportunity to Object:

Required By Law: To the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: For public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: If authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be a risk of contracting or spreading the disease or condition.

Health Oversight: To a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse and Neglect: To a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence it is our duty to notify the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: To a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tracking products; to enable product recall; to make repairs to make replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: In the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain condition in response to a subpoena, discovery request or other lawful process.

Law Enforcement: If applicable legal requirements are met for law enforcement purposes. These law enforcement purpose include (1) legal processes or otherwise require by law, (2) limited information request(s) for identification and location purposes, (3) pertaining to victims of crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: To a coroner or medical examiner for identification purposes determining cause of death or for the coroner, or medical examiner to perform other duties authorized by law. To a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. In reasonable anticipation of death, for cadaveric organs, eye or tissue donation purposes.

Research: To researchers when research has been approved by an institutional review board that has reviewed the research proposal and established protocol to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, or if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority which you are a member of that foreign military services. (4) To authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' compensation: As authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: If you are an inmate of a correctional facility and our physician created and received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you, 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 et al.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise your rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician uses for making decision about you. (A charge may be imposed for copies)

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; 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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Official if you have questions about access to your medical records.

You have the right to request a restriction of your protected health information: This means you may ask us to not use or disclose any part of your protected health information for the purpose 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 for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply. (you may be responsible for the entire medical cost of services if a restriction to your health care plan is made concerning payment)

Your physician is not required to agree to a restriction(s) that you may request. If the 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. If your physician does agree to the requested restriction(s), we may not use or disclose your protected health information in violation of that restriction(s) unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction(s) with your physician. To request a restriction(s) to your protected health information, please contact our Privacy Official for a Medical Records Restriction Form.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable request. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation of you as to the basis of the request. Please make this request in writing to our Privacy Official.

You may have the right to have your physician amend your protected health information: This means you may request an amendment to protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Official with questions about amending your medical records.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment and healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, a family member or friend involved in your care, or for notification purposes. You have the right to specific information regarding these disclosures, up to six years following records that occurred after April 14, 2003 only. You may request a shorter timeframe. The right to receive this information is subject to certain exception, restriction and limitations.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Office or with the Secretary of Health and Human Services. You may file a complaint with us by requesting a Complaint Form from our Office. We will not retaliate against you for filing a complaint.

You may contact our Office at (850) 474-4777 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003

The Wolff Center for Child and Adolescent Health.
Receipt for The Wolff Center' Notice of Privacy Practices.

The Wolff Center is required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 to provide each patient and his/her legal representative a Notice of Privacy Practices. We appreciate your cooperation in signing below to fulfill the requirement.

I, _____ acknowledge receipt of The Wolff Center for
(Parent/Guardian Name)
Child and Adolescent Health's Notice of Privacy Practices on behalf of

_____.
(Patient Name)

_____ _____
(Parent/Guardian Signature) (Date)

Patient Name: _____
Date of Birth: _____

This form will be filed in the patient's medical record.

THE WOLFF CENTER FOR CHILD & ADOLESCENT HEALTH

Release of Medical Information Authorization for Medical Care and Treatment, Financial Agreement & Assignment of Benefits

Patient Name: _____
Date of Birth: _____
Gender: _____

(A) RELEASE OF MEDICAL INFORMATION I acknowledge that records concerning the patient are the property of The Wolff Center for Child & Adolescent Health and are maintained for the use and benefit of The Wolff Center for Child & Adolescent Health to disclose all or any part of my patient record to my admitting physician, consulting physician(s), and to hospital-based physicians. I further authorize The Wolff Center for Child & Adolescent Health and all providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to The Wolff Center or to me or a family member of mine, for all or part of The Wolff Center's charges, including but not limited to hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

(B) ASSIGNMENT OF INSURANCE BENEFITS I assign payment of all insurance benefits for services to be made directly to The Wolff Center for Child & Adolescent Health as appropriate.

(C) FINANCIAL AGREEMENT For and in consideration of services rendered, each of the undersigned agrees to pay The Wolff Center for Child & Adolescent Health for all charges not covered by insurance payments as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services or treatment rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by The Wolff Center including reasonable attorney's fees which shall include, but not limited to, such fees incurred prior to institution of litigation or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statutes 222.11, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of a family which are greater than $500 per week garnished.

(D) STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT I request payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in The Wolff Center for Child & Adolescent Health, including physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

(E) STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT I request that payment of authorized Medigap benefits be made either to me or on my behalf to The Wolff Center for Child & Adolescent Health for any services furnished me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits or the benefits payable for related services.

(F) AUTHORIZATION FOR MEDICAL CARE AND TREATMENT

1.I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, and diagnostic procedures by The Wolff Center for Child & Adolescent Health and medical and professional staffs, employees and agents and as deemed necessary.

2, I authorize my physician, as provided by law, to furnish medical or surgical treatment, x-ray diagnosis or therapy and administration of anesthesia as he considers necessary and proper in the treatment of the patient, for the purpose of correcting the patient's condition and dispose of any tissue removed.

3.I am aware that the practice of medicine and surgery, and administration of medical care, are not exact sciences, and I acknowledge that no guarantees have been made to me an to the result of diagnostic procedures, surgical procedures, medical procedures, treatments, examinations or care undertaken in The Wolff Center Child & Adolescent Health.

4.If in the course of my medical care, a healthcare worker is exposed to my blood, I give consent for a sample of my blood to be tested for HIV antibodies. I will be notified of the results.

5. NEWBORN PATIENT ONLY I voluntarily consent to and authorize The Wolff Center for Child & Adolescent Health and the Physician assigned, to furnish to my newborn infant such diagnostic procedures and hospital care, and medical, surgical, x-ray, or other treatment by the Physician assigned, his assistants, or his designees, as is necessary in the judgment of the Physician.

6. I am aware that The Wolff Center for Child & Adolescent Health and medical and professional staffs, employees and agents provide services based on what is recommended by The American Academy of Pediatrics. This is not a guarantee of payment by your insurance company. It is the responsibility of the patient/guardian to understand your policy. If you have any question about covered services, please contact your insurance carrier.

I have read this form and have been given the opportunity ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

_____	_____	_____
PRINT NAME OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE

_____	_____
WITNESS	DATE

The Wolff Center for Child & Adolescent Health, L.L.C.
Office Policies

Patient Name: _____ Date of Birth: _____

Appointment Cancellation/No-Show Policy

- For the health of your child and the health and convenience of others, it is important to keep scheduled appointments. If you are unable to keep an appointment, please call our office as soon as possible, so that we may offer that time to another child.
- There is a $25.*00 no-show fee* for all missed appointments or same day appointment cancelations. This fee must be paid prior to scheduling your next appointment. Multiple no showed or late arrivals for appointments could result in dismissal from the practice.

Financial/Insurance Policy

- Prompt payment allows us to control costs. Outstanding accounts cost us both time and money. All co-pays and/or percentages not covered by insurance are due at the time of service. Any balance on the account is due before the next appointment or within 30 days from your statement.
- We will file your insurance claims upon receipt of your insurance card. Notify us of any & all insurance policies as insurance companies have rules on filing and miss information by you may result in unpaid or denied claims which will then become patient responsibility.
- Please be aware that your insurance policy is an agreement between you and your insurance company. It is your responsibility to remit payment for charges not covered by your insurer. If a problem occurs with your claim, you will be responsible for the balance in full and it will be your responsibility to resolve the matter with your insurance company. If you have any questions or concerns regarding your insurance plan, please contact your insurance company.
- It is your responsibility to know what your insurance benefits are, i.e. deductibles, well coverage, vaccines, behavior (ADHD), etc. We are not in network for any behavioral health policies and some insurance companies will process a diagnosis of ADHD or anything related to behavior or education to your behavioral health benefits and you may incur more than just a regular medical visit balance. It is very important that you review your policy before you receive services. We diagnose based on information provided by the parent, the child and physical exam, we do not diagnose based on what insurance covers.
- Please understand that our office *estimates* the expected payment by your insurance company. All claims are subject to medical necessity and any exclusion on your contract. Payment on claims is determined by your insurance company at the time the claim is received.

Prescriptions or other health related forms

In order to prevent your child from being without their medication, it is your responsibility to request prescription refills in advance. We recommend that you request prescriptions through our secure patient portal or call our office and leave a message on our prescription line to request your child's refill 1 week prior to running out of medication. Once your message is left, we will have your prescription or request ready for pick up at the front desk or if applicable electronically sent to your pharmacy after 48 hours (excluding weekends and holidays). We will not call to notify you that the request has been fulfilled, however if requested through our secure patient portal you will receive notification by the portal.

Controlled substances can not be called in and will require a printed/written prescription. This policy will be strictly enforced.

Return Check Policy

When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee ($25.00-$40.00 as allowed by law in the state of Florida) through electronic fund transfer from your account if your payment is returned unpaid. In the event that there is a second returned check, you will then be required to pay by other means (cash or credit card) for future visits.

Thank you in advance for your cooperation. Your signature below acknowledges you have read and understand the above policies and agree to abide by the provisions of this policy:

_____ _____ _____

PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE DATE

The Wolff Center for Child & Adolescent Health

- **The Wolff Center does not file any Medicaid or Florida Healthy Kids product as a secondary insurance policy.** This includes, but not limited to Medicaid, Medipass, Humana Medicaid, United Health Care Community Plan or any other Medicaid or Florida Kid Care plans.

- If your child has additional insurance other than Medicaid, Humana Medicaid, Medipass, United Health Care Community Plan or any other Medicaid or Florida Kid Care plans; you are required to provide us with that information.

- If we are notified by Medicaid or by another source that your child has other insurance, even if you were not aware of it, that other insurance coverage will be billed instead. Should your primary insurance deny any charges or leave any copayment, co-insurance or deductible the balance will be your responsibility.

- Please be aware that any state funded insurance plan is always your secondary policy, i.e: Medicaid, Florida Kid Care, Tricare, CMS. Therefore, please provide our office with all insurance plans your child has and keep us informed of any changes.

- The Wolff Center will not file your Medicaid/Florida Kid Care if we are not assigned as your primary care physician. The Wolff Center does not bill Healthease, Vista or Medically Needy, as we do not participate with these programs, you will be responsible for all charges. It is your responsibility to know what plan your child is assigned to and who the primary physician is, if you do not know this information, you may contact your case manager or insurance company for assistance.

I have read all of the above information, have had the opportunity to ask questions and understand my responsibilities as stated above.

Patient Name: _____ Date of Birth: _____

_____ _____
(Parent/Guardian Print) (Relationship)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Office Representative/Witness) (Date)

The Wolff Center for
Child & Adolescent Health

AUTHORIZATION FOR TREATMENT OF MINORS

I, _____, being the parent or legal guardian of the following
(Parent/Guardian Name)

minor, _____ _____
(Patient full legal name) (Date of birth)

and having the legal right to consent for medical treatment for the above named minor, do herby assign this right of consent to:

_____, _____, _____
(Name) (Relationship to patient) (Phone #)

_____, _____, _____
(Name) (Relationship to patient) (Phone #)

_____, _____, _____
(Name) (Relationship to patient) (Phone #)

for the period beginning _____, 20___. This consent will be active until we
(Date)
are notified in writing or a new authorization is signed.

_____ _____
(Signature of parent/guardian) (Date)

_____ _____
(Witness) (Date)