1530 East Airport Blvd.
Pensacola, FL 32504

850-474-4777
www.wolffcenter.com

Welcome to **The Wolff Center for Child & Adolescent Health**. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

For your child's initial visit, we require the following:

1. The legal parent or guardian must be present with the patient at this visit.
2. Arrive 15 minutes prior to your scheduled appointment time.
3. Bring the patient's insurance card to the appointment.
4. Bring a copy of the patient's updated shot record.
5. Legal parent or guardian must complete the enclosed New Patient Forms and the Behavioral/Medical History Survey (if applicable). **This packet must be completed upon your arrival or the appointment will be rescheduled**.

Your appointment is schedule on ________/_____/______ at _________AM/PM. If you are unable to keep this appointment, please call our office with 24 hours notice to prevent losing your deposit.

Welcome to our practice and thank you for choosing **The Wolff Center for Child & Adolescent Health** for all your health care needs.

Sincerely,

The Wolff Center Staff

ADHD Patients

Dr. Wolff has a strict policy on ADHD medication refills.

- **If your child has not had their follow up appointment as recommended, your child's medication will not be refilled.**
- **Please schedule ADHD follow up appointments before you leave the office. The schedule is booked for approximately 3 – 4 weeks in advance for routine appointments.**
- **Please request prescriptions 48 - 72 business hours in advance by leaving a message on the refill line (option 3) or for a faster response requests can be made through the patient portal.**
- **Be sure to understand your health insurance plan and how it pertains to your child's treatment for ADHD. i.e., Behavioral Health benefits. If you have any questions, please notify one of our staff members.**

Thank you for your cooperation!

BEHAVIORAL/MEDICAL HISTORY

Name:___________________________________ DOB:____________ Age:_______ Date:____________

What is your concern?

____

____

Circle areas of concern:

health problem	risk taking	unhappy at school	test taking	speech
absenteeism	peer relations	motor skills	homework	reading
motivation	immaturity	attention	completing work	writing
disobedience	self-esteem	distractibility	copying from board	spelling
inappropriate sounds	anger control	inconsistent performance	retaining information	math
inappropriate movements	hyperactivity	disruptive behavior		

Primary Physician: _________________ **Current School**:______________________ **Grade**:_____

School Performance: (circle only one) Great Good Average Poor Failing

When did problems begin? ____

Y **N** Has child been retained? What grade? _________________________

Y **N** Has child had IEP/504 evaluation?

Y **N** Special education classes? What classes? _____________________

Y **N** Currently tutored? What classes?____________________________

Past Medical History:

Y **N** Chronic illness? ____

Y **N** Previously diagnosed ADHD?
When? ____________________
By whom? ____
Any medicines tried? __________________________________

Y **N** Currently taking medication? __________________________________

Y **N** Heart defect/heart problems? _________________________________

Has your child ever had the following?

Y **N** head injury **Y** **N** near-drowning **Y** **N** poisoning **Y** **N** seizures

Y **N** vision problem **Y** **N** hearing problem **Y** **N** headaches

Y **N** meningitis or encephalitis **Y** **N** stomachaches **Y** **N** tics/repetitive movement

Birth History:

Y N Did the mother have problems with the pregnancy? What were they?____

Y N Use of recreational drugs or alcohol during the pregnancy? _______ ____

Y N Did the mother have any depression during or after the pregnancy?

Y N Was the child full term?

Y N Did the child cry and have good color after delivery?

Y N Has the child developed normally?

Has the child had any problems with the following?

Y N bed wetting
Y N snoring
Y N stool soiling
Y N temper outburst
Y N mood changes
Y N destructiveness
Y N sleep problems
Y N cruelty to animals
Y N self injury
Y N stealing
Y N anxiety
Y N depression
Y N lying
Y N getting along with peers
Y N fire setting

Family History:

Is there anyone in the family with the following problems? (M=mother F=father S=sibling, etc)
ADHD________________________ depression_______________________ OCD_____________________

alcoholism ___________________ school problems _________________ bipolar _________________

Tourette's syndrome ________________ drug addiction ______________________________

Any close family member with prolonged QT syndrome, congenital heart defect or sudden cardiac death before the age of 40? ____

Social History:

Extracurricular activities: ____

With whom does the child live? ____

____

Has there been a major stress in your child's life?

Y N Divorce? When? _______________

Y N Serious illness or death of a loved one? Who? ____________ When? _________

Y N Traumatic events? What and when? _____________________________________

Y N Experienced sexual or physical abuse? ______________________________ ____

Y N Are there any future foreseeable stressors? ___________________________ ____

Other areas not addressed:

The Wolff Center for Child & Adolescent Health
Patient Demographics

PATIENT INFORMATION			
Last name:	First:		MI:
DOB:	Gender: ☐Male ☐Female		Primary phone:
Primary street address: City:	State:		ZIP Code:
Language: ☐English ☐ French ☐ Spanish ☐Vietnamese	Ethnicity: ☐Unknown ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline to answer	Race: ☐American India/Alaskan Native ☐Asian ☐Black ☐Hawaiian Native/Pacific Islander ☐White ☐Decline to answer	Custody (if applicable): ☐Joint ☐Custodial parent is mom ☐Custodial parent is dad ☐Legal Guardian
Referred to clinic by:		Previous Physician:	

MOTHER'S INFORMATION		
Full name:		
SSN:	DOB:	Email:
Address (if different from patient):		Home phone:
		Work phone:
		Cell phone:

FATHER'S INFORMATION		
Full name:		
SSN:	DOB:	Email:
Address (if different from patient):		Home phone:
		Work phone:
		Cell phone:

STEP-PARENT(S)/EMERGENCY CONTACT INFORMATION (IF APPLICABLE)		
Stepmother:	Contact no.:	Resides with: ☐Yes ☐No
Stepfather:	Contact no.:	Resides with: ☐Yes ☐No
Emergency contact name:	Emergency contact no.:	Relationship to patient:

INSURANCE INFORMATION				
	Insurance company:	Subscriber's name:	DOB:	Relationship to patient:
Primary:				
Secondary:				

______ (*initial*) 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, and CMS.

______ (*initial*) 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 Print Name	***Signature***	***Date***

Patient name:	DOB:	Gender: ☐Male ☐Female

BIRTH HISTORY

Hospital:	Birth weight:

Delivery:	Use during pregnancy:	Complications:	Nursery problems:
☐C-section	☐Alcohol	☐Infection	☐Jaundice
☐Vaginal	☐Cigarette smoking	☐High blood pressure	☐Infection
☐Full term	☐Illegal drugs	☐Anemia	☐Breathing
☐Premature	☐Medications:	☐Diabetes	☐Feeding
Wks gestation: ______	____________________	☐Bleeding	☐Other: ____________
	____________________	☐Other: ____________	

MEDICAL HISTORY

Approx. age	Surgery/Procedures (if applicable):
________	Circumcision
________	Tonsillectomy
________	Adenoidectomy
________	Appendectomy
________	Ear surgery (specify type): ____________
________	Hernia (specify type): ______________
________	Other: __________________________

Medication allergies:

Other allergies:

Approx. age	Hospitalizations for illness (excluding previous listed surgeries):
________	Specify: ____________________________
________	Specify: ____________________________

PATIENT & FAMILY HISTORY

Have the patient or any relatives had any of the following (mark "PT" for patient or indicate what relative):

________	ADD/ADHD	________	Brain damage	________	Kidney disease
________	Allergies/hay fever	________	Diabetes	________	Seizures
________	Anemia	________	Heart disease	________	Sickle cell trait/disease
________	Asthma	________	Hepatitis	________	TB
________	Birth defects	________	High blood pressure HIV/	________	Intellectual Disability
________	Blood disorders	________	AIDS	________	Other:______________
________	Cancer/Leukemia	________	Immune deficiency		

SOCIAL HISTORY

Siblings (name and DOB):

Others living in the household:

Daycare/school :	Type of house: ☐Apartment ☐House
Grade:	☐Trailer ☐Other: ____________
Pets:	Are there smokers in the household? ☐Yes ☐No
Sports:	Are there guns kept in the home? ☐Yes ☐No

TEENS

	GIRLS!
Do you use: ☐Alcohol ☐Cigarettes ☐Drugs	Have you had your first menstrual period? ☐Yes ☐No
Are you sexually active? ☐Yes ☐No	If yes, what age?
Favorite class:	Date of last menstrual period?

Hobbies/interests:

Job:

______________________	______________________	______________
Parent/Guardian Print Name	***Signature***	***Date***

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

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received The Wolff Center's Notice of Privacy Practices.

This Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for The Wolff Center.

______________________________	______________________________
Patient's Printed Name	Patient's Date of Birth
______________________________	______________________________
Parent/Guardian Printed Name	Relationship to Patient
______________________________	______________________________
Parent/Guardian Signature	Date

____
Printed Name of Staff Member

______________________________	______________________________
Signature of Staff Member	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)

PATNO:_______

Authorization for Release of Medical Records

Patient Name:______________________________________DOB:______________
Address:____
City:______________________________ State:__________ Zip:____________
Phone:_____________________________ Other:_______________________

I do hereby authorize the facility/provider specified below to disclose/release information from my health care record.

DISCLOSE/RELEASE FROM:

Facility Name:____
Address:____
City:______________________________ State:__________ Zip:____________
Phone:_____________________________ Fax:_________________________

DISCLOSE/RELEASE TO:

The Wolff Center for Child & Adolescent Health
1530 Airport Blvd
Pensacola, FL 32504
Phone: 850-474-4777 Fax: 850-484-2656

This request and authorization applies to:

- ☐ Entire Medical Record
- ☐ Immunization Record
- ☐ Imaging/Radiology Results
- ☐ Lab Results
- ☐ History/Physical (most recent)
- ☐ Psychological Evaluation/Consults
- ☐ Psychotherapy Notes/ADHD
- ☐ Other:_________________

Reason for request:

- ☐ Personal Use
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Specialist/Continued Care
- ☐ Transfer to new Physician
  Reason:_________________
  ____
- ☐ Other:_________________

I understand that any drug abuse, alcohol abuse, sexually transmitted disease, HIV/AIDS, psychotherapy or mental health related information, if present, will be disclosed with this authorization unless excluded here:____

I understand that I may revoke this authorization, in writing, at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization will remain in effect for 90 days in order to execute the purpose for which it is given unless earlier revoked in writing.

Signature of Legal Guardian:______________________________Date:____________

Print Name of Legal Guardian:_____________________________Date:____________

Signature of Witness:____________________________________Date:____________

Wolff Center Behavioral Health Medication Management Agreement

The purpose of this form is to ensure a collaborative agreement with The Wolff Center to provide safe and responsible medication management in accordance with ALL government regulatory agencies and policies. This form will be attached to the patients account, and you will be provided with a copy. Please initial beside each statement, indicating you agree to, and understand each.

_____ Some medications require routine blood monitoring. I agree to obtain such lab work as requested by my child's provider. I will inform my child's provider of medications or supplements prescribed by other providers.

_____ I will administer the medication(s) to my child as prescribed & will not change dosage or time without consulting with my child's provider. I will keep medications safe, secure, & out of reach of children. I will NOT share, sell, or trade medications.

_____ ALL MEDICATION CHANGES REQUIRE AN APPOINTMENT. *This includes medication increases, decreases, & boosters.

_____ I understand that if a medication or written prescription is lost, it will not be replaced until the next appointment, appropriate refill time, or may not be replaced at all. I also understand that stolen prescriptions will require a police report in order to be replaced.

_____ Prescription refills should be requested no sooner than one full week (7 days) prior to refill date. *Allow 2 business days to process request. *Afterhours requests are not permitted.

_____ I understand prescription renewals and refills are contingent upon keeping scheduled appointments. ***If a follow-up medication management appointment is missed, I will NOT be approved for a renewal or refill until the next appointment has been completed. *No-show or same day cancellation fee is $25, which must be paid prior to scheduling another appointment.

_____ I understand the importance of keeping scheduled appointments & arriving on time. *Three missed appointments, including same day cancellations, will result in transferring of behavioral services outside of The Wolff Center.

_____ I understand that it is MY responsibility to make sure that I have scheduled my child's next follow-up appointment. Additional prescriptions will not be given due to lack of scheduling in advance.

_____ I understand that all financial obligations must be fulfilled prior to scheduling an appointment. Claims are sent to insurance plans as a courtesy. Non-payment/slow-payment by my health plan is ultimately patient/parent responsibility.

_____ I understand that I may lose my right to treatment at The Wolff Center if I break any part of this agreement.

______________________________	________________________	____________________________
(Patient Name – PRINT)	(Relationship to Patient)	(Parent/Guardian PRINT)
______________________________	________________________	____________________________
(Patient Date of Birth)	(Today's Date)	(Parent/Guardian Signature)