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: ☐C-section ☐Vaginal ☐Full term ☐Premature Wks gestation: _____	Use during pregnancy: ☐Alcohol ☐Cigarette smoking ☐Illegal drugs ☐Medications: _____ _____	Complications: ☐Infection ☐High blood pressure ☐Anemia ☐Diabetes ☐Bleeding ☐Other: _____	Nursery problems: ☐Jaundice ☐Infection ☐Breathing ☐Feeding ☐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 ☐Trailer ☐Other: _____
Grade:	
Pets:	Are there smokers in the household? ☐Yes ☐No
Sports:	Are there guns kept in the home? ☐Yes ☐No

TEENS

Do you use: ☐Alcohol ☐Cigarettes ☐Drugs	GIRLS!	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)