Gainesville Pediatric Associates
Financial Agreement

- It is the policy of our office to collect co-payment/coinsurance/deductible at the time that services are rendered. Any amount due at the time of service that is not collected will be assessed at a $10.00 billing fee. We accept cash/Visa/Mastercard/Discover/American Express. We also accept personal checks, however if a check is returned by the bank, there will be a $25.00 check return fee.
- For all services rendered to minor patients, we will ask the adult accompanying the patient or the parent/guardian for payment. We will not get involved in arrangements made between divorced parents or custodial agreements.
- Any services that are deemed to be the family's responsibility (additional copay, co-insurance, deductibles, or services considered non-covered by your insurance) will be applied to patient balance and will be due immediately.
- Any services that we file with your insurance that are not reimbursed after 30 days from the date of service may be transferred to patient balance. This balance will remain the responsibility of the family until payment is received or written correspondence is received by the insurance company verifying that payment is forthcoming from them. Any balances not paid in full within 90 days will be forwarded to the collection agency unless prior arrangements have been made. Appointments will not be scheduled until the balance has been paid in full or an approved payment arrangement has been made.
- We must have your child's insurance card or written verification from your insurance company that your child is currently eligible for benefits no later than the 1-month checkup. If you do not have this available, then the visit will need to be paid in full or payment arrangements must be made regarding the previous balance. Any credit amounts will be refunded to you once insurance information is received and dates of services are paid by the insurance.
- If we do not participate in your insurance plan, we ask that you pay in full at the time of services are rendered. We provide families without health insurance a private pay discount.
- **APPOINTMENTS**- As a courtesy, we allow 15 minutes for your tardiness. After 15 minutes, we reserve the right to either fit you in as a walk in or reschedule your appointment. We have a reminder policy where all scheduled patients are called 1-2 business days prior to their appointment to confirm that they will be attending. Please remember that these calls are merely a courtesy. You are solely responsible for keeping your child's appointment. We do not double book appointments. Therefore, if you do not call to cancel a scheduled appointment or call in a timely matter before your appointment, you create a vacancy in our schedule which would have been otherwise filled by another patient. We expect at least a 2-hour notice for cancelling an appointment, although 24 hours is more helpful. It is our policy to charge a $25.00 no show fee for each missed appointment. Furthermore, our office may ask that you seek medical care elsewhere after 3 no show appointments.

I have read and understand the financial agreement of the practice and I agree to be bound by its terms.

Patient(s) Name(s): _____

Parent/Guardian Signature: _____

Gainesville Pediatric Associates
Preventative Medicine Visits

A preventative medicine service includes: a comprehensive history and a thorough physical examination. It is a time to evaluate each patient for areas of reduction of risks to their health and to provide guidance. It is a time to order appropriate immunizations, screening tests, and laboratory (blood) tests to aid in disease prevention and health maintenance. Insignificant problems may also be managed at a preventative medicine visit.

There is no significant medical decision making at a preventative medicine service. It is not a problem-oriented medical service. The examination is multi-system but based on a patient's age, gender, and identified risk factors.

In accordance with the Affordable Care Act, most commercial health insurance now provides coverage of preventative medicine with decreased patient financial responsibility. In fact, preventative medicine is often 100% covered by insurance.

If at the time of a preventative care appointment, a patient has specific acute medical problems or if there is a need for management of chronic medical disease states, there will also be an evaluation and management charge. This is a legal agreement between your physician and your health insurance provider.

If evaluation and management of medical problems occurs at the same visit as preventative medicine, you will have a co-pay or possible deductible and a potential balance of financial responsibility.

Many physicians have patients come on a different day for evaluation and management of specific medical problems. At Gainesville Pediatric Associates, as a convenience to our patients, you may usually obtain both types of appointments at the same visit.

Patient Name: _____ Date of Birth: _____

Name of Responsible Party: _____ Date: _____

Signature of Responsible Party: _____

Gainesville Pediatric Associates
Permission to Treat

I, the parent/legal guardian of the below named child:

_____ Date of birth _____
Print child's name

Hereby authorize and consent to the examination and/or treatment of my child/children during office and facility visits by the physicians and clinical staff of Gainesville Pediatric Associates, Inc. In addition, I give permission for the following person(s) to bring my child to Gainesville Pediatric Associates, Inc. in my absence and to act on my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the physicians and staff of Gainesville Pediatric Associates, Inc. will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, Gainesville Pediatric Associates, Inc. will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I (we) authorize the following people to bring my child/children in for treatment:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Printed name (parent/guardian): _____

Gainesville Pediatric Associates
New Patient Medical Information Form

Date: _____
Patient Name: _____ Sex (circle one) M F Date of Birth: _____
Ethnicity: _____
Parent(s)/Guardian(s) Name: _____
How did you hear about us: _____

Child's Medical History

Child's previous Doctor:
_____

Has your child ever had:
Allergies (please list) ____NO ____YES
_____

Asthma Action plan:
_____

Asthma/Wheezing ____NO ____YES
Pneumonia ____NO ____YES
Chicken pox (year_____) ____NO ____YES
Frequent Ear infections ____NO ____YES
Vision Problems ____NO ____YES
Hearing Problems ____NO ____YES
Skin Problems/Eczema/Hives ____NO ____YES
Seasonal Allergies ____NO ____YES
Seizures/Epilepsy ____NO ____YES
High Blood Pressure ____NO ____YES
Heart Defects/Disease ____NO ____YES
Liver Disease ____NO ____YES
Diabetes ____NO ____YES
Kidney Disease ____NO ____YES
Bladder Infections ____NO ____YES
Physical or Learning Disabilities ____NO ____YES
Bleeding Disorders/Hemophilia ____NO ____YES
Sexually Transmitted Infections ____NO ____YES
Emotional/Behavior Problems ____NO ____YES
Depression/Suicidal Thoughts ____NO ____YES
Hospitalizations/Surgeries ____NO ____YES
Physical/Sexual/Emotional Abuse ____NO ____YES
Bone or Joint Injuries ____NO ____YES
Dental Problems ____NO ____YES
Obesity/Overweight ____NO ____YES
Eating Disorders ____NO ____YES
Sleep Problems ____NO ____YES
Attention Deficit Disorder ____NO ____YES
Lead Poisoning ____NO ____YES
Vaccines Up To Date ____NO ____YES

Other Concerns: _____
_____

Current Medications: _____
_____

Family Medical History

Has any parent(P), grandparent(GP),aunt(A), uncle(U), sister(S) or brother(B) had:

Severe Food Allergies ____NO ____YES Who? ___
Asthma/Wheezing ____NO ____YES Who? ___
TB/Lung Disease ____NO ____YES Who? ___
Cystic Fibrosis ____NO ____YES Who? ___
Genetic Disorders ____NO ____YES Who? ___
Migraines ____NO ____YES Who? ___
Heart Disease ____NO ____YES Who? ___
Sudden Cardiac Death ____NO ____YES Who? ___
High Blood Pressure ____NO ____YES Who? ___
Stroke ____NO ____YES Who? ___
High Cholesterol ____NO ____YES Who? ___
Blood Disorders ____NO ____YES Who? ___
Sickle Cell ____NO ____YES Who? ___
Anemia ____NO ____YES Who? ___
Thalassemia ____NO ____YES Who? ___
Clotting Disorders ____NO ____YES Who? ___
Diabetes ____NO ____YES Who? ___
Seizures ____NO ____YES Who? ___
Mental Illness ____NO ____YES Who? ___
Depression ____NO ____YES Who? ___
Suicide Attempts ____NO ____YES Who? ___
Breast Cancer ____NO ____YES Who? ___
Cervical Cancer ____NO ____YES Who? ___
Colorectal Cancer ____NO ____YES Who? ___
Other Cancer ____NO ____YES Who? ___
Birth Defects ____NO ____YES Who? ___
Hearing Loss ____NO ____YES Who? ___
Speech Problems ____NO ____YES Who? ___
Kidney Disease ____NO ____YES Who? ___
Alcohol/Drug Abuse ____NO ____YES Who? ___
Hepatitis/Liver Disease ____NO ____YES Who? ___
Irritable Bowel Syndrome ____NO ____YES Who? ___
Thyroid Disease ____NO ____YES Who? ___
Crohn's Disease ____NO ____YES Who? ___
Ulcerative Colitis ____NO ____YES Who? ___
Attention Deficit Disorder ____NO ____YES Who? ___
Mental Retardation ____NO ____YES Who? ___
Family Violence ____NO ____YES Who? ___

Has a family member ever had an unexplained, unexpected death before age 50? _____ **If yes describe - additional information**

Pregnancy and Birth History

Adopted ___NO ___YES
Prenatal Care ___NO ___YES
Illnesses during pregnancy ___NO ___YES
_____
Medications during pregnancy ___NO ___YES
_____
Alcohol/Drug Abuse ___NO ___YES
Tobacco Abuse ___NO ___YES
Problems at birth ___NO ___YES
Mom: Miscarriage ___NO ___YES
Baby: Jaundice ___NO ___YES
Heart Murmur ___NO ___YES
Infection ___NO ___YES
Breathing Problems ___NO ___YES
Birth Defects ___NO ___YES
Other: _____

Name of Hospital: _____
Week of gestation when child was born: _____
Type of delivery: ___Vaginal ___C-Section
___VBAC
Birth Weight: _____ Discharge Weight: _____
Newborn Hearing Screen ___NO ___YES
Did baby receive Hep B vaccine ___NO ___YES
Date of Hep B vaccine: _____

Feeding and Digestion

Breast Fed_____ Formula _____
Severe colic in first 3 months ___NO ___YES
Feeding Problems ___NO ___YES
Good appetite ___NO ___YES
Vitamins or other supplements ___NO ___YES
Eats balanced diet ___NO ___YES
Constipation problems ___NO ___YES
Food allergies/ issues ___NO ___YES

Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Psychosocial History

Who lives in household: _____
_____
Pets: _____
Water Source: _____
Who cares for child: _____
Is child in daycare ___NO ___YES
If in school… Grade: _____
Exercise/Sport: _____
TV use per day: _____
Dentist: _____

Parent 1: _____
DOB: _____
Occupation: _____
Parent 2: _____
DOB: _____
Occupation: _____
Are parents divorced or separated ___NO ___YES
Tobacco use in household ___NO ___YES
Sleep Problems ___NO ___YES
Other languages: _____

Medication allergies (please list): _____
_____
_____
_____

Severe Food allergies (please list): _____
_____
_____
_____

Medical History

Broken Bones ___NO ___YES
Serious Accidents ___NO ___YES
Surgeries ___NO ___YES
Hospitalizations ___NO ___YES
ER visits/Urgent Care ___NO ___YES
Explain: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____