Tampa Pediatric ENT

A Division of Florida Pediatric Associates, LLC

TAMPA OFFICE:
3000 Medical Park Drive, Suite 200
Tampa, FL 33613

WESLEY CHAPEL OFFICE:
26853 Foggy Creek Rd, Bldg 21 Suite 101
Wesley Chapel, FL 33544

PATIENT RIGHTS & RESPONSIBILITIES

You have a right:

- To be treated in a manner that recognizes your need for privacy and dignity.
- To be informed of your diagnosis, or treatment options in terms you can understand.
- To be informed about recommended treatment and alternative treatments and to be advised of the potential outcomes of each treatment.
- To refuse treatment and be advised of the probable consequences of your decision.
- To schedule a time to inspect your medical record, and to receive copies of requested pages at a nominal charge for photocopying.
- To request that your medical record be corrected or amended. If your doctor believes the record is accurate and complete, you have a right to include a statement of disagreement in your medical record. To limit access to your medical record without written consent except to health care providers, payers and law enforcement.
- To participate in making decision about your health care.
- To file a grievance with the Department of Health and Human Services.

You have a responsibility:

- To provide all medical history, including past care, illnesses, and mediations to your doctor, so the best treatment plan can be determined.
- To provide accurate health insurance information, and to inform the office of any changes in coverage
- To inform the office if you have more than one insurance coverage.
- To know the proper use of your insurance, and how to obtain covered services, and to follow the rules of your plan.
- To keep scheduled appointment, or to provide adequate notice to us if you are delayed or need to cancel.
- To pay co-payments, deductibles, and non-covered services.
- To ask questions about your care until you fully understand.
- To follow the advice of your doctor, and to inform the doctor if you refuse to comply with the medical advice given
- To be courteous to the other patient, families and office staff.

TAMPA PEDIATRIC ENT

OFFICE (813) 972-3353 FAX (813) 978-3667

Florida law provides that State agencies, including Tampa Pediatric ENT, must notify individuals of the circumstance that would require collection of social security numbers.

The following are the general scenarios under which Tampa Pediatric ENT must collect and use social security numbers:
Insurance and health benefit eligibility; classification of accounts; customer identification and verification; credit worthiness; customer billing and payments; payroll and human resource functions; benefit processing, tax reporting, and other lawful purpose necessary to conduct Tampa Pediatric ENT business.

Social Security numbers are NOT public records, but may be released to other governmental or commercial entities as required by law in Section 119.071(5), Florida Statutes.

TAMPA PEDIATRIC ENT
OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of you and/or your child's treatment. Please understand that payment of your bill is considered part of our treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

REGARDING INSURANCE

Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your first office visit in full. We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full with 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

SURGERY

We will ask you to pay 100% of any outstanding deductible prior to surgery. This is due no later than 3 days prior to surgery. Any refunds due to you will be sent 7-10 days after you have incurred the refund.

We bill secondary insurance carriers as a courtesy to our patients.

USUAL AND CUSTOMARY CHARGES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

INTEREST

We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

MINOR PATIENTS

The adult accompanying a minor and the parents 9 or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $30.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

If you bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $25.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

BILLING QUESTIONS

Please address all billing questions to Fountainhead Practice Management Solutions, LLC at 727-456-3288 or toll free 866-343-3288.

COLLECTIONS

You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for a all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

_____ _____

Signature of Responsible Party Date

_____ _____

Witness Date

Account#_____

Tampa Pediatric ENT

A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ SS#: _____-_____-_____ Sex: Male ___ Female ___

Address: _____ City: _____State: _____Zip: _____ Phone#: (____)_____

Race: □ African American/Black □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □Hispanic □Non-Hispanic □Declined

Other family members treated here:_____

Primary Care Physician: _____ Phone#: (_____) _____-_____

Pharmacy :_____ Pharmacy Phone: (_____) _____-_____

Email:_____

Preferred Method of contact: □ Email □ Mail □ Home Phone □ Cell Phone □ Text Message

Whom may we thank for referring you:_____

PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has legal Custody of the Patient: ( )Parents ( )Mother Only ( ) Father Only ( ) Foster Parent ( ) Grandparent ( ) HRS/Other

****IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT****

Mother/Guardian's name: _____ DOB: _____/_____/_____ SS#: _____-_____-_____

Address: □Check here if same as above

_____ City: _____State: _____Zip: _____

Home #: (_____)_____-_____ Cell#: (_____)_____-_____ Work#: (_____)_____-_____

Occupation:_____Employer_____ Employer Address_____

Father/Guardian's name: _____ DOB: _____/_____/_____ SS#: _____-____-_____

Address: □Check here if same as above

_____ City: _____State: _____Zip: _____

Occupation:_____Employer_____ Employer Address_____

Home #: (_____)_____-_____ Cell#: (_____)_____-_____ Work#: (_____)_____-_____

Preferred Language:_____ Preferred method of contact: Email Phone Cell Phone Text

EMERGENCY CONTACTS

#1. Name: _____ Relationship: _____ Phone#: (____) _____-_____

#2. Name: _____ Relationship: _____ Phone#: (____) _____-_____

Apr-13

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy#_____Group#_____

Policyholder's Name: _____ Date of Birth_____

Policyholder's SS#:: _____ Relationship to patient: _____

Claims Address: _____ City: _____State: _____Zip: _____

Eligibility Phone# (_____) _____-_____

Secondary Insurance Carrier: _____ Policy#_____Group#_____

Policyholder's Name: _____ Date of Birth_____

Policyholder's SS#:: _____ Relationship to patient: _____

Claims Address: _____ City: _____State: _____Zip: _____

Eligibility Phone# (_____) _____-_____

ASSIGNMENT OF BENEFITS/ACKNOWLEDGMENTS

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Parent/Guardian Signature_____Date_____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent/Guardian Signature_____Date_____

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE NOTE:
State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect __JULY 1, 2013__ and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Notice of Privacy Practices at any time by contacting our Privacy Officer, _*Lee Ann Atkinson*__. Information on contacting us can be found at the end of this notice.

OUR COMMITMENT TO YOUR PRIVACY
We understand that information about you and your health care is personal. We create a record of the care and services you receive from Florida Pediatric Associates, LLC (FPA) and are committed to protecting that information about you.
We are required by law to 1) Make sure health information that identifies you is kept private. 2) Give you this Notice of our privacy practices. 3) Follow the terms of the Notice that is currently in effect.

ROUTINE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)
(Please note: for the purposes of this document the terms "you" will pertain to the patient and/or legal guardian if appropriate)
TREATMENT: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you. Many of the people who work in our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with the details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you PHI to bill you directly for services and items.
HEALTH CARE OPERATIONS: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may do this, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
APPOINTMENT REMINDERS: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
TREATMENT OPTIONS: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives; or communicate with you regarding the scheduling, ordering or results of tests.
HEALTH RELATED BENEFITS AND SERVICES: Most uses and disclosures of PHI for marketing purposes and disclosures that constitute sale of protected health information require authorization.
RELEASE OF INFORMATION TO FAMILY & FRIENDS: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter or aunt take their child to the doctor for treatment. In this example, this person would have access to the child's medical information; *however this person must be listed on the consent for treatment form in the patient's chart and be able to present valid picture ID at the time they present to our office.*
Additionally, a parent may not speak English fluently and may have an interpreter assist them at the appointment, this person would have access to the child's medical information.
OTHER: Uses and disclosures not described in this NPP will be made only with authorization from you, the individual.

USE AND DISCLOSURE OF YOUR PHI IN SPECIAL CIRCUMSTANCES
DISCLOSURES REQUIRED BY LAW: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law; such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in the case of a medical emergency.

PUBLIC HEALTH: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

HEALTH OVERSIGHT ACTIVITIES: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

LAWSUIT OR SIMILAR PROCEEDING: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

NATIONAL SECURITY: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATIENT

You have the following rights regarding the PHI we maintain about you:

CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. At our discretion, we will accommodate all reasonable requests. You are not required to give a reason for your request.

ACCESS: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit the completed request form. You may contact our Privacy Officer for a copy of this form. Once approved an appointment can be made to review your records, during the process of review no records may be removed from the office. Copies, if requested, *will be $1.00 per page for the first 25 pages and $0.25 per page for every page over 25*. The individual office *may* choose to waive this fee at the discretion of the physician. We will try to accommodate all reasonable requests, however if we deny your request to inspect and/or copy your record you may request a written reason for the denial. You have a right to obtain a copy of your health information within the designated record set maintained in electronic form in electronic format. We will send the electronic form of your health information to you via unencrypted email if you acknowledge the risk of the sending of unencrypted emails.

AMENDMENT: You may ask us to amend your health information if you believe it is inaccurate or incomplete, and you may request that the amendment be in effect for as long as it is maintained by our practice. Your request for an amendment, must be in writing (the appropriate form can be requested from office staff) and must include an explanation of why the information should be amended. We will deny your request if you fail to submit your request with supporting explanation in writing. Also, we may deny your request if you ask us to amend information that is not created by us, or is not part of the medical information maintained by us, or if we find that the information we possess is accurate and complete. If we deny your request you will receive the denial in writing; you have a right to appeal the decision – but it must be done in writing.

RESTRICTIONS: You have the right to request that we restrict the uses or disclosure of your health information for treatment, payment or healthcare operations purposes. We are not required to comply with any other requests for restrictions, but if we do, we will abide by the written agreement (except in the case of a medical emergency). Additionally, you have a right to request that we place additional restrictions on our use or disclosure of your health information to a health plan. Specifically you have the right to request that we restrict the use or disclosure of health information to a health plan (insurance company) for purposes of payment or operations, IF you pay for the service out-of-pocket IN FULL at the time the service is provided. This request MUST be made in writing (the appropriate form can be requested from office staff). This requirement does not apply to disclosures for treatment, such as disclosures to a referring physician for continuation of care. This office is required to comply with any requests that limit disclosures to a health plan when the service has been paid out-of-pocket and in full by the patient. Such restrictions do not override disclosures that are otherwise required by law. Additionally if initial payment for services, that have a request for restriction applied to them, is returned or invalid; our office will make a good faith attempt to collect payment – if this is unsuccessful we have the right to then submit a claim for these services to the health plan.

ACCOUNTING OF DISCLOSURES: All of our patients have the right to request an accounting of all disclosures made. All requests for an accounting of disclosures must be submitted in writing (the appropriate form can be requested from office staff) and include: a time period, that must not exceed 6 years prior to the date of the request and/or be dated prior to April 14, 2003 – as information prior to that date was not required to be tracked. The first list you request within a 12-month period is free of charge. We may charge you for any additional lists requested within the same 12-month period. We will notify you of the costs involved with any additional requests prior to their completion, allowing you to withdraw your request before you incur any costs.

BREACH NOTIFICATION REQUIREMENTS: In the event that unsecured protected information about you is "breached", we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform The Department of Health and Human Services and take any other steps that are required by law.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with our practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit it in writing and to the attention of the Privacy Officer (the appropriate form can be requested from office staff). We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our Notice of Privacy Practices. To obtain a paper copy of this Notice, contact our Privacy Officer in writing.

MINORS AND PERSONS WITH LEGAL GUARDIANS:

Minors and certain disabled adults are entitled to the privacy protection of their health information. Because, by law, they cannot make health decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents and guardians can authorize the use and release of PHI and also hold all rights listed in this notice or the behalf of the minor child or disabled adult.

Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

HOW TO CONTACT US:

Please direct any questions about this Notice to our Privacy Officer at 727-456-4244

Privacy Officer address:
Florida Pediatric Associates, LLC
Attn: Privacy Officer
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

Medical Information Department address:
Florida Pediatric Associates, LLC
Attn: Medical Information Department
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

FLORIDA PEDIATRIC ASSOCIATES, LLC
FOUNTAINHEAD PRACTICE MANAGEMENT SOLUTIONS, LLC
MAY 2013

PERMISSION TO TREAT

I, _____, authorize Tampa Pediatrics ENT and its
(Print name of parent/legal guardian)
personnel to provide medical services such as medical examination and treatment, as they deem best for the child's physical or mental welfare.

_____ _____ _____
(Print child's name) *(Date of Birth)* *(Social Security #)*

I authorize the following person/people to bring my child in for treatment and to discuss any necessary treatments, medications and to even authorize any tests or labs that are necessary up to and including admission to the hospital.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

All of the above will provide identification to be placed in this patients chart

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to biological parents, step parents, referring physicians and other practitioners, and my insurance company.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES*

I have been advised and understand the Notice of Privacy Practices of Tampa Pediatric ENT.

_____ _____
Signature of legal guardian Date

Relationship to patient: _____

FOR OFFICE USES ONLY

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ INDIVIDUAL REFUSED TO SIGN
_____ COMMUNICATION BARRIERS PROHIBITED US FROM OBTAINING
_____ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING
_____ OTHER (PLEASE SPECIFY :_____)

FLORIDA
PEDIATRIC
ASSOCIATES
LLC

Patient Name: _____ Date of Birth: _____

Dear Patient / Parent:

At Florida Pediatric Associates, LLC., we are committed to providing the hightest quality of care to our patients and their families.

As Florida Pediatric Associates, LLC., continues its exciting journey using an Electronic Health Records (EHR) system, we have set goals within our organzation to not only improve the quality, safety and efficiency in patient care, but also engage patients and families, improve care coodination and ensure adequate privacy and security of your / your child's portected health information (PHI).

We are asking all of our patients to take a minute to provide the additional information below. This information will be entered into your child's electronic health record. The usage of this data is to ensure more efficient communication between your medical care Providers. Also, some diseases and conditions are more prevalent in particular racial groups than in others, making this information medically viable.

Thank you in advance for taking the time to provide this information.

	PATIENT'S RACE (Please Check One)
	African American
	American Indian, Alaskan Native
	Asian
	Caucasian
	Native Hawaiian, Other Pacific Islander
	Unknown / Undetermined

	PATIENT'S ETHNICITY (Please Check One)
	Non Hispanic or Latino
	Hispanic or Latino
	Other

Email Address: _____ Preferred Language: _____

TAMPA PEDIATRIC EAR, NOSE & THROAT

Dear Parent / Guardian:

We are pleased to welcome you to our Patient Portal!

Through our Patient Portal, you will be able to do the following:

- Request a medication refill for your child
- View & download your child's medical summary
- Request changes to your child's demographics
- Send and receive secured general messages to the Office
- Send and receive secured messages to our Billing Department
- Send and receive secured messages to our Patient Portal Administrator

To access our Patient Portal, please go to https://portal.fountaindonline.net/tpent. Use your email address for the User ID and the Pin Number from the letter given to you by our office staff for the initial password. Once you're logged in, you will be asked to change your password and answer 2 security questions.

We hope you find our Patient Portal very useful and look forward to communicating with you through this new and exciting tool.

Sincerely,
Tampa Pediatric Ear, Nose and Throat

Child's Name: _____ **Date of Birth:** _____

Florida Pediatric Associates, LLC
Patient Portal Agreement Form

******DO NOT use the Patient Portal for emergencies, CALL 911******

For urgent problems, please call our office at **(813) 972-3353**

The Patient Portal is a secure web portal that allows you as a patient's parent or guardian to access your child's personal health information. It also allows you to communicate with our office via secured messaging. Our Patient Portal Web address is: ***https://portal.fountainheadonline.net/tpent***

Important Information:

- Our hours of operation are **9:00 AM – 5:00 PM Monday – Friday**. We encourage you to use the Patient Portal at any time. However, messages are held for us until we return the next business day.
- Messages are typically handled within two business days. If your Provider is out of the office that day, your request may be held until your doctor returns to the office. You must call our office at **(813) 972-3353** if you have an urgent matter to discuss.
- Staff members other than your Provider may be involved in receiving your messages and routing them to the Provider or other staff personnel to address.
- If you are not receiving emails from us, please check your JUNK email folder before contacting our office.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify our office should your password be stolen.
- We strive to keep all of the information in your child's medical record correct and complete. If you notice information in your child's record that is incomplete or inaccurate, you agree to notify our office immediately by phone or secured message. In addition, you also agree not to provide false or misleading information.
- You agree to not hold Florida Pediatric Associates, LLC or its subsidiaries responsible for any network infractions beyond our control.
- We offer the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your expressed written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

The information on our portal is maintained by Florida Pediatric Associates, LLC. You may contact our Patient Portal Administrator at 727-456-4258 with your questions or concerns (non-patient care related) regarding the patient portal or send a secured message using the link provided on the portal.

I have read, understand and agree to the above information regarding the Florida Pediatric Associates, LLCs, Patient Portal:

Signature: _____

Print Name: _____

Email Address: _____

Portal Registration Completed by: _____ ***Assigned PIN #:*** _____

PEDIATRIC HEALTH QUESTIONNAIRE

PATIENT NAME: _____ **DATE of Visit:** _____

Date of Birth: _____ **Sex:** ___ **M** ___**F** **Age:** _____ **mo/yrs** **Primary MD**: _____

CHIEF COMPLAINT: Please Circle all that apply

Ear Infections – Sinusitis – Snoring – Tonsil and/or Adenoid problems – Hoarseness – Stridor – Tongue Tied – Nose Bleeds – Cough

BIRTH HISTORY: Normal Premature IMMUNIZATIONS UP TO DATE: YES NO

Formula Used – ☐ BREAST MILK ☐REGULAR FORMULA ☐GENTLEASE ☐HYPOALLERGENIC

☐ SPECIAL FORMULA _____

NEW BORN HEARING TEST: PASSED FAILED

MEDICAL HISTORY: Please circle all that apply

Asthma – Ear Infections – Sinus Infections – CP – Cardiac Disease ( ) Acid Reflux – Ear Tubes – Tonsils – Adenoids

FAMILY HISTORY: Please circle all that apply

Allergies (Food/environmental) - Asthma – Acid Reflux – hearing loss – Tonsil and/or adenoid disease – Ear Infections – Tubes –

Anesthesia Problems - Bleeding

HOSPITAL ADMISSIONS - Year and Operation:

SOCIAL HISTORY: Please circle all that apply

Parent Status: Married Divorced Separated Foster care **School**: Daycare School Home **Exposure**: Tobacco Pets Environmental

MEDICATION LIST:

REVIEW OF SYSTEMS: Please circle all that apply

Fevers, Nausea, vomiting, fatigue
Throat: Dysphagia, Sore Throat, Ulcers
Resp: Cough, Sob, Pneumonia
Skin/Extremity: Rash. Eczema, Joint Pain
Ears: Hearing Loss, Infection, Surgery
Neck: Stridor, Mass, Swelling
Abdominal: Diarrhea, Constipation, Acid Reflux, Pain
Neuro: Headaches, Hypotonia, Seizures
Nose: Infections, Bleeds, Runny, Sneeze, Snoring
Heart: Murmur, disease
Misc: Sleep Problems, Feeding Problems

No Other Symptoms Noted

SECTION BELOW TO BE COMPELTED BY PHYSICIAN

PHYSICAL EXAM: Wt: _____ lb/kg Ht:_____ in HR:_____ BP:_____ T:_____

IMPRESSION/PLAN:

Patient/Guardian Signature: _____ Physician Signature:_____