Pediatric care FOUR CORNERS
2508 Sand Mine Road
Davenport, FL 33897

Phone: 863-232-5527
Fax: 863-438-2776

Office Policy & Procedures

___ Appointment Cancellation / No Show Policy

At Pediatric Care Four Corners we strive to stay on schedule. As providers, we will be realistic in setting our schedule to provide enough time for appointments. As a parent, we ask that you be on time for your child's appointment. Please call to reschedule if you realize that you will be running late. You will be allotted 15 minutes past your appointment time before you are rescheduled. In fairness to our provider and all our patients, we ask for you to please call our office if you are unable to make your scheduled appointment. First time no shows will be given a courtesy call to reschedule and the patient's account will be noted. Any no show after that will be subject to a $25.00 no call / no show fee.

___ Financial / Collections Policy

Pediatric Four Corners works with many health insurance companies. We are happy to bill medical services through your families insurance. However, the bill for your child's medical care is ultimately your responsibility. If your insurance does not cover, or only partially covers a service that was provided, you will be responsible to pay for the remaining portion that the insurance company assigns to you. If unexpected financial difficulties develop, please call us in regards to developing a payment plan. If your account is more than 90 days past due, we reserve the right to pursue collections. If your account is sent to collection, you will be responsible for additional collection fees. In order to avoid having any outstanding balances sent to collections, we ask that you keep a credit card on file. You can add a credit card on file with a specified balance limit. As a courtesy, we will notify you before we charge any outstanding balances to your card. This method will ensure your account is up to date at all times, and avoids any future outstanding balances being sent to collections.

___ Form Completion

Please allow 24-48 hours for the completion of any requested forms. If there is a fee for this you will be informed ahead of time, please be prepared to pay the form fee when picking up.

___ Medical Records Request

Please allow up to 10 days for the completion of any medical record requests. Behavioral health/Confidential Records, by state law, require physician approval prior to release and will take an additional 3-4 business days for these requests to be processed. We must have a current and signed record release on file. There will be no fee if we are sending records to another physician. If we release records directly to a parent / guardian there is a fee of $1.00 for the first twenty five pages and $0.25 for every page thereafter. You will be informed of any fees ahead of time, please be prepared to pay for records when picking up.

___ RX Refill / Referral Requests

Please allow 24-48 hours for insurance referrals and prescription refill requests to be processed. Please note that in compliance with Florida State Law, some prescription medications must be picked up at our office. These

Pediatric care FOUR CORNERS
2508 Sand Mine Road
Davenport, FL 33897
Phone: 863-232-5527
Fax: 863-438-2776

prescriptions will not be sent directly to your pharmacy and you will be notified in advance if this is the case. Please be prepared to show identification if requested when picking up these items.

____ ADHD Visits

For any new patients with an established history of ADHD, you will be asked to provide medical records detailing patient's initial ADHD evaluation (usually conducted by a Psychologist, Pediatrician, Psychiatrist, or Neurologist). If your child is currently on ADHD medications, you will be asked to provide proof of medication bottles or a medication dispensary report from your pharmacy.

For all other patients with an established history of ADHD, you will be required to follow-up every 3 months to ensure your child's condition is under control. Requests for medication refills prior to the 3 month period will not be authorized.

____ CHADIS – Clinical Process Quality Improvement System

CHADIS is an online system that delivers questionnaires that help us review the health and development of your child. Using CHADIS before the visit will help your doctor take better care of your child. You will be receiving an email containing a link to the secure CHADIS portal approximately 2-3 days prior to your child's wellness visit. Please help us by filling out these online generated forms as it will help correctly identify your child's milestones.

____ Patient Portal

We encourage you to use our portal system through our secured EHR system. Through the portal, you will be able to access your child's medical records including vaccination history. You are also able to communicate with the PCFC staff and providers by sending them a message. You are also able to pay any outstanding balances posted to your account. By providing your email, you will be sent a link to establish your portal access.

- By signing below, you verify that you have read, understood and agree to comply with Pediatric Care Four Corners office policy and procedures.

_____ _____

Patient Name **Date of Birth**

_____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature**

_____

Date

Pediatric care FOUR CORNERS

2508 Sand Mine Road
Davenport, FL 33897

Phone: 863-232-5527
Fax: 863-428-2776

Vaccination Policy

Effective January 1st, 2019

Pediatric Care of Four Corners will insist that all our patients be immunized according to the vaccine schedule put forth by the American Academy of Pediatrics (AAP), Center for Disease Control (CDC), and Advisory Committee on Immunization Practices (ACIP). We firmly believe that these recommendations are in the best interest of our patients and our community.

If your family chooses not to comply with these guidelines, we understand your choice as a parent. But as a practice, we will encourage you to find another clinical practice to care for your children who shares a similar philosophy to yours regarding vaccinations.

"At Pediatric Care of Four Corners we treat every patient like our own child". We believe this mission statement. We live in a global society. Disease prevention through vaccination is a cornerstone of infectious diseases throughout the world and here in the United States.

If you have any questions or would like to discuss this matter with one of our physicians, we will be happy to sit down with you to discuss this matter.

- By signing below, you verify that you have read, understood and agree to comply with Pediatric Care Four Corners Vaccination Policy.

_____

Patient Name **Date of Birth**

_____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature**

_____

Date

Pediatric care FOUR CORNERS

Consent To Treat:

I, the undersigned parent or legal guardian who is responsible for consenting on patient's behalf, hereby request and consent to the children listed below, to be examined and treated by Dr. Eiman ElSayed and her nursing staff who may participate in the patient's care.

_____

Patient Name **Date of Birth**

_____ _____

Parent / Guardian Signature **Date**

I authorize the following people to bring my child in for treatment:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Signature of Legal Guardian **Date**

_____

Relationship to Patient

Pediatric care FOUR CORNERS
2508 Sand Mine Road
Davenport, FL 33897
Phone: 863-232-5527
Fax: 863-438-2776

Notice of Privacy Practices

I understand that Pediatric Care of Four Corners may use and disclose protected health information as indicated in the Notice of Privacy Practices law. Your protected health information may be disclosed by our organization, office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received, read and understand Pediatric Care Four Corners Notice of Privacy Practices containing a description of the uses and disclosure of my child's health information. I further understand that Pediatric Care Four Corners may update its Notice of Privacy Practices at any time and that I may receive an updated copy of the Notice of Privacy Practices by submitting a request in writing to the office.

_____

Name of Patient Date of Birth

_____

Signature of Patient/Parent/Guardian Date

Designation of Alternate Representatives

- I authorize the following relatives, family friends and/or caregiver's to be able receive information regarding my child and their health care:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Request to Receive Confidential Communications by Alternative Means

As provided by Privacy Rule Section 164.522(b), I hereby request the the Practice make all communications to me by alternative means I have listed below.

Home Phone Number:_____ □ OK to leave detailed message □ Only leave message with call back number

Cell Phone Number:_____ □ OK to leave detailed message □ Only leave message with call back number

Work Phone Number: _____ □ OK to leave detailed message □ Only leave message with call back number

_____

Parent/Guardian Signature Date