Child Neurology Center of Northwest Florida
400 Gulf Breeze Parkway, Suite 300
Gulf Breeze, FL 32561
Phone: (850) 932-5055

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Doctor/Patient Services Agreement

Welcome, your child's appointment is on:_____ at:_____

Neurology Treatment: We specialize in the care of infants, children, and adolescents with neurological disorders. We also treat some adults for specific disorders.

Appointments: We have a strict 15 minute late policy. Patients that arrive 15 minutes after their appointment will need to be rescheduled. A 24-hour notice is required to cancel an appointment.

Insurance Authorization: It is the responsibility of the patient to ensure prior insurance authorization for all follow-up appointments and procedures.

Professional Fees: Payment is due in full at the time of services, unless prior arrangement has been made. Payment of insurance deductible and insurance co-pays are due at time of service. As a courtesy we will file for all insurance companies. Payment is due in full by the 30th of the month. Please contact our billing office at 850-932-5055 option 7 for questions regarding your bill.

Contacting the Office: Phone calls are answered from 8am to 4pm, Monday through Friday.

Emergencies: For medical emergencies please call 911 or go to your local emergency room.

Consent: I authorize my insurance benefits to be paid directly to Child Neurology Center; realizing I am responsible for non-covered services. I authorize the release of pertinent medical information to insurance carriers.

Your signature below indicates that you have read the agreement and agree to its terms.

Responsible Party Patient Name Patient DOB

Patient Demographics

Patient Name:_____
Address:_____
Social Security Number:_____ Date of Birth:_____ Age:_____
Race:_____ Ethnicity:_____Language:_____ Sex:_____

Preferred Contact Method:
Home:_____ Work:_____ Cell:_____
Emergency Contact:_____Relationship:_____Phone:_____
Email:_____

Guarantor Information

Name:_____
Address:_____
Social Security Number:_____ Date of Birth:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referring Physician Information

Referring Physician:_____ Phone:_____
Address:_____

Insurance Information

Primary Insurance:_____
Member ID Number:_____ Group Number:_____
Subscriber Name:_____Subscriber DOB:_____

Secondary Insurance:_____
Member ID Number:_____ Group Number:_____
Subscriber Name:_____Subscriber DOB:_____

Authorization to pay benefits to physicians; I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider, Child Neurology Center of Northwest Florida when they accept assignment. I authorize to release medical information to my provider, Child Neurology Center of Northwest Florida, to release any information necessary for my course of treatment.

_____ _____
Signature of Patient (or parent if minor) Date

Pediatric Patient History

Patient Name:_____ Date of Birth:_____

Please complete this section for all people who currently live in the same home as the patient named above:

Full name	Relationship	Age	Job	Education level

Who has legal custody of the child?_____ Relationship:_____
Who is the child's primary doctor?_____ Phone:_____

List any other doctors that the patient sees:

Name of doctor	Address	Phone number	Specialty

Preferred Pharmacy:_____ Phone Number:_____

Reason for this visit:_____
_____
_____
_____

Biological Mother's History:

Total Number of Pregnancies:_____ This child is pregnancy number:_____

Any Miscarriages:_____ Total Miscarriages:_____

Please check any of the following boxes that occurred during the pregnancy of the child being seen today:

- ☐ Unusual Swelling
- ☐ Unusual Weight Gain
- ☐ High Blood Pressure
- ☐ Infection
- ☐ Unusual Vomiting
- ☐ Bleeding
- ☐ Alcohol Use
- ☐ Tobacco Use
- ☐ Drug Use

Child's History:

Was the child born: Early:_____ Late:_____ On Time:_____

Was labor induced?_____ Why?_____

Did mom need to have a Cesarean Section?_____ Why?_____

Child's Birth Weight:_____ Apgar score (if known):_____

Please describe any problems the baby had right after birth (if any):_____

_____

_____

Please check any of the following boxes if the child being seen today had any of these problems in the first year of life:

- ☐ Problems Sucking
- ☐ Choking
- ☐ Lots of spitting/vomiting
- ☐ Poor Eating
- ☐ Seemed Stiff
- ☐ Seemed Limp
- ☐ Cried a lot
- ☐ Seemed too quiet
- ☐ Didn't Gain Enough Weight

Any other problems during the first year (if any)?_____

_____

_____

At what age did your child first do the following tasks?

Task	Age
Hold head up	
Roll over	
Sit alone	
Crawl	
Pull up	
Walk	

Task	Age
Feed self	
Speak first word	
Use sentences	
Dress self	
Have bladder control	
Have bowel control	

Did your child ever lose any developmental milestones?_____ When?_____

_____

Describe any behavioral concerns or problems with your child (if any):_____

_____

_____

Please list all current medications:

Medication name	Amount(MG or ML)	How often	Time of day taken	What for

Please list any hospital stays or surgeries your child has had (if any):

Date of stay/surgery	Name of hospital	Reason for hospital stay	Surgery performed

Does your child have any of the following medical problems? If so describe them here.

System	Type of problem
Breathing	
Heart	
Skin	
Psychiatric/emotional	
Eyes/ears/nose/throat	
Stomach/intestines	
Kidneys/bladder	
Blood	
Immune system/infections	
Muscles/bones	
Seizures/head injury	

Are immunizations up to date? Yes:_____No:_____

Does your child have any allergies?

Allergy	Reaction

Please list any medication your child has taken in the past:

Medication name	Reason	Date started	Date stopped	Why stopped

Please check the boxes below and write either mom or dad's side of the family has these problems:

- ☐ Headaches:_____
- ☐ Weak muscles:_____
- ☐ ADHD/ADD:_____
- ☐ Miscarriages or baby who died at young age:_____
- ☐ Cerebral Palsy:_____
- ☐ Seizures:_____
- ☐ Psychiatric:_____

Please tell us about your child's school or day care:

Name:_____ Location:_____

Grade or program:_____

Receiving any special services? (If so what type):_____

Results of any special testing done:_____

Please attach a recent photograph of the patient if available.

Parent/legal guardian signature:_____Date:_____

Relation to child:_____

MD/ARNP Signature:_____ Date:_____

Standard Authorization of Use and Disclosure of Protected Health Information

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Pkwy, Suite 300
Gulf Breeze, FL 32561
Phone: 850-932-5055 Fax: 850-932-1404

The health information covered under this authorization:
Neurology office notes
EEG reports
MRI/CT scans
Laboratory results

Persons whom the above health information will be used and disclosed to:

Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number

Expiration date of this authorization expires 1 year after the date signed. This authorization can be terminated by the patient or the patient's representative at any time. To terminate or revoke this authorization the patient or patient's representative must complete a written revocation; which can be given by contacting the HIPAA compliance officer.

Potential for Re-disclosure; Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (print)	Date of Birth
Signature of Patient	Date Signed
Signature of Patient Representative and Relationship to Patient	Date Signed