jacobsonpediatrics
A division of Florida Pediatric Associates LLC

robyn jacobson, m.d.
3910 northdale boulevard • suite 204 • tampa, florida 33624
(phone) 813.570.6971 • (fax) 813.570.6977

PATIENT INFORMATION

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

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

Race: ☐ African American/Black ☐ American Indian / 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

* APPROPRIATE PAPERWORK MUST BE PRESENTED AT TIME OF VISIT

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

Address: ☐Check here if same as above

_____ City: _____State: _____Zip: _____

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

☐ Check this box if we may use this cell # for text and/or robocall appointment reminders

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#: (_____)_____-_____

☐ Check this box if we may use this cell # for text and/or robocall appointment reminders

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

EMERGENCY CONTACTS

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

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

Dec-14

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

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.

Parent/Guardian Signature_____Date_____

LATE ARRIVALS / CANCELLATIONS / NO SHOW POLICY

Patients arriving more than 15 minutes after their scheduled appointment time may be rescheduled. Late arrivals may be seen later only if open appointment is available. If you call to alert us of your late arrival, we will try our best to work you into the day's schedule but cannot guarantee you will be seen the same day as your appointment.

Cancellation of office visits require a 24 hour notice or are subject to a $25.00 charge.

Our office also has a No Show policy of $25.00 if you miss your appointment. Excessive "No Show" visits without cancellation may result in you being discharged from our care.

I have read and understand the policy for late arrivals, cancellations and no-show visits and agree to the terms as stated.

Parent/Guardian Signature_____Date_____

PATIENT HEALTH HISTORY

Child's Name: _____ Date of Birth: _____

HISTORY	MOTHER	FATHER	SISTER(S)	BROTHER(S)	PATIENT
ADD or ADHD					
ALLERGIES					
ASTHMA					
BLEEDING DISORDERS					
CANCER (PLEASE SPECIFY)					
DEPRESSION					
DIABETES					
EAR INFECTIONS					
HEADACHES OR MIGRAINES					
HEARING LOSS					
HYPERTENSION					
HYPERLIPIDEMIA					
HEART DISEASE					
KIDNEY DISEASE					
SEIZURE DISORDER					
SINUS INFECTIONS					
SNORING OR SLEEP APNEA					
TONSIL INFECTION					
THYROID DISEASE					
BIRTH DEFECTS					
OTHER					

Has your Child had any previous Hospitalizations/Surgeries or any Serious Illnesses? If yes, please explain: _____

_____

Does your Child have any medication or other Allergies:

- ☐ No known medication or other Allergies
- ☐ Yes. Name: _____
  Name: _____
  Name: _____

Is your Child currently taking any Medications?

- ☐ Not currently taking any medications
- ☐ Yes Name: _____mg
  Name: _____mg
  Name: _____mg
  Name: _____mg
  Name: _____mg

FLORIDA PEDIATRIC ASSOCIATES

AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient's Name _____ DOB: _____

I give permission to _____ to VERBALLY discuss the following medical and billing information about me (check all that apply)

- ☐ Scheduling/Appointment Information
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan. *This does not include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDS testing and treatment, pregnancy testing and treatment, birth control or family planning.*
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ Chemical dependency information, including symptoms, diagnosis, medications and treatment plan.
- ☐ Information related to STD testing and treatment and/or HIV testing and treatment.
- ☐ Information related to pregnancy testing and treatment, birth control and/or family planning.

The following people are permitted to receive the above information:

NAME	DOB	PHONE #	RELATIONSHIP TO PATIENT

This authorization will expire on _____ **(NOTE: If this line is left blank this authorization will automatically expire in one year)**

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization (except to the extent that action was already taken in accordance of this signed authorization) at any time by notifying this office in writing (the appropriate form can be obtained from office staff).
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____

Patient Signature Date

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) 570-6971**

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/jpeds***

Important Information:

- Our hours of operation are **8:00 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 Physician is out of the office, your request may be held until your Physician returns to the office. You must call our office at **(813) 570-6971** if you have an urgent matter to discuss.
- Staff members other than your Physician may be involved in receiving your messages and routing them to the Physician 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 #:*** _____

Jacobson Pediatrics

Dear Parent:

We are pleased to welcome you to our Patient Portal!

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

- Request a Medication Refill
- Request an Appointment to see your Physician
- View & download your medical chart summary
- Send and receive secured messages to our Office
- Send and receive secured messages to our Billing Department
- Request Medical Records
- Take a Patient Satisfaction Survey

To access our Patient Portal, please go to https://portal.fountaindonline.net/jpeds. 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,
Jacobson Pediatrics