CAPERNAUM
Medical Center

Office Policies

Patient Name: _____ **Date of Birth:** _____

We appreciate the trust you have in our providers at Capernaum Medical Center for Kids by choosing us to care for your child. We will do our best to satisfy your needs. If you have any questions or concerns during your communication with our office or during any visit, please discuss them with the office administrator.

1. Due to the complexity of most of our patients' medical needs, anyone who has **3 NO SHOWS (WITHOUT NOTICE)** or refuses to follow our recommendations may be considered to have left our practice and may not be scheduled for another appointment. There is also a **$25.00 No Show fee** for office visits **and $50.00 No Show fee** for any testing done at our office.
2. All co-pays and/or patient account balances must be paid at the time of the visit.
3. You are responsible for requesting your referral and/or authorization from the patients **Primary Care Physician** at least **5 business days prior to your appointment in our office.** You must bring the referral and/or authorization at the time of your visit or it can be faxed to 1-863-337-5728.
4. Urgent messages will be returned within **24-48 hours**. Non-urgent messages will be returned within **48-72 hours**, usually at the end of the day.
5. **We DO NOT accept walk-ins**! If you feel that you have an emergency call 911 or go to the nearest Emergency Room.
6. Prescription refills may be requested by e-mail at or by calling the main number and selecting the option for prescriptions.
7. **Prescription pick-up times** are Mondays and Fridays at any time from 8:00am-4:00pm and Tuesdays-Thursdays from 7:30 am- 9:00am due to the high volume of patients in our office.
8. There may be a $25.00 fee for any forms or formal letters that require completion by our office. We require 7-10 business days to complete these requests and/or any fees associated with these documents must be paid prior to the release of the form/letter.
9. It is vital that for us to always have an accurate telephone number where we can reach you at all times! But It is your responsibility to update your telephone number(s), address and/or any insurance information.
10. We reserve the right to terminate ANY patient/relationship who is disrespectful or abusive to our staff at all!

_____ _____ _____

Signature Parent/Legal Guardian/ Self Relationship Date

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Patient name: _____ **Date of Birth:** _____

Sex: ___M/F___ **SS#**_____ **Phone Number:** _____

Current address: _____ **CITY:** _____
ZIP: _____

Reason for visit: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

RESPONSIBLE PARTY: Parent or Legal Guardian, Please present photo ID

Father's name: _____ SS#: _____

Father's date of birth: _____ Mother's date of Birth: _____

Mother's name: _____ SS#: _____

Street Address: _____

City/State/Zip Code: _____

P. O. Box: _____

Home phone: _____ Cell phone: _____ Fax number: _____

Emergency Contact Person (other than self): _____

Phone number: _____ Relationship: _____

Father's employer: _____ Phone number: _____

Mother's employer: _____ Phone number: _____

If Patient is of legal age or an emancipated minor, please indicate consent/authorization to discuss financial and /or medical information with your parent or guardian. YES_____ NO _____

Please continue to the next page and fill out everything that applies to the patient...

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INSURANCE COMPANY: Please present Insurance ID card(s):

Name: _____

Address: _____

City/State/Zip Code: _____

Phone#: _____ Name of insured: _____

Policy#: _____Group#: _____

Managed Care? YES ____ NO ____ Authorization: _____

SECONDARY INSURANCE: if applicable

Name:

_____

Address:

_____

Name of insured: _____ Policy #: _____

Group#: _____Phone #: _____

I consent for all medical care deemed necessary and appropriate by Capernaum Kids for my child or myself.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered to me/my child. I agree to notify you of any/all changes in my health insurance and will be held responsible for any services not covered by insurance or denied due to incorrect insurance information given at time of service.

I hereby irrevocably assign and transfer payment of services, including Medicaid, directly to Capernaum Medical Center.

***Missed appointments are an inconvenience for all. If for any reason you can not make an appointment, please provide at least a 24-hour prior notice. Cancellations or NO SHOWS without 24-hour prior notice will be charged a *$50.00* missed appointment fee, not billable to your insurance company and/or Medicaid.**

_____ _____ _____

Signature Parent/Legal Guardian/Self **Relationship** **Date**

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Permission to Treat

I the **Parent/Legal Guardian,** _____ authorize *CAPERNAUM MEDICAL CENTER* and its personnel to deliver medical services to my child(ren):

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I authorize the following people to bring my child in for Medical treatment (follow up appointments, diagnostic testing) and allow to make any medical decisions in my absence.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____

Date: _____

CAPERNAUM
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Consent to Obtain External Prescription History

Patient Name: _____ **Date of Birth:** _____

I, **(Parent/Legal Guardian)** _____, whose signature appears below, authorize **Capernaum Medical Center** and its affiliated providers to view my external prescription history via the Rx Hub service. I have been given documentation regarding e-prescribing and acknowledge further information can be obtained at www.LearnAboutePrescriptions.com.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions from the past several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Print Parent Name (Legal Guardian/Self): _____

Parent Signature (Legal Guardian/Self): _____ **Date:** _____

(Office only) Witness Signature: _____ **Date:** _____

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Phone# or Address: _____

**Please be specific on which location and name of the pharmacy so we can ensure we are faxing your prescription to the correct pharmacy! **

CAPERNAUM
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Patient Consent of Medical Photography

Today's Date: _____

Patient Name: _____ ***Date of Birth:*** _____

☐ ***Check here if patient is a minor to sign for Parental Consent (17 and under)***

I consent for medical photographs to be taken of my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may do so by completing a new photo consent form.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

Print Name of Parent/Legal Guardian: _____

• *I agree to use of my image for medical records/chart* ***ONLY.***

_____ *(Signature)* _____ *(Witness)*

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Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____

For the purpose of releasing Medical Records, I (Parent/Legal Guardian) _____ give permission to release the above stated patient's medical records from the following medical clinic:

Capernaum Medical Center
5129 S. Lakeland, Lakeland, FL 33813
Phone (863) 232-4323

The medical records as listed above are to be released to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Comments: _____
_____

Capernaum Medical Center

1. I understand that this consent includes and authorizes access to all of the identified patient's health information. I also understand that this consent is voluntary and not required to receive services.
2. I understand that this consent is revocable upon notice. I also understand that the consent shall remain in effect until revoked in writing.
3. I understand that this consent authorizes release of any psychiatric information, if present.
4. I understand that this consent authorizes release of AIDS/ARC information and/or HIV antibody testing/results, if present.

_____ _____
Signature of Parent/Legal Guardian/Self Date

_____ _____
Print Name Relationship

CONFIDENTIALITY NOTICE

This paper contains information which is confidential or privileged. The information is intended to be for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this paper is prohibited. If you have received this telecopy in error, please notify us by telephone at (863) 232-4323 immediately so that we can arrange for the retrieval of the information at no cost to you.

FORM: Authorization for Release of Information

CAPERNAUM
Medical Center

Authorization to Receive Information for Continuation of Care

Patient Name: _____ **Patient Date of Birth:** _____

For the purpose of continuing care, I, **(Parent/Legal Guardian)** _____, authorize *Capernaum Medical Center* to receive copies of the above identified patient medical records including any Medical, Psychiatric Care, Drug and Alcohol Abuse, and HIV/AIDS/ARC related information.

Capernaum Medical Center
5129 S. Lakeland Dr. Unit 2, Lakeland, FL 33813
Phone: (863) 232-4323 Fax: (863)337-5728

1. I understand that this consent includes and authorizes access to all of the identified patient's health information. I also understand that this consent is voluntary and not required to receive services.
2. I understand that this consent is revocable upon notice. I also understand that the consent shall remain in effect until revoked in writing.
3. I understand that this consent authorizes release of psychiatric information, if present.
4. I understand that this consent authorizes release of AIDS/ARC information and/or HIV antibody testing/results, if present.

Signature of Parent/Legal Guardian/Self: _____

Print Name of Parent/Legal Guardian/Self: _____

Relationship to Patient: _____ **Date:** _____

(Office Only) Witness: _____ **Date:** _____

Summary Notice of Privacy Practices

CAPERNAUM
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To our patients:

Our commitment to your privacy,

Our practice has always been dedicated to protecting the privacy, integrity and security of the healthcare and financial information entrusted to us by our patients. New regulations created as a result of the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires the confidentiality of this information for virtually all patients regardless of where they live or receive health care. We want you to know how we protect, how we use and how you can get access to your health information. We value your trust and confidence in our ability to manage this protected information and want to assure you that we are properly safeguarding this important information. We will protect all information collected about you and will restrict access to this information by maintaining physical, electronic, and procedural safeguards. We will restrict access to protected data only to individuals who must use it in the performance of their job-related duties. Employees who violate our privacy policy will be subjected to disciplinary action, which may include termination. Please take a moment to review our privacy policy.

PERSONAL INFORMATION WE COLLECT

We collect personal information that you provide on applications, other forms, and interviews. We additionally maintain information such as fee payments, insurance coverage and payment history. We may obtain additional information from third parties that may include employers, other insurers, or other healthcare providers while administrating your healthcare processing your financial claims.

Information We May Disclose

We may share your personal financial and health information on a confidential basis only with authorized employees, representatives and third parties. We will disclose only the information that is necessary to such individuals and companies who perform healthcare or financial services on your behalf. An example would be your health insurance company in order to ensure your maximum benefit. We may release PHI (Private Health Information) to a friend or family member. An example, a friend or family member that is involved in your child's care, or assist in your child's care, i.e. a Grandparent/caretaker taking your child to a physician for treatment. In this example, the Grandparent/caretaker would have access to this child's medical record. We will not disclose any non-public personal information about you except as authorized by law, as described in this Privacy Notice. If we need to make disclosure/release of any personal information for any other reason than those stated, it will be done only with your authorization. That authorization will be specific to the reason cited, in writing, and can be revoked by you in writing at any time.

Use and Disclosure of your Health Information in Certain Circumstances

The following circumstances may require us to use or disclose/release your health information:

- *To public health authorities and health oversight agencies that are authorized by law to collect information.*
- *Lawsuits and similar proceedings in response to a court or administrative order.*
- *If required to do so by law enforcement official.*

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- *When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.*
- *If you are a member of US or foreign military forces and if required by the appropriate authorities.*
- *To federal officials for intelligence and national security activities authorized by law.*
- *To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.*
- *Workers Compensation and similar programs.*

You're Rights Regarding Your Health Information:

- *Communications- You can request that our practice communicate with you about your health and related issues in a particular manner or certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.*
- *I understand that access to the medical record of my child will not be denied to either parent unless proof of Court Order is in the patient's file.*
- *You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you/your child, including patient medical records and billing records, but not including psychotherapy notes. There may be a fee for copies. You must submit your request in writing to:*

Capernaum Medical Center
5129 S. Lakeland Dr.
Unit 2
Lakeland, FL, 33813

This form must be reviewed and signed before ANY services will be provided by our facility.

_____ _____
Parent Signature/Legal Guardian/Self ***Date***

_____ _____
(Office Only) Witness Signature ***Date***

CAPERNAUM
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INFORMED CONSENT FOR GENETIC TESTING

Patient Name: _____ **Date:** _____

DOB: _____

Testing for genetic conditions can be complex. If warranted, obtain professional genetic counseling prior to giving consent to fully understand what the risks and benefits are to having the testing completed.

I hereby consent to participate in testing for _____ using a genetic test. I understand that a biologic specimen (blood, tissue, amniotic fluid, or chorionic villi) will be obtained from me and/or members of my family. I understand that this biologic specimen will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease.

It has been explained to me and I understand that:

This test is specific for _____.

• A positive result is an indication that I may be predisposed to or have the specific disease, or condition. Further testing may be needed to confirm the diagnosis. I understand I will be given the opportunity to talk with my physician or a genetic counselor about these results.

• There is a chance that I will have this genetic condition but that the genetic test results will be negative. Due to limitations in technology and incomplete knowledge of genes, some changes in DNA or protein products that cause disease, may not be detected by the test.

• There may be a possibility that the laboratory findings will be uninterpretable or of unknown significance. In rare circumstances, findings may be suggestive of a condition different than the diagnosis that was originally considered.

• At this time, it is not standard practice for the laboratory to systematically re-review likely pathogenic variants, and variants of uncertain significance that have been detected and reported. Health care providers are encouraged to contact the laboratory at any time to learn how the classification of a particular variant may have changed over time.

• In many cases, a genetic test directly detects an abnormality. Molecular testing may detect a change in the DNA (mutation). Cytogenetic testing may identify whether there is extra, missing or rearranged genetic material. Biochemical methods are sometimes used to look at abnormalities in the protein products that are produced by the genes. Most tests are highly sensitive and specific. However, sensitivity and specificity are test dependent.

• The accuracy of the test depends on correct family history. An error in diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated. In addition,

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INFORMED CONSENT FOR GENETIC TESTING

testing may inadvertently detect non-paternity. Non-paternity means that the father of an individual is not the person stated to be the father.

• An erroneous clinical diagnosis in a family member can lead to an incorrect diagnosis for other related individuals in question.

• The tests offered are considered to be the best available at this time. This testing is often complex and utilizes specialized materials. However, there is always a small chance an error may occur.

• Because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician, genetic counselor, or other identified health care provider. The results are confidential to the extent allowed by law. They will only be released to other medical professionals or other parties with my written consent or as otherwise allowed by law. Participation in genetic testing is completely voluntary.

Signatures

My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional and I have been provided the additional technical information (as applicable) describing the test(s) to be performed.

_____ _____

Parent/Guardian Name Parent/Guardian Signature Date

Provider's or Counselor's Statement: I have explained genetic testing (including the risks, benefits, and alternatives) to this individual. I have addressed the limitations outlined above, and I have answered this person's questions to the best of my ability.

_____ _____

Provider Name Provider Signature Date