Children's Cardiology Clinic

Patient Information

PATIENT

Last Name:		First Name:			
Birth Date:		Gender:		Phone Number:	
Street Address:				Apt/Unit #:	
City:		State:		Zip Code:	
Email Address (for portal access):					
How did you hear about us?					

PARENT/GUARDIAN (If patient is under 18)

Mother Name:		☐ Primary contact for patient	
Email Address:		Phone Number:	
Father Name:		☐ Primary contact for patient	
Email Address:		Phone Number:	

EMERGENCY CONTACT

Full Name:			
Phone Number:		Relationship to Patient:	

PRIMARY INSURANCE

Insurance Name:				Insurance Phone:	
Policyholder Name:				Birth Date:	
Relationship to Patient:		ID# / Policy #:		Group #:	

SECONDARY INSURANCE

Insurance Name:				Insurance Phone:	
Policyholder Name:				Birth Date:	
Relationship to Patient:		ID# / Policy #:		Group #:	

PRIMARY CARE PHYSICIAN (PCP)

PCP Name:				Phone:	
PCP Address:					
City:		State:		Zip Code:	

PREFERRED PHARMACY

Pharmacy Name:				Phone:	
Pharmacy Address:					
City:		State:		Zip Code:	

CHILDREN'S CARDIOLOGY CLINIC

a Division of Florida Pediatric Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, the practice creates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means for communication among health professionals who contribute to my care, such as referrals
- Source of information for applying my diagnosis and treatment information to my bill
- Means by which a third-party payer can verify that services billed were actually rendered
- Tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I acknowledge that I have been provided with a "*Notice of Patient Privacy Practices*" that provides a more complete description of information uses and disclosures and of my privacy rights. I understand that I have the right to:

- Review the "*Notice*' prior to acknowledging this consent
- Restrict or revoke the use or disclosure of my health information for other uses or purposes
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

I hereby permit and authorize the practice to discuss my/the patient's protected health information (PHI) with the individuals listed below including any who may accompany me/the patient to this office for medical evaluation or treatment. Authorized individuals must present positive identification in person or state my passcode if communicating by phone. I understand that I may contact this office to edit or rescind this authorization at any time. Parents/legal guardians of minor patients do not need to include their names.

Optional passcode to be used by authorized individuals: _____

Name:_____Relation:_____ Phone:_____

Name:_____Relation:_____ Phone:_____

Name:_____Relation:_____ Phone:_____

By signing below, I certify that I have read and understand this document, that I have the legal right and authority to execute this document, and that I accept its terms as the Patient or the parent or legal guardian of the Patient. If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if I signed this document in paper form.

PATIENT NAME: _____ **DOB:** _____

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature _____ **Date**: _____

(Patient/Authorized Representative)

Print Name of Authorized Representative (if different from patient): _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

CHILDREN'S CARDIOLOGY CLINIC

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AUTHORIZATION AND CONSENT FOR TREATMENT

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING.

General Consent for Treatment. I consent to the medical care and treatment for the patient named below (the "Patient") by this division of Florida Pediatric Associates, LLC and its contracted or employed practitioners (collectively referred to as the "Practice"), to include without limitation, routine medical and physical examinations, laboratory orders and procedures, diagnostic testing, the administration and prescribing of medications, immunizations (when indicated and provided by this office), and other medical and/or diagnostic services as deemed necessary or advisable in the judgment of the physician or other practitioners providing care to the Patient at the Practice. I understand that certain aspects of care may be offered at a facility owned by the Practice or treating physician, and if so, this information will be disclosed and alternative facilities identified. I understand and agree that health care professional students that are not employees of the Practice may participate in the Patient's care under the supervision of an attending physician or other health care professional. I am aware that the practice of medicine (including surgery and diagnostic testing) is not an exact science, and I acknowledge that no providers nor office staff of the Practice has made any guarantee or assurance as to the results that may be obtained. I understand that the Practice may refuse to provide care if I refuse to sign this consent or if, at any time, I choose to revoke this General Consent for Treatment.

Consent for Electronic Prescriptions (E-Prescribing). I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, and review pharmacy benefit information and medication dispensing history for as long as a physician/patient relationship exists.

Photography & Recording. I consent to a Patient photograph that will only be used for identification purposes. Depending on the Patient's treatment needs, the use of clinical photography may also be needed in relation to the ongoing diagnosis and treatment of certain conditions, and I consent to images being taken of the Patient during the course of the Patient's treatment for treatment purposes when indicated. Photographs will be used for treatment and identification purposes will be maintained in the Patient's medical records and will be subject to HIPAA confidentiality requirements. I acknowledge that recording the Practice's staff, patients, and providers is prohibited. For the privacy of all patients and providers, I agree not to make audio or visual recordings (including via use of a smart phone) at the Practice without prior consent of the Practice.

Consent to the Disclosure of Health Information. I understand that the Practice, its business associates, other treating providers and/or my insurance company may obtain, use and/or disclose the Patient's health information for treatment and payment purposes ("Authorized Purposes"). I consent to the use and disclosure of the Patient's information for these Authorized Purposes and as further described in the Practice's Notice of Privacy Practices. This consent for the use and disclosure of the Patient's health information specifically includes all medical records, billing records, complete plans of treatment, progress summaries, treatment notes, and any other information contained in the Patient's designated record set at the Practice, including without limitation mental health information and diagnosis, reproductive health information, HIV/AIDS and/or other STD test and diagnosis information, substance use or abuse information, genetic information, and any other related documents or information on record at the Practice. I authorize the Practice to request and release such information to outside treatment providers and any third-party payor responsible for payment for the services provided to the Patient. If the Practice participates in research, I consent to the use and disclosure of the Patient's health information for reviews preparatory to research and for research purposes when an institutional review board has approved the research and the research meets the requirements under applicable law.

_____ By checking here, I acknowledge that I received a copy of the Practice's Notice of Privacy Practices.

Communications Consent. Ensuring timely communication with the Practice is critical to the quality of patient care. I understand and agree that the Practice may need to contact me regarding appointments, preventative care, test results, treatment recommendations, my bill, outstanding balances, other treatment or payment related matters, or to request feedback on the services received or offer me an opportunity to complete a survey. I consent to being contacted about such matters and understand that these communications may be made via automated calls, emails, and/or text messaging sent to my landline and/or mobile device. If I provide a phone number or email address to the Practice, I authorize the Practice and its business associates to contact me via telephone call, email message, or text messaging at the contact information provided or later acquired and to leave live, pre-recorded messages, or text messages regarding the matters described herein. I acknowledge that I am responsible for any charges that may be incurred from my telecommunications provider and that using any unsecure electronic

communication (such as regular email or standard text messaging) to communicate can present risks to the security of information. These risks include possible interception of the information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. By providing a mobile telephone number and/or email address to the Practice, or by contacting the Practice using these forms of communication, I agree to accept these risks and confirm that any phone number or email address I provide is associated with me and a not third-party. I understand that I am responsible for keeping my contact information current with the Practice. I may opt-out of text messaging or email communications, report concerns, or request a restriction at any time by contacting the Practice's Privacy at (866)-635-8765 or icomply@floridapeditrics.com. I further acknowledge that if I update my information or communication preferences with the Practice, electronic systems may take time to update, and that I may receive messages that are not current until such update has been completed in the systems that maintain my information. If a message about my account is received after my account becomes current or other updates are made, I understand that I may disregard the message.

Consent Testing in the Event of Healthcare Worker Exposure. In the event a healthcare worker is accidentally exposed to the Patient's blood or bodily fluids, it may be necessary for the Patient to undergo a blood test to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing and testing a small amount of the Patient's blood. I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person has actually been exposed (false negative). If any test is positive, the Practice will provide counseling about the meaning of these tests as it relates to the Patient's healthcare. These test results will be maintained in accordance with applicable privacy laws and will only be disclosed as authorized by law.

Treatment Plans. Practice practitioners may recommend treatment plans that may include diagnostic testing, therapy modalities, prescribed medications and/or specialty referrals required to effectively diagnose and/or treat the patient's condition. Failing to follow the recommended treatment plan can negatively affect health outcomes and the practitioner-patient relationship. I agree to speak with the Patient's provider if I have any questions or concerns about the recommended plan of care or treatment alternatives. I understand that ongoing failure to comply with the Patient's treatment plan may impede the practitioner-patient relationship to the extent that the Patient's provider may determine that termination from the Practice is necessary.

By signing below, I certify that I have read and understand this document, that I have the legal right and authority to execute this document, and that I accept its terms as the Patient or the parent or legal guardian of the Patient. If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if I signed this document in paper form.

PATIENT NAME: _____ **DOB:** _____

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature _____ **Date**: _____

(Patient/Authorized Representative)

Print Name of Authorized Representative (if different from patient): _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

CHILDREN'S CARDIOLOGY CLINIC

a Division of Florida Pediatric Associates

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Financial Responsibility. By signing this form, I acknowledge that I am responsible for the payment for the services rendered to the patient named above (the "Patient") by this division of Florida Pediatric Associates, LLC and its providers (collectively the "Practice"), and hereby assume and guarantee prompt payment of all expenses incurred at this Practice for the Patient. In consideration of services rendered to the Patient, I accept financial responsibility and agree to pay charges for all services ordered or otherwise provided to the Patient by this Practice. I agree to pay all applicable co-payments, co-insurance, and any remaining deductible that applies prior to or at the time of service. I understand that any balance due for non-covered services, or as a result of being uninsured or under-insured, is payable immediately. I further understand that if I fail to timely pay balances owed, my account associated with the Patient may be referred to a collection agent and/or attorney, and I agree to pay all reasonable collection costs. I understand that failure to maintain up-to-date insurance information at the Practice or to comply with my insurance plan's applicable requirements may result in reduction or denial of benefit payment and I will be responsible for any balances due. Self-pay and uninsured patients will be provided with a good faith estimate, in writing or electronically, of the total expected cost of any health care items or services to be received by the Patient upon request or when scheduling such items or services.

Assignment of Benefits. I hereby assign all insurance and/or other third-party payor benefits, inclusive of Medicare and all other third-party payors, to the Practice and request that payment of authorized insurance benefits be made on my behalf directly to the Practice. By signing below, I acknowledge that I am responsible for any deductibles, co-payments, co-insurance, and any other out of pocket expenses required by my insurance. I authorize the Practice to take all actions necessary, including filing legal actions, on my behalf to pursue payments from my insurance provider or any other third party required to make payments for the services provided by the Practice.

Release of Medical Information for Payment Purposes. I specifically authorize the use and disclosure of the Patient's health information as needed for payment purposes, including the disclosure of health information to any third-party responsible for payment, including but not limited to my insurance carrier, collection agencies, and credit bureaus where applicable. I acknowledge and agree that information disclosed pursuant to this authorization may include all medical records, and the following information (if maintained by the Practice in relation to the Patient): reproductive health information, psychiatric and mental health information, substance use disorder treatment information, genetic information, and/or HIV/AIDs status. I understand that if I do not consent to release of information for payment purposes, the Practice may be unable to process claims for payment through my insurance company or other third party responsible for payment and I will be billed directly for such services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. I further 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 may be sent to the Health Care Financing Administration, my insurance company or other entity if requested.

Unauthorized, Non-Covered, or Out of Plan Services. I acknowledge that some services performed by the Practice may not be covered by my insurance carrier, Medicaid, or Medicare, as applicable ("Non-Covered Services"). In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim and/or additional documentation related to the services provided that the claim pertains to. I understand that if my health plan does not consider any service rendered to be a "covered service" under my health plan, or if my health plan has not authorized this service, they will not pay for the service rendered by the Practice. I also understand and acknowledge that in the case the services provided to the Patient are services that are out of plan/network services, there may be reduced benefits, and I may be required to pay larger out of pocket charges than if covered by my health plan. I understand that I am responsible for the entire bill or balance of the bill as determined by the Practice and/or my health plan if the submitted claims or any part of them are denied for payment, subject to applicable law and the agreement in place between the Practice and my health plan (if any). However, if I receive non-emergency or emergency care in a facility in which my insurer has a participating contract or if I have Medicaid coverage, the Practice will not charge me or attempt to collect from me more than what is statutorily allowed.

For Medicare Recipients Only. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Practice for any services furnished to the Patient by the Practice. I authorize any holder of medical information about the Patient to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party that accepts assignment.

By signing below, I certify that I have read and understand this document, that I have the legal right and authority to execute this document, and that I accept its terms as the Patient or the parent or legal guardian of the Patient. If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if I signed this document in paper form.

PATIENT NAME: _____ **DOB:** _____

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature _____ **Date**: _____

(Patient/Authorized Representative)

Print Name of Authorized Representative (if different from patient): _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

CARDIOLOGY CLINIC

a Division of Florida Pediatric Associates

PAYMENT POLICY

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Thank you for choosing this division of Florida Pediatric Associates, LLC (collectively referred to as the "Practice" or "we"), for the patient's healthcare needs. Our relationship is best served when expectations are clearly understood. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy to help you better understand your financial responsibilities in relation to the medical care we provide. We ask that you read the policy, ask any questions you may have and sign your name at the end of this form. A copy will be provided to you upon request. All patients or their legal guardian, as applicable, must provide the Practice with valid identification (such as a driver's license) and a current copy of your primary (and secondary if applicable) insurance card(s). We do our best to confirm insurance eligibility and determine what amounts you will owe prior to your visit, but sometimes that amount changes depending on the scope of services actually provided. We accept cash, personal checks, debit, and credit card payments. However, additional fees may apply if a personal check is denied for insufficient funds. We reserve the right to deny non-urgent care if you refuse to fulfill your payment obligations.

Insurance. This Practice is contracted with most insurance companies, including Medicaid and Medicare, and we will submit claims to such third-party payors on your behalf when you have informed us of the coverage you have for the services provided. However, you should note that insurance plans may restrict the type and/or number of services covered and/or the number or type of eligible providers. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage and confirm that our providers participate in your insurance plan, whether or not a primary care referral or insurance authorization is required, and that the services you require will be covered by your health plan. If you are insured by a health plan we do business with, but you don't have your insurance information or an up-to-date insurance card, subject to any limitations under applicable law payment in full for each visit is required until your coverage is verified. In the event insurance information is not provided until a later date, we will submit a claim for services when we have received insurance information from you and will issue a refund as applicable for any amounts owed to you after your insurance carrier processes the claim. If we are not contracted with your insurance company, payment for all services is expected at the time of service. As a courtesy, we will submit claims to your insurance company. If you do not have insurance coverage, payment for all services is expected at the time of service. We will provide self-pay patients with a good faith estimate, in writing or electronically, of the total expected cost of any health care items or services to be received upon request or when scheduling such items or services.

Invoices and Payment. All co-payments, deductibles, and co-insurance amounts required by your insurance company must be paid at the time of service without exception, unless other arrangements are made in advance (subject your insurance plan's requirements). You will be provided with one invoice and up to one reminder related to any balances owed on your account. You are required to promptly pay all amounts determined to be your responsibility by your insurance carrier. If your account is not paid within 90 days of the date of service, the Practice may ask for the assistance of an outside collection agency or attorney. If you have not timely paid your account and we use a collection agency for the collection of balances owed on your account with the Practice, you agree to be responsible for any reasonable cost of collection, including credit checks, court costs, and attorney's fees. If you provide a phone number or email address, you authorize the Practice and its outside collection agency or attorney to contact you about the status of your bill via telephone call or text messaging at the number or address provided, which may be through an auto-dialer. By signing below, you acknowledge your understanding that you are responsible for keeping your contact information current and agree to be responsible for any fees applied by your telephone communications carrier. You further acknowledge that systems may take time to update after you make payments on your account, and that you may receive messages that are not current until systems are updated (in which case you may disregard such messages). If you have any questions regarding your bill or have a financial hardship, please call our office to make other arrangements.

Non-Covered Services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of visit. If you are an uninsured or self-pay patient, we will provide you with a good faith estimate of all expected primary items and services upon your scheduling of the items or services or upon your request. This good faith estimate will include any anticipated charges for expected items or services to be rendered by co-providers. If we are considered a non-participating provider in your insurance network but provide you with services in a participating facility, we will only charge you what is statutorily allowed for covered

services. However, if your insurance plan does not cover services or items in the facility and such services are considered non-emergency services, you understand that you must pay in full for non-covered services.

Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that once we have fulfilled any applicable claims submission obligations, the remaining balance of your account for amounts deemed to be patient responsibility will be your responsibility.

Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency as described above, and you may be discharged from the Practice.

Missed Appointments. Please help us to serve you better by keeping your regularly scheduled appointment and providing at least 24 business hours prior notice if you need to cancel or reschedule your appointment. A missed appointment charge of $50 will apply if you miss or cancel an appointment without providing prior notice of at least one business day, except in the limited case of an emergency. Missed appointment fees are your responsibility and must be paid prior to scheduling your next appointment. This policy applies to all patients, unless prohibited by any applicable third-party payor. You should note that missed appointment fees are not payable by insurance coverage. Rather, you will be responsible for paying missed appointment fees out-of-pocket. Excessive missed appointments may also result in discharge from the Practice. By signing this form, you agree to pay missed appointment fees as described in this policy.

Minor Patients. The adult accompanying a minor and/or the parent(s) (or guardian(s) of the minor) is responsible for payment at the time of service. Non-emergency treatment for unaccompanied minors will be denied unless payment arrangements have been made in advance.

Billing Questions
If you have a billing related question please contact Florida Pediatric Associates, LLC at **727-456-4256**.

By signing below, I certify that I have read and understand this document, that I have the legal right and authority to execute this document, and that I accept its terms as the Patient or the parent or legal guardian of the Patient. If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if I signed this document in paper form.

PATIENT NAME: _____ **DOB:** _____

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature _____ **Date**: _____
(Patient/Authorized Representative)
Print Name of Authorized Representative (if different from patient): _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Appointment Policy

PATIENT NAME: _____ **DOB:** _____

_____ Please be advised that our clinic has a 24-hour cancellation policy. Please contact us at least 24 hours before your appointment if you need to change it, and we will be happy to reschedule you. (Appointments scheduled on Mondays must be cancelled on the Friday before.) This helps us ensure that others on the waiting list can be offered that appointment slot, and we can continue to offer the highest level of care to all our patients.

_____ We do understand that sometimes unexpected issues arise which prevent you from keeping your appointment with us. The first time you fail to provide a 24-hour notice to cancel or change your appointment, you will not be charged. However, subsequent cancellations or rescheduling without at least a 24-hour notice are subject to a **$50** fee. After three short-term cancellations and/or no-show appointments, the Children's Cardiology Clinic reserves the right to refuse to schedule any further appointments for you in our clinic. At that time, we will forward your records to the cardiologist of your choosing.

_____ Because our goal is to see patients at the time of their scheduled appointment and minimize wait times, please be advised that if you are more than 15 minutes late for your appointment, you may have an extended wait time, or it might be necessary for us to reschedule that appointment.

We appreciate your timeliness for your appointments because it helps the Clinic run smoothly for everyone.

Please initial the above paragraphs and sign below to acknowledge receipt of this policy.

I have read the Clinic Appointment Policy for the Children's Cardiology Clinic.

Patient/Guardian Signature _____

Full Name of Guardian _____

Date _____

CHILDREN'S CARDIOLOGY CLINIC

a Division of Florida Pediatric Associates

CONSENT FORM FOR THE E-PRESCRIBE PROGRAM

Divisions of Florida Pediatric Associates, LLC have implemented e-prescribing as part of an on-going effort to improve your health care. E-prescribing refers to a system used to submit prescriptions electronically to a pharmacy of your choice. By eliminating paper, e-prescribing creates a more efficient and safer process for patients to access their medications. This electronic process aims to prevent prescription errors and improve patient safety. The ePrescribe Program may also include:

Formulary and benefit transactions – Provides information to your health care practitioner about which drugs are covered by your drug benefit plan.

Fill status notification - Allows your health care practitioner to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

Medication history transactions - Provides your health care practitioner with information about your current and past prescriptions to minimize potential medication issues and adverse medication events. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your Florida Pediatric Associates health care practitioner as well as other health care providers involved in your care. Medication history information may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

CONSENT

By signing this consent form you agree that your Florida Pediatric Associates health care practitioner may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Florida Pediatric Associates, LLC health care practitioner to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

By signing below, I certify that I have read and understand this document, that I have the legal right and authority to execute this document, and that I accept its terms as the Patient or the parent or legal guardian of the Patient. If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if I signed this document in paper form.

PATIENT NAME: _____ **DOB:** _____

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature _____ **Date**: _____

(Patient/Authorized Representative)

Print Name of Authorized Representative (if different from patient): _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

CHILDREN'S CARDIOLOGY CLINIC

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Telehealth Consent Form

Telemedicine is the delivery of healthcare services when the healthcare provider and the patient (the "Patient") are not in the same physical location and communicate through technology. Electronically transmitted information may be used for diagnosis, treatment, follow-up, prescription, or education and may include medical records, medical images, interactive audio, video and/or data communications, and output data from medical devices, sound and video files. The Patient understands the following with respect to telemedicine offered by FLORIDA PEDIATRIC ASSOCIATES, LLC (the "Practice"):

1. The Patient has elected to have a telemedicine visit instead of an in-office visit at the Practice. The Patient agrees that the Practice will determine whether the Patient's condition is appropriate for telemedicine and acknowledges that the Practice may recommend an in-person visit.

2. There are potential risks associated with the use of telemedicine, including, but not limited to: the information transmitted may be less comprehensive than that available from an in-person visit and result in decreased accuracy of diagnosis or medical decision-making; delays in medical evaluation or treatment could occur due to deficiencies or failures of the telemedicine equipment; and security protocols could fail, causing a breach of privacy. The Patient understands that telemedicine often involves electronic transmission of the Patient's protected health information ("PHI"). The Patient's PHI includes, but is not limited to, the Patient's identifying information; medical history; diagnoses; communications to and from the Patient's other health care provider(s); etc. The Patient understands that PHI may be lost due to technical failures, cyber intrusion or other issues disrupting the Patient's telemedicine visit or causing delays in response from the Practice. The Patient assumes these risks and holds the Practice and its providers harmless from any claims arising out of the use of telemedicine to conduct the visit.

3. The Patient understands that telemedicine visits may be recorded and that the laws that protect privacy and confidentiality of medical information also apply to telemedicine. The Patient understands that PHI obtained during the telemedicine visit will not be disclosed to other entities without the Patient's consent unless otherwise permitted by applicable law or in accordance with the Practice's Notice of Privacy Practices. The Patient has the right to withhold or withdraw consent for telemedicine at any time without affecting the right to the Patient's future care, treatment, benefits, or programs for which he or she is otherwise entitled. Any such withhold or withdrawal of consent shall be given in writing, and shall be deemed to be properly delivered upon receipt if sent by: (a) certified U.S. mail, return receipt requested, (b) facsimile, or (c) personal delivery with receipt, to the principal address of the Practice. The Patient understands that if others are present at Patient's location during the Patient's telemedicine visit, the confidentiality of the Patient's telemedicine visit may be compromised.

4. The Patient understands the alternatives to telemedicine as they have been explained, and in choosing to participate in a telemedicine visit understands that some parts of the exam may require physical testing to be performed at another location at the direction of the Practice.

5. THE PATIENT UNDERSTANDS IT IS POSSIBLE THAT HEALTH INSURANCE WILL NOT COVER THE TELEMEDICINE VISIT(S). THE PATIENT MAY ELECT TO PAY OUT OF POCKET FOR THE TELEMEDICINE SERVICES IF THEY ARE NOT COVERED BY HEALTH INSURANCE. THE PATIENT AGREES THAT IF THE HEALTH INSURER DOES NOT PAY FOR THE TELEMEDICINE SERVICES, THE PATIENT WILL BE RESPONSIBLE FOR PAYMENT. THE PATIENT FURTHER UNDERSTANDS THAT HE OR SHE IS RESPONSIBLE FOR ALL COST SHARING OBLIGATIONS (E.G., COPAYMENT, DEDUCTIBLE) REQUIRED BY THE HEALTH INSURANCE PLAN ("COST SHARING OBLIGATIONS"). ALL OUT-OF-POCKET EXPENSES ASSOCIATED WITH THE TELEMEDICINE VISIT, INCLUDING COST SHARING OBLIGATIONS AND PAYMENT FOR NON-COVERED SERVICES, ARE DUE PRIOR TO THE TELEMEDICINE VISIT IF SUCH AMOUNTS ARE KNOWN AT THAT TIME.

6. The Patient understands that a patient must be physically located in the State of Florida during his or her telemedicine consultation(s) and represents that the Patient is located in the State of Florida during the entirety of each telemedicine visit. The Patient understands that if he or she is not physically located in the State of Florida, the Practice may decline to treat him or her via telemedicine.

7. The Patient understands that the Practice and its providers are located in the State of Florida and provide telemedicine services within the State of Florida. The Patient agrees that the venue of any action or proceeding relating to, involving, or resulting from the telemedicine services offered or provided or enforcement of this Telemedicine Consent shall be in Pinellas County, Florida, regardless of the location where telemedicine services are provided to the Patient. The laws of the State of Florida will govern any such disputes and the Patient consents to jurisdiction in the State of Florida.

8. The Patient has been advised of all the potential risks, consequences and benefits of telemedicine. The Practice has discussed with him or her the information provided above and the Patient has had the opportunity to ask questions about the information presented on this form. All the Patient's questions have been answered, and he or she understands the information.

By signing this form, I, _____, consent to telemedicine services to be rendered by the Practice. I represent and warrant that I am authorized to consent to services described herein.

_____	_____	_____
Print Patient Name	Signature of Patient/Guardian	Date

Children's Cardiology Clinic

Release of Medical Records
DIVULGACIÓN DE REGISTROS MÉDICOS

PATIENT NAME: _____ **DOB:** _____
(Nombre del paciente) (Nacimiento)

Release of Medical Records TO Children's Cardiology Clinic FROM:
Divulgación de registros médicos A la Clínica de Cardiología Infantil DE:

Name (Nombre): _____

Address (dirección): _____

Phone (Teléfono): _____

Fax: _____

******Please include any cardiology clinic notes, echocardiogram reports, ECG's, cardiac monitor results, genetic test results and EP or Cath lab reports for _____ to _____.***
DATE FROM DATE TO
Please fax records to 888-494-2369. Call the office at 407-588-0550 if any questions. ****

Please use SEPARATE forms for different providers. (Por favor use un formulario separado para diferentes medicos.)

Release of Medical Records FROM Children's Cardiology Clinic TO:
Divulgación de registros médicos DE la Clínica de Cardiología Infantil A:

Name (Nombre): _____

Address (dirección): _____

Phone (Teléfono): _____

Fax: _____

I consent to allow my protected health information to be released as noted above. I understand that this authorization will expire one year from the date it is signed unless I specify otherwise. I understand that there may be a $25 Medical Records Processing Fee associated with records being forwarded from Children's Cardiology Clinic to another healthcare provider.

Doy mi consentimiento para permitir que mi información de salud protegida sea divulgada como se indicó anteriormente. Entiendo que esta autorización expirará un año a partir de la fecha en que se firme, a menos que especifique lo contrario. Entiendo que puede haber una tarifa de procesamiento de registros médicos de $25 asociada con los registros que se envían de Children's Cardiology Clinic a otro proveedor de atención médica.

Patient/Guardian Signature (firma)_____

Full Name of Guardian (nombre de tutor) _____

Date (fecha) _____

Children's Cardiology Clinic
A Division of Florida Pediatric Associates, LLC

AUTHORIZATION FOR ACCOMPANIMENT OF MINOR

(Only to be completed if parent/guardian is not accompanying the patient for appointment)

I, _____, parent/guardian for

_____ (DOB _____) authorize

_____ (relationship _____)

to accompany _____ for their appointment

scheduled with Dr. Bhavya Trivedi. I also authorize the Children's Cardiology Clinic, a division of Florida Pediatric Associates, and Dr. Trivedi to provide any necessary Protected Health Information to _____ during the office visit.

Name of adult accompanying patient

Signature of Parent/Guardian: _____

Date: _____

www.childrens-cardiology.com info@childrens-cardiology.com
Phone: (407) 588-0550 Fax: (888) 494-2369