Sergio J. Jacinto, M.D., P.A.

Pediatric Neurology

4507 N. Armenia Avenue – Tampa, FL 33603

244 S. Moon Avenue (Suite 240) – Brandon, FL 33511

Telephone: (813)876-4100 • Fax: (813)876-4153

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ DOB: ____/_____/_____ SSN: _____-_____-_____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____

RACE: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White ☐ Native Hawaiian

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

PRIMARY CARE PHYSICIAN: _____PHONE: _____

SCHOOL NAME: _____ COUNTY: _____ GRADE: _____

PARENT/LEGAL GUARDIAN INFORMATION

Who has legal custody of the patient? ☐ Parents ☐ Mother Only ☐ Father Only ☐ *Foster Parent ☐ *Other
If you checked a box with an (*) in front of it, appropriate paperwork MUST be presented before the visit.

MOTHER/GUARDIAN'S NAME: _____ AGE: _____ DOB: ____/_____/_____ SSN: _____-____-_____

PREFERRED LANGUAGE: _____EMAIL: _____ PHONE: _____

ADDRESS (if different than patient's): _____CITY: _____ STATE:_____ ZIP:_____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____

FATHER/GUARDIAN'S NAME: _____ AGE: _____ DOB: _____/_____/_____ SSN: _____-____-_____

PREFERRED LANGUAGE: _____EMAIL: _____ PHONE: _____

ADDRESS (if different than patient's): _____CITY: _____ STATE:_____ ZIP:_____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____ POLICY/ID #: _____ GROUP: _____

SUBSCRIBER'S NAME: _____ DOB: _____/_____/_____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S ADDRESS (if different than patient's):_____CITY: _____ STATE: ____ ZIP:_____

SECONDARY INSURANCE COMPANY: _____ POLICY/ID #: _____ GROUP: _____

SUBSCRIBER'S NAME: _____ DOB: _____/_____/_____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S ADDRESS (if different than patient's):_____CITY: _____ STATE: ____ ZIP:_____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE: _____ FAX: _____

ADDRESS or CROSS STREETS: _____ CITY: _____STATE:_____ ZIP:_____

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PATIENT MEDICAL HISTORY

REASON FOR TODAY'S VISIT: _____

Is this due to an auto accident: ☐ YES ☐ NO **(If yes, please answer the following questions)**

Are there attorney's involved: ☐ YES ☐ NO

What date did the accident occur: ____/_____/_____What is the attorney's name: _____ Phone: _____

IMMUNIZATIONS

Up to date: ☐ YES ☐ NO – If not, please explain: _____

HOSPITALIZATIONS

Date: _____/_____/_____ Hospital: _____ Reason: _____

Date: _____/_____/_____ Hospital: _____ Reason: _____

Date: _____/_____/_____ Hospital: _____ Reason: _____

SURGERIES

Date: _____/_____/_____ Surgery Description: _____

Date: _____/_____/_____ Surgery Description: _____

Date: _____/_____/_____ Surgery Description: _____

ALLERGIES

Medications: _____ Food: _____

CURRENT MEDICATIONS

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

PREVIOUS MEDICATIONS

Name: _____ Reason for discontinuing: _____

Name: _____ Reason for discontinuing: _____

Name: _____ Reason for discontinuing: _____

BIRTH HISTORY

Type of Delivery: ☐ Vaginal ☐ Vaginal Via Forceps Assist ☐ Vaginal Via Vacuum Assist ☐ C-Section

Birth Weight: _____ Gestational Age (Weeks): _____ If premature, how many weeks: _____Length of stay in hospital/NICU: _____

Complications during pregnancy: _____

Fetal complications: _____

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FAMILY HISTORY

Review the list below and put a check (√) next to the condition/diagnosis if anyone in your family has been diagnosed with any of them.

	Condition/Diagnosis		Condition/Diagnosis		Condition/Diagnosis
	ADHD		Down's Syndrome		Muscular Dystrophy
	Aneurysm		Dyslexia		Narcolepsy
	Anxiety		Epilepsy		Obsessive Compulsive Disorder (OCD)
	Asperger's Syndrome		Fainting		Opposition Defiant Disorder (ODD)
	Autism		Febrile Seizures		Pervasive Developmental Disorder (PDD)
	Bell's Palsy		Fibromyalgia		Plagiocephaly (flat spot on the head)
	Bipolar		Headaches		PTSD
	Brain Tumor		Learning Disability		Seizures
	Cerebral Palsy		Lupus		Sleep Apnea
	Chiari Malformation		Macrocephaly (large head)		Stroke
	Depression		Mental Retardation		Syncope
	Dementia		Microcephaly (small head)		Tics
	Developmental Delays		Migraines		Tourette's

SOCIAL HISTORY

Type of Living Arrangement: ☐ Mobile Home ☐ House ☐ Shared House ☐ Apartment/Condo ☐ Trailer☐ Care Facility ☐ Homeless ☐ Townhome ☐ Other

Number of children in the household: _____ Number of adults in the household: _____

Does the patient smoke: ☐ N/A ☐ No ☐ Yes

Has the patient used marijuana: ☐ N/A ☐ No ☐ Yes

Does the patient drink alcohol: ☐ N/A ☐ No ☐ Yes

AUTHORIZATION OF RELEASE

List any person whom we may inform about general medical condition and diagnosis information to (including treatment, payment and healthcare operations

_____ _____

Persons Full Name **Relationship to Patient**

_____ _____

Persons Full Name **Relationship to Patient**

List any person of whom we may inform about you/your child's medical condition ONLY IN AN EMERGENCY

_____ _____ (____) _____-_____

Persons Full Name **Relationship to Patient** **Phone Number**

_____ _____ (____) _____-_____

Persons Full Name **Relationship to Patient** **Phone Number**

Can confidential messages, such as appointment reminders/test results/return phone calls/etc., be left on your voice mail to the phone numbers that you have provided us: ☐ Yes ☐ No

_____ _____

Patient Name **Patient DOB**

_____ _____ _____ _____

Print Parent/Legal Guardian Name **Signature of Parent/Legal Guardian** **Relationship to Patient** **Date**

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INSURANCE CERTIFICATION FOR PAYMENT

Assignment of Benefits

I, _____, parent/legal guardian of _____ authorize payment of medical benefits to Dr. Sergio J. Jacinto, M.D., P.A., for professional services rendered.

Release of Information

I authorize the release of all medical records and/or other information regarding my/my child's treatment for hospitalizations and /or outpatient care, including psychological/psychiatric treatment, drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and any other test/information that could be compromising to myself that may be needed to process the medical claims. I understand that this authorization may be voided by me at any time upon written notice.

_____	_____	_____	_____
Print Parent/Legal Guardian Name	**Signature of Parent/Legal Guardian**	**Relationship to Patient**	**Date**

FINANCIAL POLICY

Dr. Sergio J. Jacinto and his staff would like to welcome you to our practice. We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. We ask for your help by cooperating with our financial policy.

Please read this policy and sign below confirming that you understand the following:

- A parent/legal guardian **MUST** accompany minors. Any non-emergency treatment will be **DENIED** to unaccompanied minors.
- All patients **MUST** complete our "New Patient Information Packet" prior to being treated by the doctor.
- Our office participates with multiple insurance companies; however, it is your responsibility to understand the requirements and covered benefits of your plan.
- It is your responsibility to provide current insurance coverage prior to being seen.
- If your insurance company requires you to obtain a referral and/or authorization to be seen by a specialist, it is your responsibility to contact your primary care physician to obtain one prior to being seen.
- If we have not received your referral and/or authorization prior to being seen your appointment will be rescheduled or you will be considered a self-pay patient as your insurance company will not cover the appointment.
- All payments, such as copays/deductibles/coinsurance/balances, will be collected in full prior to being seen unless prior arrangements have been made with our office.
- You are responsible for any non-covered and/or denied claims. If your insurance company denies a claim or states that it was a non-covered service under your plan you will receive a statement of denied charges and payment will be due within 30 days of the statement date.
- Your account is to be kept current. Any balance over 90 days will be sent to collections
- If you have a credit on your account your refund will be issued within 6-8 weeks of the date requested, if there are no pending insurance claims.

ALL CHANGES TO YOUR INSURANCE MUST BE REPORTED TO OUR OFFICE 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT

***Your insurance plan is a contract between your and them! We file medical claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding copays, coinsurances, deductibles and non-covered charges. ***

_____	_____	_____	_____
Print Parent/Legal Guardian Name	**Signature of Parent/Legal Guardian**	**Relationship to Patient**	**Date**

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OFFICE POLICIES

Read our office policies listed below. Once you have read and understand our policies initial next to each one then print, sign and date the bottom of this form.

_____ If you arrive more than 15 minutes after your scheduled appointment time without notifying our office your appointment will be Rescheduled.

_____ It is your responsibility to cancel or reschedule your scheduled appointment 24 hours prior to that scheduled appointment.

_____ If your appointment is not canceled or rescheduled within 24 hours of your scheduled appointment you will be charged a $35.00 fee. ***THIS FEE HAS TO BE PAID PRIOR TO YOUR NEXT APPOINTMENT!!!***

_____ If you "no show" your scheduled appointment you will be charged a $35.00 fee. ***THIS FEE HAS TO BE PAID PRIOR TO YOUR NEXT APPOINTMENT***

_____ If you reschedule, cancel or no show your scheduled appointment and we are prescribing your child's medication you will not receive a refill until they are seen again. ***KEEP IN MIND THAT AT TIMES WE ARE SCHEDULING FOLLOW-UP APPOINTMENTS 2-3 MONTHS AWAY!!!***

_____ After the 3rd reschedule, canceled, no showed appointment you will be discharged from our practice as we cannot properly take care of your child's healthcare needs under these circumstances.

_____ Medical records are to be requested in writing. They are $1.00 per page. ***WE HAVE UP TO 30 DAYS TO SUPPLY YOU WITH THE REQUESTED MEDICAL RECORDS.***

_____ Copays, balances, deductibles and coinsurances are due prior to being treated (further information is on our Financial Policy).

_____ There is a $35.00 charge for completion of paperwork such as disability forms, FMLA paperwork or letters that are requested to be done by our office. You will be required to pay this fee prior to having the paperwork completed. ***WE HAVE UP TO 14 DAYS TO COMPLETE THE REQUESTED PAPERWORK.***

_____ _____

Patient Name **Patient DOB**

_____ _____ _____ _____

Print Parent/Legal Guardian Name **Signature of Parent/Legal Guardian** **Relationship to Patient** **Date**

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected healthcare information about you/your child. The notice contains a Patient Rights section describing your rights under the law. You have the right to review the notice before signing this consent. The terms of our notice may change at any time. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you/your child is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor your request.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by yourself, parent or legal guardian. However, such revocation shall not affect any disclosures we have already made in reliance to your prior consent. Our practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient, Parent, Legal Guardian understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operation.
- Our practice has a Notice of Privacy Practice and that the patient has the opportunity to review the notice at any time.
- Our practice reserves the right to change the Notice of Privacy Policies at any time.
- The patient has the right to restrict the use of their information, but our practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then be ceased.
- Our practice may condition treatment upon the execution of this consent.

_____ _____

Patient Name **Patient DOB**

_____ _____ _____ _____

Print Parent/Legal Guardian Name **Signature of Parent/Legal Guardian** **Relationship to Patient** **Date**

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HIPAA NOTICE OF PRIVACY PRACTICES

EFFECTIVE: SEPTEMBER 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY AND AT THE END MAKE SURE TO FILL OUT THE "ACKNOWLEDGEMENT OF RECEIPT"

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations (HIPAA). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule Requirements.

1. **Your Rights:**
   - You have the right to request restrictions on the uses and disclosure of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of healthcare charges to your insurance carrier if you pay for those services, in full, by other means.
   - You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.
   - You have the right to inspect a copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.
   - You have the right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with this denial.
   - You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account
     for disclosures: authorized by you; made for treatment, payment, healthcare operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family member; and/or for certain government functions, to name a few.
   - You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at (813)876-4100.
2. **We may also use or disclose your Health Information for purposes of treatment, payment, or healthcare operations without obtaining your prior authorization and here is an example of each:**
   - We may provide your Health Information to other health care professionals – including doctors, nurses and technicians – for purposes of providing you/your child with care.
   - Our billing department may access your information and may send relevant parts to your insurance companies to allow us to be paid for the services rendered to you/your child.
   - We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.
3. **We may also use or disclose your Health Information under certain circumstances without obtaining your prior authorizations. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but not limited to:**
   - To notify and/or communicate with your family. We will only communicate with people that we are authorized to communicate with based on the completion of the *Authorization of Release* form as required by law.
   - For health oversite activities. We may use or disclose your Health Information to health oversite agencies during the course of audits, investigations, certification and other proceedings.
   - In response to Civil Subpoenas or for Judicial Administrative Proceedings: We may use or disclose your Health Information as directed, in the course of any civil administrative or judicial proceedings.
   - To Law Enforcement Personnel: We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.
   - For Purposes of Organ Donation: We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
   - For Worker's Compensation: We may use or disclose your Health Information as necessary to comply with Worker's Compensation Laws.

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4. **For all other circumstances:**
   We may only use and disclose your Health Information after you have signed an authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time:
   - Fundraising: Should our practice use patient information for fundraising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.
   - Marketing: Should our practice use information for marketing purposes, we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI will require a separate written authorization.
   - Use or disclosure of psychotherapy notes: Written authorization is required if our practice intends to use or disclose psychotherapy notes.
   - Breach notice: All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by HIPAA regulations.
   - Right to request restrictions for disclosures related to self-payment: Our practice is required to comply with a request not to disclose Health Information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance" form.
5. **You should be advised that we may also use or disclose your Health Information for the following purposes:**
   - Appointment reminders: We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health related benefits and services that may be of interest to you.
   - Change of ownership: In the event that our practice is sold or merged with another organization, your Health Information/records will become the property of the new owner.
6. **Our Duties:**
   - We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this notice.
   - We are also required to abide by the terms of this notice.
   - We reserve the right to amend this notice at any time in the future and to make the new notice provisions applicable to all your Health Information – even if it was created prior to the change in the notice. If any such amendment is made that materially changes this notice, we will send you an updated copy.
7. **Complaints to our practice and the government:**
   - You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS) if you believe your rights have been violated.
   - We will review all complaints in a professional manner and keep you informed of your rights as our patient.
   - We promise not to retaliate against you for any complaint you make about our privacy practices.
8. **Contact information:**
   - You may contact us about our privacy practices or file a complaint by calling our Privacy Officer at (813)876-4100.
   - You may contact DHHS at The U.S. Department of Health and Human Services; 200 Independence Avenue, S.W., Washington, D.C. 20201; Telephone: (202)619-0257, Toll Free: 1-877-696-6775.

ACKNOWLEDGEMENT RECEIPTNOTICE OF PRIVACY PRACTICE RULES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this offices Notice of Privacy Practices.
Print Name of Parent/Legal Guardian

_____ _____
Patient Name **Patient DOB**

_____ _____ _____ _____
Print Parent/Legal Guardian Name **Signature of Parent/Legal Guardian** **Relationship to Patient** **Date**

****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency prevented us from obtaining the acknowledgment
- ☐ Other (please specify): _____

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Height:
Weight:
Temp:
SpO2:
HR:
HC:
BP: