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

Pediatric Neurology
4507 N. Armenia Avenue – Tampa, FL 33603
Tel: 813-876-4100 – Fax: 813-876-4153

PATIENT INFORMATION **TODAYS DATE: / /**

Patient's Name: _____ Sex: M or F

DOB: _____ AGE: _____ SSN: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone # (_____) _____-_____ Secondary Phone # (_____) _____-_____

School Name: _____ Grade: _____

Race: __ American Indian __ Asian __ Black or African American __ Hispanic
__ White __ Native Hawaiian
Ethnicity: __Hispanic or __ Not Hispanic Preferred Language _____

Primary care Physician: _____ Phone: (_____) _____-_____

INSURANCE INFORMATION

Insurance Company Name: _____
Subscriber's Name: _____ DOB: _____

Policy / ID # _____ Relation to Patient: _____

FAMILY HISTORY INFORMATION

Mother's Name: _____ Age _____ Occupation: _____
Employer _____ SSN _____-_____-_____

Work # (_____) _____ Ext: _____

Father's Name: _____ Age _____ Occupation: _____

Employer _____ SSN _____-_____-_____

Work # (_____) _____ Ext: _____

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Significant Family History _____

Brothers & Sisters _____ Sex _____ Age _____
_____ Sex _____ Age _____

PAST MEDICAL HISTORY

Birth Weight: _____

Hospitalization: Date: _____ Reason: _____
Date: _____ Reason: _____

Surgeries: Date: _____ Reason: _____
Date: _____ Reason: _____

List Allergies: _____

Are Your Immunization Up To Date: Yes _____NO _____ if not explain: _____
_____

Current Medications: 1. _____
2. _____
3. _____

Reason for Visit: 1. _____
2. _____
3. _____

Is this due to an Auto accident: Yes _____ No _____

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INSURANCE CERTIFICATION FOR PAYMENT

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to Dr. Sergio Jacinto, for professional services rendered.

Sign _____ Date: _____

RELEASE OF INFORMATION:

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

Sign _____ Date: _____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected Health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. 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 is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, sighed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operation.
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the 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 cease.
- The Practice may condition treatment upon the execution of this Consent.

Sign: _____

This Consent was signed by: _____
Printed Name of Resprestative / Patient

Relationship to the Patient _____ Date: _____

Witness _____ Date _____
Print Name

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AUTHORIZATION FOR RELEASE

1. Please list the family members or other persons, if any, whom we may inform about general medical condition and your diagnosis (including treatment, payment and health care operation)

   _____

   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name _____ Phone # (____) _____-_____

   Name _____ Phone # (____) _____-_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than you home

   Address _____ City _____

   State _____ Zip code _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"

   YES _____ NO _____

5. Please print the telephone number where you want to receive calls about your appointment, lab and x-ray results, or other health care information if other than your home phone number:_____
6. Can confidential message (i.e., appointment reminder) be left on your telephone answering machine or voicemail? YES or NO

Patient Name: _____

Patient/Guardian signature: _____ Date: _____

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Office Policies

We thank you for being a patient at SERGIO J. JACINTO, M.D. Due to our continuing efforts in meeting the needs of all our patients; we need to make you aware of some of our policies. **Please initial each policy showing that you have read and understand each policy. Also, please sign and print your name at the bottom of the form.**

- _____Our office hours are Monday thru Friday 8:30am to 4:00pm. Our phone will be on service from 12 – 1pm M-F, but we **do not** close for lunch.
- _____Please arrive 15 minutes prior to your appointment time. If you arrive more than 15 minutes after appointment time, it may be rescheduled.
- _____If you are unable to attend your scheduled appointment please contact our office 24-hours in advance. If we do not receive a call to cancel or reschedule your appointment, you will be responsible for a **$35.00 NO SHOW FEE**. This is not covered by your insurance and must be paid before the next visit. **After the 3rd missed appointment, without notification, we will no longer be able to offer medical care for your child. You will be discharged from our practice!** It is your responsibility to remember and keep your appointments. We do courtesy calls when possible.
- _____After hours calls are as follows: If your call is an **EMERGENCY –call 911.** Or go to the nearest emergency room. If your call is an urgent one that cannot wait until regular business hors you can page the on-call physician through our answering service.
- _____Payment for services is payable in full prior to services rendered and is the responsibility of the responsible party. **Please see financial policy attachment.**
- _____Medical records copied for patients will be charged $1.00 per page. You will have to sign a request with time in order to have your records copied. We only handle records on Friday, so please be aware of that. **We will not mail any records**. They have to be picked up in person. We only fax records to other physician involved in the care of your child.
- _____**You have to keep your follow up appointments in order to get refills of your medications.** Substance controlled medications cannot be called to the pharmacy; they have to be picked up in person from our office. Please call the prescription line and follow the prompts. **Refills must be called in 5-7 business days previous to your last dose**.

Patient's Name: _____ **DOB:** _____

Parent/Guardian Signature _____ **Date**

_____

Parent/Guardian Print: _____

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PHARMACY INFORMATION

- Pharmacy' s Name: _____
- Address: _____

  City: _____ State: _____ Zip: _____
- Phone Number: _____
- Fax Number: _____

Patient's Name: _____ DOB: _____

SERGIO J. JACINTO, M.D., P.A.

FINANCIAL POLICY

Dr. Sergio Jacinto and 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 understanding and cooperating with our financial policy.

Please read this policy, and initial & sign below confirming you understand the following:

- A parent or guardian MUST accompany minors. Any none emergency treatment will be denied to unaccompanied minors.
- All patients MUST complete our "Patient Information Packet" before seeing the doctor.
- You are responsible to supply current insurance coverage information prior to the visit.
- Insurance pre-authorization is the responsibility of the patient.
- If your insurance company requires you to obtain a referral to be seen by a specialist, it is **your responsibility** to contact your primary care physician, to obtain the referral before the doctor sees you. If you do not have a referral for your visit/procedure, you will be required to pay for the visit before being seen, or your appointment will be rescheduled.
- Your account is to be kept current.
- Full payment is due at the time of service, unless prior arrangements have been made or we are providers for your insurance company.
- All payments, self-pay fees, insurance deductibles, copayments, and co-insurances will be collected in full before you are seen.
- If you do not have your payment(s), your appointment will be rescheduled.
- If you have insurance we will work to ensure you receive the maximum benefits. Although, we DO NOT provide services to any cases involving attorneys (example: Auto Accident, Slip & Fall, No Fault, etc.)
- **WE DO NOT FILE TO SECONDARY INSURANCES.**
- Any balance of 90 days may be sent to collections.
- Our practice participates with multiple insurance companies; it is your responsibility to understand the requirements and covered benefits of your plan.
- You are responsible for any non-covered and/or denied claim; you will receive a statement of denied charges and payment is due within 30 days of statement.
- Refunds will be issued within 6 weeks from the date requested, if there is no pending insurance claims.
- There is a **$35.00** charge for completion of paperwork (example: disability, FMLA, etc.) Paperwork may take up to 7-14 days for completion.
- All changes to insurance, address, and phone numbers must be reported to our office prior to appointment.
- You are required to cancel appointments **24 hours prior** to appointment time to avoid **$35.00** cancellation charge. Initials _____

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We file as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding DEDUCTIBLES, COPAYMENTS, CO-INSURANCES, and COVERED CHARGES, SECONDARY INSURANCES, "USUAL & CUSTOMARY" charges, etc., other supply factual information necessary. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

We realize that temporary finance problems may arise affecting timely payment. Please call 813.876.4100 option 6 to set up the correct management of your account.

Responsible Party Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

PRACTICE NAME: SERGIO J. JACINTO, M.D., P.A.

EFFECTIVE DATE: SEPTEMBER 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

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.

I. 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 health care 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 and 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 a 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, health care 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.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses, and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

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 confidentially when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances Without Obtaining Your Prior Authorization. However, in general, we will attempt to insure 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 are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.
As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

TURN PAGE →

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 proceeding.

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.

IV. For all Other Circumstances:

We May Only Use or 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 fund raising 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 patient 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 the 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.

V. 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 mat be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/ records will become the property of the new owner.

VI. 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 another copy.

VII. 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.

VIII. Contact Information.

You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Yanet Pacheco 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.

SERGIO J. JACINTO, M.D., P.A.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ , have received a copy of this
PRINT NAME

office's Notice of Privacy Practices.

_____
(PLEASE PRINT NAME)

_____
(SIGNATURE)

_____
(DATE)

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

_____