Pediatric Specialist

4950 S. LeJeune Rd.
Suite F
Coral Gables, FL 33146
(305) 665-3523 (p)
(305) 665-2272 (f)

New Patient Paperwork

Dear Parent,

Thank you for your interest in your child(ren) becoming a patient at Pediatric Specialist!

The following is what is needed in order for your child(ren) to become a patient at our practice:

1. Fill out the attached paperwork in its entirety and bring them to your scheduled appointment.
2. If your child(ren) is coming from another provider, be sure to fill out the *Medical Record Release Form* and we will forward it to the former provider on your behalf. Please note, we are unable to determine immunizations status at a well-child appointment without your child's previous records.
3. Call your insurance company to change your child's Primary Care Provider (PCP) to Gary M. Kramer, MD.
4. At your child's first appointment bring:
    a. Parent Photo ID/Driver's License
    b. Hospital or Former Provider Records
    c. Insurance Card for all Insurance Policies (Primary/Secondary/Tertiary).
    d. ***If you do not bring all of these items, your appointment may be rescheduled.***
5. We require the parent of the child to be present at the first appointment for the accuracy of all medical history and to sign our Consent to Treat Form.

NEWBORN APPOINTMENTS: Please be informed that we recommend accurate Insurance information, be given to us during the scheduling of your newborns first office visit appointment. Enrollment to the Insurance provided is highly important, as Payers grant a designated time frame for this process.

Due to Healthcare changes, there are certain Networks within Insurance Companies that do not grant us Participation.

If you have any questions or concerns regarding this information, please do not hesitate to call our office (305)665-3523.

Sincerely,
Pediatric Specialist

Pediatric Specialist

Gary M. Kramer, M.D., PA

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Patient's Last Name: _____ Patient's First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ MALE ☐ FEMALE Date of Birth _____

Race (check one) ☐ 1-American Indian/Alaska Native ☐ 02-Asian ☐ 03-Black/African American ☐ 04-White ☐ 05-Pacific Islander ☐ 06-Refuse

Ethnicity (check one) ☐ 1-Hispanic or Latino or Spanish origin ☐ 02-Non Hispanic or Latino or Spanish origin ☐ 03-Refuse

Preferred Language: _____ Parents Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single

Home Phone: _____ Cell Phone (Mom) _____ Cell Phone (Dad) _____

Email Address: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Who referred you? _____

PRIMARY CONTACT PERSON FOR FAMILY (this primary contact will be the preferred contact person for Reminder calls)

(Circle) one: Mother / Father Social Security#: _____

Check one: ☐ Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Legal Guardian ☐ Other: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____ Email: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Do you live with patient? ☐ Yes ☐ No Name of Employer: _____

Check preferred means of contact for messages: ☐ Home ☐ Cell ☐ Work ☐ Email

Check preferred means of contact for Appointment Reminders: ☐ Home ☐ Cell ☐ Work ☐ Email

SECONDARY CONTACT PERSON FOR FAMILY (this primary contact will be the preferred contact person for Reminder calls)

(Circle) one: Mother / Father Social Security#: _____

Check one: ☐ Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Legal Guardian ☐ Other: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____ Email: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Do you live with patient? ☐ Yes ☐ No Name of Employer: _____

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) _____

(If either biological parent has NO parental rights per a SIGNED COURT ORDER, a copy of that Court Order is required to be on file.)

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: _____ Relationship to Patient: _____ Phone: _____

FINANCIAL GUARANTOR: _____ Relationship to Patient: _____

Insurance Company name: _____ Primary Insured name: _____

ID# or Member# _____ Group # _____

_____ _____ ☐ MALE ☐ FEMALE

Name **Date of Birth**

_____ _____ ☐ MALE ☐ FEMALE

Name **Date of Birth**

_____ _____ ☐ MALE ☐ FEMALE

Name **Date of Birth**

_____ _____

Parent/Guardian Signature **Date**

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Thank you for choosing our office and allowing us to provide your child's healthcare needs. We are committed to providing the best care for your children. Please read this statement so you will understand your financial responsibility and our payment policy. Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or sex. It is our intent to never have the care of our patients compromised for financial reasons. Please contact our billing office to make arrangements if needed.

Responsibility for the Bill
All patients and guarantors are financially responsible for timely patient of medical services. We will file insurance claims for payment of the bill(s) as a courtesy to the patient, but the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s).

Time of Service Collections
Payment for services is expected at the time of visit. If there is insurance, it is the patient's/guarantor's responsibility to pay their co pay or their portion of the bill at the time of service. If for any reason the co pay is not made at that time, there may be a $5.00 service charge added to the account.

Acceptance of Insurance
It is the patient's/guarantor's responsibility to understand their own insurance coverage and to schedule their appointments with a doctor who is a provider with their insurance. It is also their responsibility to know where they can go for lab work and other services as referred by the pediatrician. Gary M. Kramer, M.D., PA will not be financially responsible for outside services. We will be happy to file insurance claims on your behalf.

Release of Information
By signing this form, you provide us with the authority to release such information as is necessary to collect from the insurance companies and other third party payers. You consent to receive calls from Gary M. Kramer, M.D., PA for your protected healthcare and other service via any information give to us by you (verbally or in writing). You may be charged for calls by your wireless carrier and such calls may be generated by an automated dialing system.

Balance on Account
Balances are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with our Business Office. Any balance over 30 days will be charged as interest rate for 1.5% per month (18% APY). Our office cannot become involved with third party liability matters and we will expect payment from the patient/guarantor.

Financial Responsibility of Divorced Parents
The parent who seeks medical care of the child is responsible for any unpaid amount. Although divorced parents may have a divorce decree that establishes their financial responsibilities., we are not a party to the decree. We required the parent accompanying the child for treatment to accept primary responsibility for payment of those services. We will bill the parent who brought the child into our office for any unpaid amount. Any responsibility of the other parent, as set forth in the divorce decree, or implied or agreed upon by the parents, will be the responsibility of the parents and we will not be involved.

Bad Debts/Collections/Legal Action
Gary M. Kramer, M.D., PA reserves the right to request payment for outstanding balances. In the event any balance is not paid as agreed, the undersigned agrees to pay collection fees, up to 40% of the balance owing.

School Health Forms
Gary M. Kramer M.D., PA reserves the right to request a $15 charge for School Health Forms. Which will be collected at the time of pick-up.

_____ _____

Parent Signature **Date**

_____ _____

Print Name **Witnessed by Gary M. Kramer, M.D., PA employee**

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Pediatric Specialist Well Child Service Policy

Health Plan Terms to Know

- **Co-Payment:** A fixed amount that you pay for certain health services before the health plan pays.
- **Coinsurance:** The portion of the charge that is not paid by the health plan (usually a fixed percent of each amount paid by the plan)
- **Deductible:** An amount that must be paid before the health plan pays for covered services.

Good health care for newborns, infants, children and adolescents includes regular well-child visits (checkups). Checkups focus on *preventative* services. Our office provides these services based on an initiative called **Bright Futures** developed by the American Academy of Pediatrics (AAP) with support from the U.S. Health Resources and Services Administration. Bright Futures includes recommendations for preventative pediatric health care for children from birth to 21 years of age, such as physical examinations, screenings, assessments, and advice about health and safety. We also follow the AAP vaccination schedule for newborns, infants, children and adolescents.

The Patient Protection and Affordable Care Act (ACA) requires most health plans to cover *specific preventive services* without cost sharing (i.e., pay in full), including all preventive care services recommend by Bright Futures and immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. [1] This is not always, true, though, *as grandfathered plans do not have to pay in full for preventive services.*

There may also be times when a child needs a service that is not part of a checkup on the same day as a well-child visit. If a child is not well or a problem is found during the checkup that needs to be addressed, the doctor may need to provide an additional office visit service (such as a sick visit). This is a different service and is billed to your health plan in addition to the checkup. *If services are provided that are not part of the Bright Future's preventive care recommendations, your health plan may not pay for it in full.* If your health plan requires a co-payment, coinsurance, or a deductible for these non-checkup services, our office will charge you these amounts.

Some services that may be provided and billed in addition to preventative services include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (e.g., if the doctor gives a prescription, orders or performs tests that are not included in Bright Futures, or changes care for a known health problem)
- Medical treatments (e.g., breathing treatments)
- Any surgery (e.g., removing splinters or something the child put in his nose or ear)

We value your time and want to make the most of each appointment. This is why we try to address any problem that needs a doctor's care during well-child visits so that only one trip is needed. However, in some cases, such as when the additional service is not urgent and will interfere with other patients' appointments, you may have to schedule another appointment.

We do not want you to be surprised by a bill. We bill your health plan and you based on actual services provided. Please feel free to ask about services that may not be paid in full by your health plan on the day of your visit.

[1] ACA Section 2713, 42 U.S.C. § 300gg-13; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Service Under the ACA, 75 Fed. Reg. 41726 (July 19, 2010)

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Pediatric Specialist Vaccination Policy

We here at Pediatric Specialist firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe all children and young adults should receive all of the recommended vaccines according to the schedule published by the American Academy of Pediatrics and the Center for Disease Control.

We firmly believe, based on all available literature, evidence, and current studies – vaccines do not cause autism or other developmental disabilities.

We firmly believe vaccinating children may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and schedule are the result of many years of scientific study and data gathering on millions of children by our brightest scientists and physicians.

Unfortunately, the vaccine campaign is truly a victim of its own success. It is because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccinations, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. You have never known a friend or family member whose child died of one of these diseases. Such successes can make us complacent about the need for vaccination. However, as the opinion of "vaccines are not necessary" is becoming more globally widespread, we are witnessing the resurgence of many of these diseases.

We are making you aware of these facts not to scare you, or to coerce you, but to emphasize the importance of vaccinating your child. We recognize the choice may be a very emotional one for some parents. We will try our best to address your concerns and doubts to help show you that vaccinating according to the recommended schedule is in the best interest of your child and the community as a whole.

That said, we will respect and honor request to alter the schedule to accommodate parental reservations. However, please be advised that delaying or modifying the schedule to give only one or two vaccines at a time over several visits goes against AAP/CDC recommendations and can theoretically put your child at risk for serious illness. We remind parents who are modifying the recommended schedule to inform all medical providers (nurses, ER physicians, on-call providers) if your child is not fully vaccinated. We also ask you to inform us if you plan to travel out of the country as many other countries have higher incidences of vaccine preventable diseases. Also, please be aware if your child is ill, and not fully vaccinated, our list of possible diagnoses will be more extensive and thus an evaluation may involve more invasive testing (e.g. blood draws, lumbar punctures, etc.)

We will gladly address any additional items you would like to discuss on an individual basis.

Thank you for your time in reading our policy.

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Privacy Policy

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

<u>Uses and Disclosures of Protected Health Information</u>
Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party..For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may

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call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

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You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/or before 4/5/2017.

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Notice of Privacy Policy Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices and that I may contact the practice at any time to obtain a copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian Date

_____

Signature

PEDIATRIC SPECIALIST
PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I _____, am the:
Print Parent/Guardian Name

☐ Natural or Adoptive Parent of

☐ Guardian of

☐ Person, who under court order, is authorized to give consent for

the minor: NAME:_____ DOB_____
Print Name of Minor Minor's DOB

I authorize PEDIATRIC SPECIALIST (Gary M. Kramer, M.D., PA), to discuss and provide medical treatment of the above named minor with the following authorized adult(s) who are over the age of 18 (ie: Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc.):

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

_____
SIGNATURE OF PARENT/GUARDIAN

_____
DATE SIGNED

Gary M. Kramer, M.D., P.A.

Patient Consent for On-Site Laboratory Testing:

We provide as a COURTESY on-site laboratory testing. Medical illnesses often times require diagnostic testing to help direct appropriate treatment. Our laboratory is certified by CLIA to perform the following tests:

- Complete Blood Count w/Manual Differential (CBC)
- Cholesterol Levels
- Urinalysis
- Rapid Strep Test
- Glucose Levels
- Mono Test

Most Insurance companies will pay for the tests we perform in our office lab or for the handling of specimens. At times, some patient benefit plans will not cover certain tests or reimburse below acceptable levels for our services. Please realize that Dr. Kramer provides to all of his patients One Standard Level of Care and orders appropriate laboratory tests at his discretion, without regard to reimbursement rates and policies.

Financial Acknowledgement

My signature below indicates that I have read (or had read to me) and understand the information in this disclosure. I also understand that I may have a personal responsibility for laboratory testing which may not be a covered service per my benefit plan.

Signature_____ Relationship_____ Date_____