Capernaum Kids Lakeland
PATIENT INFORMATION FORM

Forms must be completed, signed and brought to office appointment to provide services to you/your child

Patient name: _____ Chart number: _____
Sex: _____ Date of Birth: _____ SS#_____
Reason for visit: _____
ALLERGIES: _____ YES _____ NO **MEDICATIONS**: _____YES_____ NO
See attached history form to list specifics
REFERRING PHYSICIAN: _____
PRIMARY CARE PHYSICIAN: _____

RESPONSIBLE PARTY: Parent or Legal Guardian, Please present photo ID
Father's/Guardian name: _____ SS#:_____
Father's/Guardian date of birth: _____ Mother's/Guardian date of Birth: _____
Mother's/Guardian name: _____ SS#:_____
Street Address: _____
City/State/Zip Code: _____
P. O. Box: _____
Home phone: _____ Cell phone: _____ Email: _____
Emergency Contact Person (other than self):_____
Phone number: _____ Relationship: _____
Father's employer: _____ Phone number: _____
Mother's employer: _____ Phone number: _____
If Patient is of legal age or an emancipated minor please indicate consent/authorization to discuss financial and /or medical information with your parent or guardian. YES____ NO _____
INSURANCE COMPANY: Please present Insurance ID card(s):
Name: _____
Address: _____
City/State/Zip Code: _____
Phone#: _____ Name of insured: _____
Policy #:_____ Group#:_____
Managed Care? YES ___ NO ___ Authorization: _____
SECONDARY INSURANCE: if applicable
Name: _____
Address: _____
Name of insured: _____ Policy #: _____
Group#:_____ Phone #: _____

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

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

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

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

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

CAPERNAUM
Medical Center

Patient History, Family, and Social History

Patient Name: _____

Allergies: None_____ Yes(write down allergies):_____

List Medications: _____

_____

Any unexplained Deaths in Family: No _____ Yes (explain): _____

Birth History:

Were there any complications during the pregnancy? No ____ Yes (explain): _____

_____

Was it a Full-Term Pregnancy: Yes _____ No_____ How many weeks? _____

Birth Weight: _____ Birth Height: _____

Developmental History:

Motor Skills (walking): On Time _____ Delayed_____ IS the patient receiving any type of therapy? _____

Has the patient ever been diagnosed with anything? If yes please explain, _____

_____

Please list all past surgeries/hospitalizations with dates:

_____ _____

_____ _____

_____ _____

_____ _____

Family History:

Please list any health conditions:

Mother _____ Father_____

Brothers and sisters: _____

Grandparents _____

_____ _____ _____

Signature Parent/Legal Guardian/ Self Relationship Date

CAPERNAUM
Medical Center

(683) 232-4323
help@cmcwecare.com
www.cmcwecare.com

Permission to Treat

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

1. Patient Name: _____ Date of Birth: _____
2. Patient Name: _____ Date of Birth: _____
3. Patient Name: _____ Date of Birth: _____
4. Patient Name: _____ Date of Birth: _____
5. Patient Name: _____ Date of Birth: _____
6. Patient Name: _____ Date of Birth: _____

I authorize the following people to bring my child in for treatment (follow up appointments, diagnostic testing)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Parent/ Legal Guardian: _____
Printed Name of Parent/ Legal Guardian: _____
Date: _____

CAPERNAUM
Medical Center

(863) 232-4323
help@cmcwecare.com
www.cmcwecare.com

Patient Consent of Medical Photography

Today's Date: _____

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

☐ **Check here if minor or unable to provide consent**

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

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

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

☐ **Check here if 18 years or older and able to provide consent**

I consent for these photographs to be used in medical publications, including medical journals, textbooks and electronic publications including the company website. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ (Signature) _____ (Witness)

• I agree for my image to be shown for teaching purposes **AND** to be for my medical record but **NOT FOR** medical publication.

_____ (Signature) _____ (Witness)

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

_____ (Signature) _____ (Witness)

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www.cmcwecare.com

Authorization to Receive Information for Continuation of Care

Patient Name: _____ Patient Date of Birth: _____

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

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

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

Signature of Patient/Legal Guardian: _____

Printed Name of Patient/Legal Guardian: _____

Relationship To Patient: _____

Date: _____

Witness: _____

Date: _____

CONFIDENTIALITY NOTICE

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

(863) 232-4323
help@cmcwecare.com
www.cmcwecare.com

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize CAPERNAUM MEDICAL CENTER FOR KIDS and its affiliated providers to view my external prescription history via the RxHub service. I have been given documentation regarding e-prescribing and acknowledge further information can be obtained at www.LearnAboutePrescriptions.com.

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

My signature certifies that I read and understand the scope of my consent and that I authorize access.

Print Patient Name/Legal Guardian: _____

Parent/Legal Guardian Signature: _____

Witness Signature: _____

Date: _____

PATIENT INFORMATION:

Name: _____

Date of Birth: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Phone # or Address: _____

CAPERNAUM
Medical Center

Capernaum Kids Lakeland

Office Policies

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

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

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

_____ _____ _____

Signature Parent/Legal Guardian/ Self | Relationship | Date

Capernaum Kids Lakeland
Summary of Notice of Privacy Practices
To our Patients:

Form must be reviewed, signed and brought to office appointment in order for services to be provided.

Our Commitment to your privacy

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

Personal Information We Collect

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

Information We May Disclose

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

Use and Disclosure of Your Health Information in Certain Circumstances

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

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

You're Rights Regarding Your Health Information.

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

Capernaum Kids Lakeland
Compliance Complaint Officer
5129 S Lakeland Dr., Ste. 2
Lakeland, FL 33813