Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Parkway; Suite 300
Gulf Breeze, FL 32561
Phone: (850) 932-5055

J. Ben Renfroe, M.D Weldon Mauney, M.D. Sara Winchester, M.D.
Genei Bougher, ARNP Tracy Ezelle, ARNP Theresa Keohane, ARNP

DOCTOR-PATIENT SERVICES AGREEMENT

Welcome to our office. Your child's appointment is on _____
at _____ with the nurse practitioner and physician.

Neurology Treatment: We specialize in the care of infants, children, and adolescents with neurological disorders. We also treat adults for some specific disorders.

Appointments: We have a 20-minute late policy. Patients arriving 20 minutes late will need to reschedule their appointment. Appointments missed three times will not be rescheduled without a repeat referral from your primary care physician.

Identity Protection: To better protect your identity and account information, we may ask patient/parent/ or guardian for a photo-ID.

Insurance Authorizations: Please bring your insurance card to each visit. It is the responsibility of the patient to ensure prior insurance authorization for appointments and procedures. Please contact our office prior to each visit to verify that we have received the appropriate insurance authorization(s).

Professional Fees: Payment in full is due at the time of service unless prior arrangements have been made for self-pay patients. Payment of insurance deductibles and insurance co-pays are due at the time of service. As a courtesy, we will continue to file for all insurance companies. Monthly statements will be sent for patient balances. Please contact our billing office for questions regarding your bill.

Contacting the Office: Phones are answered from 8:00 a.m.- 4:00 p.m. cst. Monday through Friday. All medication refills, questions, or other concerns should be addressed within normal business hours. Routine calls will be addressed within 24-48 hours.

Emergencies: For medical emergencies, call 911 or go to the local emergency room.

Consent: I authorize my insurance benefits to be paid directly to Child Neurology Center, realizing I am responsible for non-covered services. I authorize the release of pertinent medical information to insurance carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Responsible Party Patient Name Patient DOB

Pediatric History for Sleep Study Patients

Name of Child: _____ SSN: _____
Last First Middle

Date of Birth: ____/____/____ Place of Birth: Hospital: _____
City/State: _____

Child's Address: _____
Street Apt. City State Zip

Home Phone Number: ( ) _____ Cell Phone Number: ( ) _____

Work Phone Number: ( ) _____ To Leave Messages: ( ) _____
What is this person's name? _____

Please complete this section for all people who live in the same household as the child.

Full Name	How Related	Age	Work	Education

Who has legal custody of the child? _____ Relationship _____

Who is the child's primary doctor? _____
Name Phone

Do other doctors also see the child? If so, please list them.

Name of Doctor	Address	Phone Number	Why does child see this doctor?

What pharmacy do you usually use? _____ ( ) _____
Name Location Phone

Patient Name:_____ DOB:_____

General History

Biological Mother's Pregnancy History:

Total number of pregnancies:_____ This was pregnancy number: _____

Did mom have any miscarriages? _____ If yes, how many? _____

Please check the box if any of the following problems occurred during the pregnancy of the child we are seeing today.

Unusual swelling	Unusual weight gain	High blood pressure
Infection	Unusual vomiting	Bleeding
Alcohol use	Tobacco use	Drug use

Child's History:

Birth

Early? _____ Weeks Late? _____ Weeks On time? _____

Birth weight: _____pounds _____ounces APGAR scores (if known): _____ 1 min _____ 5 min

Was labor induced? ____ If yes, why? _____

Vaginal delivery? _____ C-section? _____ Why? _____

Please describe any problems the baby had immediately after birth: _____

_____

Please check the box if any of the following problems occurred during the first year of your child's life.

Problems sucking	Choking	Lots of spitting / vomiting
Poor eating	Seemed stiff	Seemed limp
Cried a lot	Seemed too quiet	Didn't gain enough weight

Describe any other problems during the first year of your child's life: _____

_____

At what age did your child first do each of these things?

Hold head up	Roll over	Sit alone
Crawl	Pull up	Walk
Feed self	Speak first word	Use sentences
Dress self	Have bladder control	Have bowel control

Did your child ever lose any developmental milestones? When? _____

_____

Patient Name:_____ DOB:_____

Behavior: Describe any unusual behavioral concerns or problems with your child:

_____

Please tell us about all the medicines and supplements your child takes at this time.

Name of medicine	Amount taken	How often	What for

Please tell us about all the medicines or supplements your child has taken in the past.

Name of medicine	Why taken	When start / stop	Why stopped

Please tell us about any hospitalizations or surgeries your child has had. Be sure to include any ENT or lung procedures.

Date of stay/ surgery	Name of hospital	Reason for hospitalization	Surgery performed

Are your child's immunizations up to date? Yes_____ No _____

Does your child have any allergies?

Allergy	Reaction

Patient Name:_____ DOB:_____

ENT / Respiratory History
Does your child have any of the following problems?

Problem	Present	Not Present
Frequent nasal congestion		
Trouble breathing through nose		
Sinus problems		
Chronic bronchitis /cough		
Snoring during sleep		
Allergies		
Asthma		
Frequent colds / flu		
Frequent ear infections		
Frequent throat infections		
Difficulty swallowing		
Hearing problems		
Speech problems		
Problems with facial bones or structure		
Other		
Other		

Does your child have any other medical problems?

System	Type of problem(s) or describe
Heart	
Skin	
Psych / emotional	
Stomach/intestines (including acid reflux)	
Kidneys/bladder	
Blood	
Immune system/infection	
Muscles / bones	
Seizures / head injury	
Poor or delayed growth	
Excessive weight	
Morning headaches	
High blood pressure	
Genetic disease	
Thyroid problems	
Pain	
Other	

Patient Name:_____ DOB:_____

Please check the box and write if anyone on either side of the family has these problems.

Headaches	Cerebral Palsy	Mental retardation or slow development
Weak muscles	Miscarriages or baby who died at a young age	Tics
ADHD / ADD	Psychiatric problems	Seizures
Insomnia	Sleep apnea / CPAP	Restless leg syndrome
Narcolepsy	Sleepwalking	Snoring

Please tell us about your child's school or day care.

Name and city where located	
Grade or program your child is in	
How are your child's grades in school?	
Receiving any special services? What type?	
Results of any special testing performed	

Please list any significant life changes or social stressors (good or bad) that have affected your child in the past 6-12 months: _____

_____

Sleep History

What are your major concerns about your child's sleep? _____

_____

What things have you tried to help your child's sleep problem? _____

_____

Does your child drink caffeinated beverages (i.e. Coke, Pepsi, tea, Mountain Dew, coffee, energy drinks) ? Yes _____ (Amount per day _____) No _____

What is your child's bedtime Monday – Friday? _____

What time do they usually wake up? _____

Patient Name:_____ DOB:_____

What is your child's bedtime on weekends and vacation? _____
What time do they usually wake up? _____
How long does it typically take your child to fall asleep? _____
How many naps does your child take during the day? _____
How long are your child's naps? _____
Does your child fall asleep at school? Yes_____ No _____
Does your child have a regular bedtime routine? Yes_____ No _____
If "no", do you consider this a problem? Yes _____ No _____
Does your child have his / her own bedroom? Yes _____ No _____
Is a parent present when your child falls asleep? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
What electronic devices (TV, radio, computer, IPOD, etc.) are on at bedtime?
_____
Does your child resist going to bed? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
Does your child awaken during the night? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
How many times? _____ What time of the night? _____
Does your child have difficulty falling back to sleep after a nighttime awakening?
Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
How do you respond to nighttime awakenings (i.e., child is put in parents' bed, put back in their own bed, etc.)? _____
_____
Is your child difficult to awaken in the morning? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____

Check the boxes that apply to your child.

Child usually falls asleep in:	Child usually wakes in morning in:	Child spends most of the night in:
Own bed alone	Own bed alone	Own bed alone
Parents' room in own bed	Parents' room in own bed	Parents' room in own bed
Parents' room in parent's bed	Parents' room in parent's bed	Parents' room in parent's bed
Sibling's room in own bed	Sibling's room in own bed	Sibling's room in own bed
Sibling's room in sibling's bed	Sibling's room in sibling's bed	Sibling's room in sibling's bed
Other location	Other location	Other location

Patient Name:_____ DOB:_____

Current Sleep Symptoms

Check the box that describes the frequency of your child's symptoms.

Never = Does not happen
Sometimes = 1-2 times a week
Often = 3-5 times a week
Always = 6-7 times a week

Symptom	Never	Sometimes	Often	Always
Difficulty breathing when asleep				
Stops breathing during sleep				
Snores				
Restless sleep				
Sweating during sleep				
Daytime sleepiness				
Nightmares / Night terrors				
Sleepwalking				
Sleeptalking				
Sleeps in unusual positions				
Kicks legs in sleep				
Wakes up at night				
Gets out of bed at night				
Trouble staying in own bed				
Grinds teeth				
Wets bed (over age 6)				
Discomfort in legs				
Trouble getting up in the morning				
Falls asleep in school				
Naps after school				
Feels weak or loses muscle control when laughing or upset				
Morning headaches				
Not rested after a night's sleep				
Feels like can't move upon awakening				

Parent / Legal Guardian Signature: _____ Date: _____

Physician / ARNP Signature: _____ Date: _____

Patient Name: **DOB:**

Pediatric Epworth Sleepiness Scale

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to their usual way of life in recent times. Even if they have not done some of these things recently try to imagine how it would have affected them.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze or sleep
1 = Slight chance of dozing or sleeping
2 = Moderate change of dozing or sleeping
3 = High chance of dozing or sleeping

_____	1.	Sitting and reading
_____	2.	Watching TV
_____	3.	Sitting inactive in a public place
_____	4.	Being a passenger in a motor vehicle without a break
_____	5.	Lying down in the afternoon when circumstances permit
_____	6.	Sitting and talking to someone
_____	7.	Sitting quietly after lunch
_____	8.	Doing homework or taking a test

Total score _____

Child Neurology Center of NW FL

PATIENT INFORMATION

Please review and update

Name: _____ Patient#: _____

Address: _____ Social Security #: _____ Sex: _____

_____ Date of Birth: _____ Age: _____

Home Phone#: _____ Race: _____

Work Phone#: _____ Ethnicity: _____

Cell Phone#: _____ Language: _____

Emergency Contact: _____ Emergency Phone#: _____

Emergency Relationship: _____

GUARANTOR INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security#: _____

_____

Home Phone#: _____ Cell Phone#: _____

Work Phone#: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ Phone#: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Certificate#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____

Certificate#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Child Neurology Center of Northwest Florida when they accept assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Child Neurology Center of NW FL, to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

HIPAA Notice of Privacy Practices

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Pkwy, Suite 300
Gulf Breeze, FL 32561
850-932-5055
850-932-1404 fax

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Your signature below is only acknowledgement that you have received this notice of our privacy practices.

Patient Name Patient's Date of Birth

Parent/Guardian Name Parent/Guardian Signature

Date Signed

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Parkway; Suite 300, Gulf Breeze, FL 32561
850-932-5055

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 of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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 physician's 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 physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your 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, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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 as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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 are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected 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 your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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.

You have the right to request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Genei Bougher/Suzanne Barker 850-932-5055; suzanne.barker@cneurology.com

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Pkwy, Suite 300
Gulf Breeze, FL 32561
Phone 850-932-5055 Fax 850-932-1404

Information to be Used or Disclosed
The information covered by this authorization includes:

1) Neurology Office Notes
2) EEG Reports
3) Neuroimaging Reports (i.e. MRI, CT Scan)
4) Laboratory Results
5) Other:

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Child Neurology Center of Northwest Florida

Persons to Whom Information may be Disclosed
Information described above may be disclosed to:

1) _____ Name of person or organization
2) _____ Name of person or organization
3) _____ Name of person or organization
4) _____ Name of person or organization

Expiration Date of Authorization
This authorization is effective while under the care of Child Neurology Center unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Child Neurology Center of Northwest Florida. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____
Name of patient (print) Date of Birth

_____
Signature of patient Date signed

_____
Signature of patient representative Relationship to Patient Date signed

YOUR SLEEP STUDY

You have been scheduled for an overnight sleep study at Child Neurology Center. The office is located in the Region's Bank Building. The address is:

400 Gulf Breeze Parkway
Gulf Breeze, FL 32561

The Sleep Lab is located in the Neurodiagnostics Suite 202 on the second floor. The phone number is: (850) 916-4351.

What is a Sleep Study?

A sleep study (also called a polysomnogram) is a way for your provider to diagnose possible sleep disorders. A sleep study measures your sleep cycles and stages by recording:

a. oxygen levels
b. body position
c. brain waves (EEG or electroencephalogram)
d. breathing rate
e. electrical activity of muscles
f. eye movement
g. heart rate

What happens during a Sleep Study?

After arriving and settling in, several wires will be attached to your head, chest, legs and face. The wires are attached with a sticky substance and they do not hurt. These wires help to monitor your breathing, oxygen, brain waves, and heart rate. The wires must remain in place while you sleep.

You will sleep in a bed in the sleep lab. One parent or guardian is allowed to sleep in the room with you. A specially trained health care provider will directly observe you while you sleep and note any changes in your breathing or heart rate. A video camera will record your movements while you sleep.

You will sleep in the bed in the sleep lab all night. The next morning, the wires will be removed (again, they do not hurt) and you will be ready to go home.

Child Neurology Center of Northwest Florida, P.A.
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Gulf Breeze, FL 32561
850-932-5055

From the west (Mobile):

1. Take I-10 east toward Pensacola.
2. From I-10 take Exit 12 (which merges onto I-110 south) toward Pensacola/Pensacola Beach.
3. Go approximately 7 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Bruno's shopping center. Continue across the parking lot to the Regions Bank. (Starbucks is in the same complex).
7. Child Neurology Center is INSIDE the Regions Bank building.
8. Take the elevator to the 3rd floor, Suite 300. EEG department is on the 2nd floor.

From the East (Milton, Crestview, Defuniak Springs)

1. Take I-10 west until you reach Pensacola.
2. From I-10 take Exit 12 (which merges onto I-110 south) toward Pensacola/Pensacola Beach.
3. Go approximately 5.5 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Bruno's shopping center. Continue across the parking lot to the Regions Bank. (Starbucks is in the same complex).
7. Child Neurology Center is INSIDE the Regions Bank building.
8. Take the elevator to the 3rd floor, Suite 300. EEG department is on the 2nd floor.

From the South (Gulf Breeze, Fort Walton Beach, Destin)

1. Take US Highway 98 West to Gulf Breeze.
2. Continue through Gulf Breeze. You will pass Gulf Breeze Elementary, Middle, and High Schools on your left. The football stadium is on your right.
3. Go 1 block past the football stadium. Turn right into the Starbucks entrance, then into the Regions Bank parking lot. (Bruno's is in the same complex).
4. Do NOT cross the 3-Mile Bridge into Pensacola!
5. Child Neurology Center is INSIDE the Regions Bank building.
6. Take the elevator to the 3rd floor, Suite 300. EEG department is on the 2nd floor.

From the North (Cantonment, Century)

1. Take US Highway 29 toward Pensacola.
2. Merge onto I-10 east via the ramp to Tallahassee.
3. Go approximately 7 miles on I-110 and take Exit 1B toward Gulf Breeze, (this will be E Chase Street).
4. Go approximately .5 miles and turn left onto Bayfront Pkwy/ US-98.
5. Continue on this road for approximately 4.3 miles. You will cross the 3-Mile Bridge, which will take you into Gulf Breeze.
6. Turn left at the 1st traffic light. Then turn right into the Bruno's shopping center. Continue across the parking lot to the Regions Bank. (Starbucks is in the same complex).
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