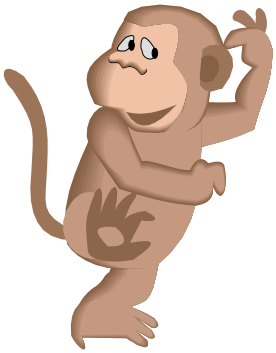
CHILD NEUROLOGY CENTER OF ORLANDO, P.A.

Dr. Jasna Kojic

6000 Turkey Lake Rd.
Suite 205
Orlando, FL 32819
PHONE: (407) 649-1848 FAX: (407) 649-1979



Dear Parent/Guardian of _____ :
We welcome you and your son/daughter to our office and are happy to have the opportunity to serve you. We pride ourselves on trying to make your medical care and treatment a pleasant experience.

Your appointment is scheduled for:

Date **Time**

YOU MUST BRING WITH YOU:

1. **The attached information. *(COMPLETELY FILLED OUT)***

2. **Any related test results *(x-rays, ultrasound, CT, MRI, and LABS)* – You WILL need to bring the actual REPORTS. These can be picked up from the facility in which they were done or your Referring Doctor's Office!**

3. **Your insurance card, parent or guardian photo ID, and insurance authorization (if needed)**

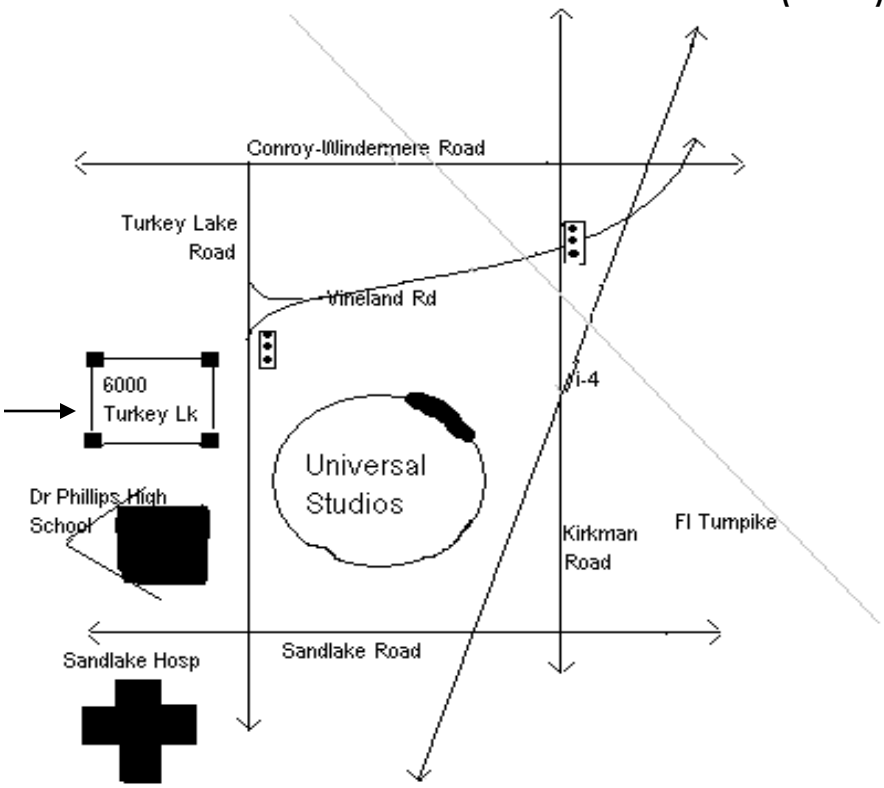
4. **Payment or co-payment is expected at the time of the visit.**

IF YOU SHOW UP WITHOUT ANY OF THE LISTED ITEMS, WE WILL RESCHEDULE!!!

(DIRECTIONS ARE ATTACHED)

Child Neurology Center of Orlando,P.A.

6000 Turkey Lake Road, ste 205 Phone: (407)649-1848
Orlando, Florida 32819 Fax: (407)649-1979



Coming from the North: (Daytona/Altamonte Springs) Take I-4 West to Kirkman Road North (exit 75 B)
Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

Coming from the South: (Tampa/Lakeland/Kissimmee) Take I-4 East to Kirkman Road North (exit 75 B **the only exit on your Left**). Stay in the left lane but DO NOT enter the TURN LANES into Universal Studios from the exit ramp! Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

Coming from the West: (Clermont/Winter Garden) Take the Turnpike to I-4 West (exit 259). Take I-4 West to Kirkman Road North (exit 75 B) Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

Coming from the East: (Melbourne/Cocoa/Palm Bay)Take the 528 toll road (Beeline) to Orlando and it dead ends at I-4. Take I-4 East to Kirkman Road North (exit 75 B **the only exit on your Left**). Stay in the left lane but DO NOT enter the TURN LANES into Universal Studios from the exit ramp! Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

Coming from East Orlando: (UCF/Waterford Lakes/Oviedo) Take the 408 toll road west to I-4 West; Take I-4 West to Kirkman Road North (exit 75 B) Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

Coming from West Orlando: (Ocoee/ Pine Hills) Take the 408 toll road east to I-4 West; Take I-4 West to Kirkman Road North (exit 75 B) Go to your 2nd traffic light, Vineland Rd., and turn left. Follow Vineland Rd. to the end. At Turkey Lake Rd. turn Left we are ¼ of mile on your right (you will pass a traffic light just before entering our complex)

CHILD NEUROLOGY CENTER OF ORLANDO, P.A.

Patient Registration

Date: _____ ***PLEASE PRINT CAREFULLY***

Patient Name: _____ **DOB:** _____ **Sex: M ☐ F ☐**
Last First MI

Address:_____ **City:** _____ **ZIP:**_____

Social Security #: _____ Phone: _____

Pediatrician/ PCP: _____ Phone:_____

Address: _____ City: _____ ZIP: _____

Mother/Guardian name: _____

Address: _____ City: _____ ZIP: _____

Phone: _____ _____ _____
Home Work Cell: (mom)

Email: _____ Profession:_____

Father/Guardian name: _____

Address: _____ City: _____ Zip:_____

Phone: _____ _____ _____
Home Work Cell: (dad)

E-mail:_____ Profession: _____

Insurance (name): _____

Policyholder's name: _____ DOB ____/____/____
(Only if Different from Patient)

Policy Holder SS#: _____

Policy ID#: _____ Group #: _____

Member Service Phone: _____ Effective Date: _____

Claims Address: _____ City: _____ ZIP: _____

ALLERGIES: NO ☐ YES ☐ If yes, specify: _____

Pharmacy Name: _____ Phone: _____

Referring Doctor_____
(If different from PCP) Name: Address:

*If parents/guardian cannot bring the patient to the appointment you must send a signed letter stating the persons name that is bringing the patient to the office!

FINANCIAL POLICY
READ CAREFULLY
BEFORE YOU SIGN!

This statement has been prepared to prevent confusion and/or uncertainty regarding the financial policies and procedures of CHILD NEUROLOGY OF ORLANDO, P.A.

WE REQUIRE THAT OUR PROFESSIONAL FEES BE PAID AT THE TIME OF EACH VISIT. The policy is explained to each patient or parent when the initial visit is scheduled. At the time of payment, we will provide you with An encounter form, which you may submit to your insurance company for reimbursement.

The only exception to our fee-at-the time of service policy is:

1. HMOs and PPOs primary insurance in which we are under contract with, provided the visit has been pre-authorized by the referring agency. Please check with our office assistant or billing manager if we are currently under contract with your insurance company.

2. **MEDICAID**- Approved Medicaid, which can be verified through the Tallahassee main office only. No pending papers are accepted. Also, **WE DO NOT ACCEPT MEDICAID AS A SECONDARY INSURANCE**. However we will provide you with an encounter form, which you can submit to Medicaid for reimbursement.

AUTHORIZATIONS ARE THE PATIENTS RESPONSIBILITY. YOU MUST CONTACT YOUR PCP FOR AUTHORIZATION.

UNAUTHORIZED VISITS MUST BE PAID FOR IN FULL OR APPOINTMENTS MUST BE RESCHEDULED.

Cancellations require 24 hours prior notice, or a $25 No Show fee will apply.

All returned checks will result in a $25 fee.

OFFICE POLICIES AND PROCEDURES

- Our office hours are Monday through Thursday 7:30 am to 5:30 pm and Friday 7:30 am to 11:30 am
- All messages left during business hours will be returned within 24 hours.
- If your call is an **EMERGENCY**, page on call physician or go to the nearest emergency department
- **YOU WILL BE NOTIFIED BY MAIL or PHONE of your LABS/ MRI/ EEG results. If you have not received the results within 2-3 weeks, please contact us. It is possible that results of the testing were not forwarded to our office.**
- **Prescriptions:** Bring all current medications or a list of all current medications including doses and frequency the medications are being given, to your appointment.
- **Please request any prescription refills** that are needed at the time of your appointment. Refills may be obtained by calling the office between 8:00a.m and 4:30p.m Monday through Thursday and 8:00 – 11:00 am on Friday.
- If your child has **not** been seen in our clinic within the **past six month**, we will NOT be able to fill prescriptions without a return visit appointment being scheduled. Your child's prescriptions will then be refilled with enough medication to last through the month of the scheduled appointment.
- Our office will **NOT** make any appointments for patients with excessive No Shows and cancellations!

I have read and understand the above financial policy and the Office Policy. I understand that I am ultimately financially responsible for all charges incurred.

Patient's Name: _____

Signature (Guardian): _____ Print:_____

Date: _____

CHILD NEUROLOGY CENTER OF ORLANDO, P.A.

6000 Turkey Lake Rd.
Suite 205
Orlando, FL 32819
Tel: (407) 649-1848 Fax: (407) 649-1979

MEDICAL RECORDS RELEASE TO CHILD NEUROLOGY CENTER OF ORLANDO, P.A.

In order to achieve appropriate medical care, I authorize the release of all my medical records to CHILD NEUROLOGY CENTER OF ORLANDO, P.A. The release of records will remain in effect until terminated by me in writing.

It is expressly understood that a photocopy of this signature shall be considered as effective and valid as the original.

Patient's Name: _____Date: __ _____

Parent/Guardian Signature: _____

Print Name(Parent/Guardian) _____

ACKNOWLEDGMENT FORM

I have received the Notice of Health Practices. I have been provided an opportunity to review it and ask questions. (Hippa Privacy Policy)

Patient's Name: _____Date: _____

Patient's Guardian's Signature: _____

Print Name (Guardian): _____

MEDICAL RECORDS RELEASE AND ASSIGNMENT

I authorize CHILD NEUROLOGY CENTER OF ORLANDO, P.A. to release to any third party, such as insurance company(s) or government agency, and/or Healthcare Providers and Facilities, any medical information and records regarding diagnosis and treatment for use in determining claim payment.

I authorize and request that all hospital and medical office insurance benefits be directly paid to Child Neurology Center of Orlando, P.A., for services provided to the patient named below.

It is expressly understood that a photocopy of this signature shall be considered as effective and valid as the original.

I have read and understand the above and with my signature do assign all benefits.

Patient's Name: _____Date: _____

Patient's Guardian's Signature: _____

Print (Guardian): _____

CHILD NEUROLOGY CENTER OF ORLANDO, P.A.
Notice of Health Information Practices
THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Child Neurology Center of Orlando, P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective July 7, 2004, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information Each time you visit Child Neurology Center of Orlando, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Child Neurology Center of Orlando, P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
Child Neurology Center of Orlando, P.A. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem If have questions and would like additional information, you may contact the practice's Privacy Officer at 407-649-1848. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below: *Office for Civil Rights* U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example**:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide

your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this office.

We will use your health information for payment For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a billing service we use. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third- party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. \

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.