Welcome to
MEYER PEDIATRICS

Dear Patient/Parent:

Welcome to Dr. Ted's Circus! The purpose of this letter is to introduce new patients to the Meyer Pediatrics Family as well as reacquaint our current patients with our providers, office hours, scheduling, telephone calls, and billing/insurance questions. We are dedicated to doing everything that we can to make your visit to our office as easy as possible for you and we sincerely appreciate your cooperation and understanding of all our office policies and procedures. Our goal is to help families raise healthy children. We believe you will find our entire staff eager to serve you in a professional manner and friendly manner.

Thank you for choosing Meyer Pediatrics for your medical needs. We are pleased to welcome you to our practice and look forward to a mutually satisfactory relationship.

Sincerely,

Dr. Ted Meyer

OFFICE HOURS

We schedule appointments from 8:45am to 11:30am and 1:30pm to 4:30pm on weekdays. On Saturdays we are open only for same-day sick visits by appointment for established patients from 8:30am to 11:00am. We are NOT open on Sundays. On weekdays we have a "walk-in" hour from 7:30am to 8:15am for which appointments are not necessary. The walk-in hour is for sick visits only. Please do not wait until 8:15 a.m. to arrive for walk-in or you may have to wait for an available appointment later in the morning. The office is open from 8:30am to 12:00pm and 1:30pm to 4.30pm to drop off or pick up prescriptions or health forms. If calling for prescription refills or health forms, please call during regular office hours and always give a 24-hour notice.

TELEPHONE CALLS

Our clinical staff has been trained to answer questions regarding your child's illness and symptoms. Please remember that phone calls are answered based upon matter of urgency first, then the order in which they are received. Depending upon how many phone calls are pending, it may take some time to return your call. We strive to answer each call the same day. Please be available for a return call from the nurse as we will attempt to contact you a maximum of two times in the same day. For prescription refills, please call your pharmacy first to request the refill as you may not need our nurse to "call it in" for you. Otherwise, provide the name of the medication, last dose and regimen prescribed, and pharmacy immediately available. For written prescriptions please allow 24 hours notice.

Because of the high volume of calls, we ask that you save routine, non-emergency questions for your well-baby visit. Unless you specifically request that the doctor call you back, you will likely get a call back from our nurse. If you wish to speak only to a Provider, make this known when you call, we will take a message for you and they will return your call by the end of their workday.

WHEN YOU NEED US AFTER HOURS

When calling after hours, those calls should be urgent in nature. Our answering service will take a message from you and page the provider on call. Should you have a medical emergency, call 911. Please remember the afterhours call service is not intended for medication refills, concerns regarding growth and development, behavioral and/or emotional concerns. The service is intended ONLY to alleviate concerns regarding an acute illness that may arise during non-office hours. Also, please note that we have an arrangement with Dr. Nevenka Horvat to share your calls on the evenings and weekends that we are not "on call."

SCHEDULING

Well visits include infant examinations, and yearly check-ups. Please schedule these appointments well in advance of the required date so that you are better able to choose the provider and or time that is more convenient for you. Please try to allow 4-6 weeks to schedule a comprehensive well visit.

Sick visits are for those patients who need quick attention. Our goal is to be able to see every sick child on any given day. We have a dedicated walk-in hour from 7:30am–8:15am M-F.

To be seen for a sick visit after walk-in hour you need an appointment and will always be scheduled the same day that you call. We do not pre-book sick visits. All appointments are scheduled by time of day beginning with our morning appointments. Please do not walk into the office after walk-in hour and expect to be seen without an appointment.
Consultations are scheduled for the end of the day on weekdays.

At Meyer Pediatrics, we pride ourselves in seeing patients on time. We work very hard at this and try not to let you wait longer than 15 minutes. We ask that you inform the receptionist if you have been waiting more than 15 minutes beyond your scheduled appointment time. If you are 15 minutes late or more, we will reschedule your appointment if necessary. Please note: a rescheduled well visit appointment could be booked several weeks out. Please give 24-hour notice to avoid the following "Missed Appointment" charges on your account.

NO SHOW POLICY

Your child's health is very important to us. Keeping appointments with your child's physician is essential for your child's health. A "No-Show" is defined as missing a scheduled appointment without calling us in advance to cancel the appointment. Not cancelling an appointment in a timely manner is unfair to the physician, staff, and other patients who may have needed that appointment slot. We require a 24 hour notice for cancellation of well child checks and a same day cancellation for all sick visits. The first two no-shows will be followed by a letter and notification of charges. After each no-show, your account will be charged as follows: $50.00 for a missed well child check and $35.00 for a missed sick appointment. Patients who no-show three times in a calendar year will be subject to dismissal from the practice. We do understand that situations occasionally arise when an appointment cannot be kept and required notice is not possible. These situations will be considered on a case-by-case basis. Thank you for your cooperation.

BILLING/INSURANCE

Our office participates in many insurance plans. Please check with your individual insurance company to make sure we are participating providers. If we do not participate with your insurance company, we will not file claims and you will be responsible for payment at the time of service. If for any reason your insurance company does not pay for the visit, you are responsible for payment. You are expected to know the requirements of your specific insurance company.

The person bringing the patient into the office is responsible for payment at the time services are rendered, including any deductibles, co pays, and non-covered services. We will need to see your insurance card at each and every visit. If you forgot your card, we will still honor your appointment. However, you will be responsible for payment at the time of the visit. We accept cash, checks, MasterCard, Visa, Discover and Health Saving Account cards.

REFERRALS

If your insurance company requires a referral to a specialist's office or for testing, please make sure the doctor and/or facility is participating with your insurance plan. When you call in for

a referral, please have all the information required. Specifically, see that the appointment date has been scheduled, the procedure and diagnosis codes are correct, and you have the specialist name and address. We need five (5) working days to obtain that referral on your behalf.

REQUIRED INFORMATION

For our **new patients**, please fill out the following enclosed forms: (You can fill them out electronically by typing in your answers, or you can print and fill them out by hand.)

1. Patient Information: Please fill out completely.
2. Medical Records Release Request: Please fill out completely, sign, and include the fax number of your previous doctor's office so we can send for your records.
3. Guarantor Statement and Financial Responsibility: Please read and sign so we know you understand our policies and procedures and your financial responsibility.
4. Insurance Information: We will need a copy of both sides of your insurance card each visit in order that we may file for you.
5. HIPAA Notice of Privacy Practices (optional): This document states the privacy practices of Meyer Pediatrics. You do not have to print this form out. Copies also available at the office.
6. Acknowledgement of Receipt of HIPAA Privacy Practices (optional): Please sign this form and return to office.

When you have completed all the required forms, please email the packet to **medicalrecords@meyerpeds.com** or fax them to **(941) 366-5728** or deliver/mail them to: **Meyer Pediatrics, 1666 Mound St., Sarasota, FL 34236**. If you choose to email the forms, don't forget to save the forms to your computer ***after*** filling them out. Then email the completed forms as an attachment. It usually takes about 10 to 14 business days after you have returned the required forms for our office to process the information and receive your prior medical records. At that time we will call you to verify the receipt of your medical records and answer any additional questions you may have.

You will not be an established patient of Meyer Pediatrics until we have all of the required forms and all medical records from your previous pediatrician. Until you are an established patient, we will not be able to prescribe any medications your child might already be on, or make appointments for a physical or well visit. However, we can see your child if he/she is sick during regular office hours while waiting for forms to be processed or records to arrive.

Thank you for taking time to read this packet and to provide all of the required information. We look forward to a long, happy, and healthy relationship with your family!

Meyer Pediatrics
Patient Information

RESPONSIBLE PARENT INFORMATION				
NAME (Last, First)		SSN#	DATE OF BIRTH	
MAILING ADDRESS		CITY, STATE, ZIP		Lives with patient?
CELL PHONE:	HOME PHONE:	EMAIL ADDRESS (used for secure patient portal access)		
EMPLOYER		WORK PHONE	RELATIONSHIP TO PATIENT	

OTHER PARENT INFORMATION				
NAME (Last, First)		SSN#	DATE OF BIRTH	
MAILING ADDRESS (If different from above)		CITY, STATE, ZIP		Lives with patient?
CELL PHONE:	HOME PHONE:	EMAIL ADDRESS (used for secure patient portal access)		

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY ID NUMBER	GROUP NUMBER
NAME OF OWNER OF POLICY	RELATIONSHIP OF OWNER OF POLICY TO PATIENT	
OWNER OF POLICY DATE OF BIRTH	OWNER OF POLICY EMPLOYER	

AUTHORIZED INDIVIDUALS TO ACCOMPANY CHILD FOR MEDICAL CARE – Please list anyone who may ever need to bring your child in to the office in the event that you cannot, such as in an emergency. Only people you authorize and are listed on your child's chart, per HIPAA requirements, will be able to accompany your child for treatment without you being present. Your signature below acknowledges your approval of these individuals to accompany your child for treatment only. (For access to medical records see HIPAA form.)

NAME (Last, First)	RELATIONSHIP	DATE OF BIRTH	PRIMARY PHONE
NAME (Last, First)	RELATIONSHIP	DATE OF BIRTH	PRIMARY PHONE
NAME (Last, First)	RELATIONSHIP	DATE OF BIRTH	PRIMARY PHONE

PHARMACY INFORMATION		
NAME OF PHARMACY	PHONE	ADDRESS/CROSS STREET/INTERSECTION

PREFERRED METHOD OF COMMUNICATION FOR APPOINTMENTS, LABS, AND OTHER NOTIFICATIONS?
Choose ONE Only:

☐ Email ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Note: *Confirmations are made as a courtesy. You are still responsible for keeping all scheduled appointments or cancelling at least 24 hrs prior. Thank you!*

Revised 10.20.14

PATIENT ENROLLMENT INFORMATION

NAME (Last, First)	**DATE OF BIRTH:** ☐ MALE ☐ FEMALE
ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Choose not to report/Decline	**RACE:** ☐ Black/African Amer. ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Other ☐ Decline
NAME (Last, First)	**DATE OF BIRTH:** ☐ MALE ☐ FEMALE
ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Choose not to report/Decline	**RACE:** ☐ Black/African Amer. ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Other ☐ Decline
NAME (Last, First)	**DATE OF BIRTH:** ☐ MALE ☐ FEMALE
ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Choose not to report/Decline	**RACE:** ☐ Black/African Amer. ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Other ☐ Decline
NAME (Last, First)	**DATE OF BIRTH:** ☐ MALE ☐ FEMALE
ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Choose not to report/Decline	**RACE:** ☐ Black/African Amer. ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Other ☐ Decline
NAME (Last, First)	**DATE OF BIRTH:** ☐ MALE ☐ FEMALE
ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Choose not to report/Decline	**RACE:** ☐ Black/African Amer. ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Other ☐ Decline

I hereby agree that this information is correct and I understand that I must provide in writing any changes to the above information. I understand that supplying my insurance information does not guarantee payment by my insurance and that I am responsible for payment of any charges not covered by my insurance.

_______________________________________ Printed Name of Parent or Guardian

_______________________________________ Signature of Parent or Guardian

Note: If completing form online or digitally, your typed name in the above field will be considered legally binding as a written signature.

___________________ Date

Meyer Pediatrics
1666 Mound St., Sarasota, FL 34236
Ph: (941)365-5898 Fax: (941)366-5728

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT INSTRUCTIONS: Complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient (guardian).

PROVIDER INSTRUCTIONS: Please note we will not accept more than 25 pages of faxed medical records per patient. If record exceeds 25 pages, please mail. Thank you!

I HEREBY AUTHORIZE MY PREVIOUS PEDIATRICIAN:_____

Address: _____

Fax: _____ Phone: _____

TO RELEASE THE HEALTH RECORDS OF THE FOLLOWING PATIENTS:*

Last Name	First	MI	Birth Date	Social Security #	Vaccinated? (Y or N)

Phone # _____ Wk #_____

THIS INFORMATION IS TO BE RELEASED TO:
Meyer Pediatrics 1666 Mound St, Sarasota, FL 34236
Fax: 941-366-5728 Phone: 941-365-5898 Email: medicalrecords@meyerpeds.com

FOR THE PURPOSE OF:
( ) Transfer ( ) Continuing Treatment ( ) Billing ( ) Personal ( ) Insurance ( ) other_____

* Please note: If you object to the release of HIV, psychiatric and substance abuse records, please initial here:_____

POSSIBILITY OF RE-DISCLOSURE: I understand that any Information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 1 year from the date I sign it or _____days (if less), or the duration of_____ (event). I have the right to revoke this authorization In writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining Insurance coverage

_____ _____
Signature of Patient/Guardian Date Signed

_____ _____
Relationship to Patient Witness/Date

Processed by:_____ Number of pages:_____ Date Sent:_____

Note: If completing form online or digitally, your typed name in the above field will be considered legally binding as a written signature.

Meyer Pediatrics

HIPAA Privacy Policy

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have received my Health Information Privacy Policy Notice as required by the HIPAA Act of 1996. Further, I understand that I may call Meyer Pediatrics at any time and request to speak to the Privacy Officer regarding any aspects of my protected health information (or that of my children or dependents). I understand that Meyer Pediatrics may use or disclose my protected health information (or that of my children) to others only for the treatment, payment, or healthcare operations unless I give my written permission. I understand that I have the right to inspect, correct, amend, or receive copies of my protected health Information (with certain exceptions). Finally, I understand that I may contact the Privacy Officer at Meyer Pediatrics at any time regarding any privacy concerns, or for an explanation of any issues regarding my rights as detailed in the HIPAA Act, and that I have received a copy of the entire Notice of Privacy Practice.

I give my permission to release my Protected Health Information (PHI) (or that of my children and dependants) to the following individuals. I understand that Meyer Pediatrics will release my only to covered entities as detailed in the Notice of Privacy Practice and to the following individuals only. Please list the names and relationship to the children or child. Please include caretakers, relatives, day care, school officials, and anyone who you would like to give permission to bring your child to this office for medical treatment and care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Printed name of Guarantor/Parent/Guardian Date

_____

Signature of Guarantor/Parent/Guardian

Note: If completing form online or digitally, your typed name in the above field will be considered legally binding as a written signature.

Revised 08/27/14

Meyer Pediatrics

Guarantor Statement and Financial Responsibility

GUARANTOR STATEMENT & FINANCIAL RESPONSIBILITY AGREEMENT

- I understand that Meyer Pediatrics is a primary care office.
- I understand scheduling of appointments as well as the "Missed Appointment" charges for failure to give at least 24 hours notice to cancel or reschedule.
- I understand Meyer Pediatrics office hours, the "on call" procedures that give 24 hours, 7 days per week coverage, and the policy for nurse callbacks and provider callbacks.
- I understand the need to give at least 24 hours notice for prescription refills and completion of health forms.
- I understand five (5) working days for referral to a specialist's office are required. I further understand that it is my responsibility to get the information necessary from my insurance company.
- I understand that Meyer Pediatrics does not provide immunizations/vaccinations to patients insured by Medicaid or any Medicaid HMO including Amerigroup, Healthease, Integral, Staywell, Medipass, or Universal Healthcare. Those patients will be referred to their local health department for vaccinations.
- I understand **I must bring my insurance card to each and every appointment** or expect to pay for the office visit and file my own claim.
- I understand any deductibles, co-pays, and non-covered services are collected at the time of the office visit, and the person bringing the patient into the office is responsible for these payments.
- I understand that **if for any reason my insurance company does not pay for the visit, or any services incurred during the visit, I am responsible for payment at the time of service**. Further, if for any reason my account is sent to a collection agency, any costs incurred in collecting past due or delinquent charges will be added to my account.
- I authorize the release of any medical information to my insurance company in order to process a claim. This authorization/ agreement is effective until revoked in writing.

I have read and understand the Policies & Procedures of Meyer Pediatrics and I am financially responsible for this account.

Guarantor Name (print): _____

Signature of Guarantor:_____ **Date:** _____

Note: If completing form online or digitally, your typed name in the above field will be considered legally binding as a written signature.