JULIA BARRIGA MD PA
5001 E. BUSCH BLVD.
TAMPA, FL 33617
PHONE: (813) 984 8846
FAX: (813) 984 8827
www. juliabarrigamd.com
JULIA BARRIGA MD PA
Board Certified Pediatrician

Office Policies

9-3-19 (PARENT COPY)

Welcome to Julia Barriga, M.D.,P.A. Thank you for choosing our Practice as your child's medical home. Our mission is to bring Health and Happiness to children. Please take a moment to review that the expectations and philosophies of our providers are in line with those of your family. We believe mutual respect and trust is necessary to serve you and your family.

Office Hours
Mondays 8:00 am – 5:00 pm, Tuesdays 8:00 am -7:00 pm, Wednesdays 8:00-1:00 pm, Thursdays 8:00 am – 5:00 pm, Fridays 8:00 am – 5:00 pm, Alternating Saturdays 9:00 am-1:00pm.

Appointment Policy
We see patients by appointments only, you can schedule an appointment by phone or via text message to our Main Number (813) 984-8846 during regular office hours, and AFTER HOURS on our website or your Patient Portal. Evening, after school and Saturday appointments are booked quickly, if these are your preferred times, please schedule them at least a month in advanced.

Sick Appointments
Acute sick appointments are scheduled as same day appointments only. We have same day sick appointments available for our established patients. There may be a wait time as we will be working you in between the regular scheduled appointments. Our phone lines open at 8:00 am, please call us as early as possible in order to accommodate your child. Chronic sick appointments and consultations generally require more time than a standard acute sick appointment and will need to be scheduled two weeks or more in advance.

Well Child or Physical Appointments
We follow the American Academy of Pediatrics, Bright Futures Schedule and HEDIS, NCQA guidelines very closely and we expect that the Families of our practice follow that schedule as close as possible. We request that patients schedule their Well Child Appointments not later than a month after the patient is due. Our Practice's Care Coordinator will provide and explain such schedule and we will encourage you to schedule your next Well Child Appointment every time you contact our Office.
Well Child appointments are scheduled to focus on preventive health, if you need to address an acute problem or Chronic Problem we may ask you to schedule an appointment to concentrate on this matter.

No-Show Appointment Policy
There will be a NO-SHOW FEE for every no-show appointment: Appointments not cancelled 24 hours in advance – $50.
Failure to notify our office with a cancellation at least 2 HOURS prior to your appointment time will result in the above no show fees.
3 NO-SHOWS in a 6 month period are grounds for dismissal from the Practice for the Patient and the Entire Family.
This is not to be uncaring; it is an effort to continue prompt care throughout the day for our ill children.
These charges will not be billed to your insurance company; you will be responsible for payment.

Cancellations of Appointment
If you should need to cancel a pre-scheduled appointment, please notify our office 24 business hours in advance so that we may accommodate families who are on a waiting list for an earlier appointment. Failure to cancel your appointment within 24 business hours OR in case of emergencies with at least 2 hours prior to the appointment will result in a $50.00 charge. This charge must be paid prior to scheduling your next appointment and cannot be charged to your Insurance.

Saturday, Evening appointments and After Hours
Tuesdays 5:00pm -7:00 pm and Alternating Saturdays 9:00 am-1:00pm. We have a provider on call 24/7/365. And a Nurse Triage Line. This is available by calling our main number (813) 984-8846. We expect that you call 911 for a life threatening emergency. And that you call our Providers before you go the Emergency Department or Urgent Care.

Vaccine Policy
Julia Barriga, M.D.,P.A follows the American Academy of Pediatrics guidelines and CDC guidelines for well care and immunizations. We believe strongly in immunizations and protecting infants and children. We do not support alternate vaccine schedules or not vaccinating children. If your philosophy differs from ours, we request that you find another pediatrician. (read more on next page)

13 year old and older Privacy Policy (see Full Policy Description on next page)
I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the Providers feels the patient is a danger to themselves or has been abused.

Medical Home

Our team of Providers, Medical Assistants, Nurses and Supportive staff work very hard to provide comprehensive medical care and serve as your Medical Home. Therefore, we expect that you contact our office FIRST, before seeking specialty care, (going to see a Specialist) or heading to Urgent Care Facility. We have a provider on call who will be happy to guide you if you are worry about your child.

Patient Surveys

Surveys are an integral part of the visit since we can obtain information to provide you with the highest quality of care. If you choose not to complete these, we will be unable to adequately assess your child and do not feel comfortable providing care with only the surveys that insurance companies cover as this does not follow AAP guidelines.

We require that you complete these surveys BEFORE YOUR APPOINTMENT. You can complete these surveys before your child's appointment on your patient portal.

Patient Portal And Technology

We expect that all parents communicate to us through our Patient Portal for most of your needs, non urgent appointments request, refills, medical records request, Lab Results, School forms, Missed school forms, etc. We do will give more priority to this method of communication.

We use automated reminders please confirm your appointment via this method or you can request a cancelation as well.

Urgent Care

We offer evening hours and Saturday appointments. Please note that according to your insurance these Appointments Saturdays are subject to your insurance Urgent Care fees.

Specialist Care

As your medical home, we expect that you will contact our office to discuss care plans before scheduling an appointment with a specialist. We want to be involved in either providing care in our office where appropriate or referring you to the most appropriate specialist and helping coordinate your care. Whenever you do see a specialist, we ask that you request a report be sent directly to our office so we can coordinate all of your care. If you decide to go on your own and your insurance requires an authorization or referral we cannot do retroactive referrals. After we referred you to your specialist we need 10 business days in order to forward the referral notes and /or process an insurance authorizations. Please contact us via your patient portal with the specialist name and fax number in order to this. Please place this request 10 business days before your apt with Specialist.

Billing and Financial Responsibilities

It is expected that you solve ALL Insurance CONCERNS before you arrive to our office.

This includes changing PCP's, calling your policy to understand your policy or dispute a copayment or deductible during your appointment because this will cause a delay on your appointment. If the Concerns are not solved before your appointment, the appointment will be RESCHEDULED.

Payment is always due at time of service, and it is the patient's responsibility (patient's legal guardian) to understand how your insurance works including deductibles and co-insurance and to provide up-to-date insurance information at every visit. We will bill your insurance company, but if any charges are denied, payment responsibility returns to the patient and will be collected at your next visit. You can always make payments through the Patient Portal. Please refer to the detailed Financial Policy for more information.

Late Arrival Policy

We value your time and will make every attempt to see your child in a timely fashion. Please extend us the same courtesy and be on time for your appointment. If you are running late for your appointment please notify our office and we will attempt to make accommodations within our schedule. Patients who are more than 15 minutes late for their appointment may be considered a "No-show" and may be asked to reschedule their appointment.

School/Work Excuses

We are only able to provide school and work excuses for patients and/or parents who are seen within our office. At check-out you will be provided a note excusing the day that you were seen and the date deemed appropriate for you to return to work or school by the appointment provider.

Family Members or Other Guardians bringing patient to an appointment

Parent or Guardian may authorize someone else not already authorized on the New Patient Registration Form by filling out our form "Authorization for Medical Treatment of Minors" posted on our website, and handing it to the front desk before the appointment. Make sure this person knows about the condition of the child, and is ready to make necessary payments if required. (Please refer to detailed information on form).

Medical Forms and Immunization Records Form Requests (we only accept Pre-Paid requests)

- Medical Records: Request for medical records must be made in writing and contain the signature of a parent or guardian. Medical records requested for personal use will incur a charge of $25 for the first 25 pages,$1.00 per page, $0.25 for each additional page . There is no charge to send medical records to another physician. Allow 10 business days to complete the request.

- FMLA Forms: will be ONLY completed during a visit EXCLUSIVE for this reason. Parent must know what his/her employer is requiring on the form.
- State of Florida Shot Records and Physical Forms are FREE of charge on your Patient Portal 24 hours after your kind request. Or $2.00 per page if we print them in our office 24 hours after your request, or $ 5.00 per page for a same day Rushed request.
- Sports Physicals, if a "Sports Physical" is requested by your school or camp, patient needs an additional Well Child Exam appointment and parent needs to fill out front section of the Sports Physical Form. Sports Physical and Well Child Exam are different.
- Regular Shot Records are available and can be printed from your patient portal at any time.
- All other Letters are $50.00 per letter and require 10 business days. Rush requests will be fulfilled provided we have all information in hand and the provider is available to complete it. Additional Rush Requests $25.00

Medication Refills

Please allow our office 72 hours for prescription refills. Medication refills will only be done during our normal business hours. The on-call physician will not prescribe non-urgent refills after hours or on weekends. Patients must be seen prior to filling any new prescriptions that our office did not originally prescribe. Controlled medications (such as those for ADHD) cannot be e-scribed and will require a visit every 3 months. We don't do refills on Antibiotics or Asthma Medications. Some prescriptions require a visit at least every 3, 6 or 12 months, depending on the medication.
Please request all prescription refills via the Patient Portal.

Legal action

If legal actions occur in which a physician or any employee of Julia Barriga, M.D.,P.A is requested or subpoenaed to provide testimony (such as a custody case), you will be responsible to pay Julia Barriga, M.D.,P.A directly for providing the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent appearing in court. Charges for legal services will be billed at $300.00 per hour. If this legal action requires the physician to step away from patient care for an entire day, the fee will be $15,000 for each day that they are unable to see patients. This fee is NOT reimbursable by a Third-Party Payer and is therefore the full legal responsibility of the patient and/or the patient's parent or legal guardian.

Custody/Divorce Agreements

Divorce decrees are a contract between two parents and not the physician and the parent. We cannot and will not withhold patient information from one parent at the request of the other parent without receiving a copy of the divorce decree verifying full custody. Unless a divorce decree is submitted to the patient's chart, we will provide care for the child regardless of which parent is at the appointment. Payment is due at time of service regardless of which parent holds the financial responsibility for medical services.

Misconduct and Threats to Staff and/or Providers

As a Practice WE DO NOT TOLERATE any verbal or physical threats made against our providers or staff. If a threat is made either verbally or in written form, the physician-patient relationship has been compromised, and the patient (and any family members, if applicable) will be discharged from the practice.

By signing below, you acknowledge and fully understand the Office Policies.

_____ _____ _____

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

HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protocol health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that as part of my healthcare, Julia Barriga, M.D.,P.A . originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I have received, read, and understand, or declined to read, your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.

_____ _____ _____

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

Welcome to Julia Barriga, M.D., P.A. !

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FINANCIAL POLICY

FINANCIAL GUARANTOR (This is the person that will receive Billing Statements in the mail. (Parents must agree on this and work arrangements out among themselves for payment issues)

Please be advised that you are initiating services to be rendered and ultimately you are financially responsible for all charges incurred whether paid by your insurance or not.

Patients are expected to:

1. Bring and present their insurance card to every visit. We must have a copy of insurance card to submit claims. We must have accurate personal and insurance information or patient may be given a 30 day notice of dismissal from the practice.
2. Newborns: Give the office current insurance plan information within 30 days of the date of service or we cannot file a claim to your insurance and you will be responsible for payment.
3. Have our name, Julia Barriga MD PA, listed on their insurance card as PCP if they have an HMO plan. If another doctor or facility is listed we cannot see the patient. Newborns have 30 days to have us added as PCP.
4. Review our Referral and Authorization Policy attached.
5. Pay co-payments, co-insurance, or the flat fee of $80.00 if you have not met your deductible assigned by your insurance. When we receive an "explanation of benefits" from your insurance company, we will apply this amount towards your responsibility.
6. Pay personal balance due on account that is over 30 days old before next visit.
7. Methods of Payments include: Cash, Visa, Discover and Master Card, American Express, or online on Patient Portal via Instamed.
8. Understand there will be a $30.00 fee assessed for any returned personal check or credit card that denies.
9. Keep appointments and arrive promptly. Notify our office of any need to cancel or reschedule. If appointments are "no shows" or canceled with less than 24 hours notice there will be a charge assessed. A courtesy reminder call is made, when possible, but it is your responsibility to know the date and time of your appointment.
10. Understand your insurance policy and its benefits. Understand there may be things your insurance plan does NOT cover. Every plan is different, and it is your responsibility to know your specific coverage. This is a contract between you and your plan.
11. Verify with your employer or insurance company if we are participating with your specific plan BEFORE scheduling appointments.
12. Understand if you will be responsible for the full charge if you choose to use our services and we are non-participating with your insurance. This payment is due on the date of service. We will with documentation to file a claim for your visit to your insurance company. They will reimburse you.
13. Provide coordination of benefits information to your insurance. If not, claims will be denied and will be your responsibility to pay.
14. Work with YOUR insurance to get prompt payment of claims. We will handle your claims according to our claims agreement with that insurance company.
15. Call us if you have any questions regarding the payment by your insurance company, our insurance department will try to assist you. Please have the "Explanation of Benefits" you received from your insurance on hand when you call our office.
16. Understand we will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc.,other than to supply factual information as necessary. You will need to resolve these with your insurance.
17. Understand we cannot become involved in domestic disputes over who is responsible for the bill.
18. Understand once your account if 90 days delinquent and you have not made any attempt to make a payment or set up a payment schedule you may be sent to a collection agency and you may be discharged from the practice.
19. If you have a previous balance that has been turned over to the Collection Agency, you must to be prepared to pay it in full. at the time of your future appointments.

Financial Guarantor

The adult signing this policy is responsible for full payment. It is your responsibility to arrange transfer of amount due to the grandparent/ guardian/ friend who accompanies child to the office.

Julia Barriga, M.D.,P.A will NOT honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements").

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. Upon request, Julia Barriga, M.D.,P.A will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

I hereby grant permission to Julia Barriga, M.D.,P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Julia Barriga, M.D.,P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

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Vaccine Policy

Effective August 22nd, 2019

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
Our physicians believe that all children should be fully immunized unless there are medical contradictions.

Because all available scientific evidence favors vaccinating according to the schedule set forth by the CDC, American Academy of Pediatrics, and ACIP, and because not following this schedule can potentially harm other children in our office.

- We will no longer see families who choose not to vaccinate their children according to the recommended schedule.*
- We will no longer follow "Alternative Vaccine Schedules".
- Patients who currently use such schedules will need to follow the recommended catch-up schedule* should they continue to choose our doctors for their child's pediatrician.

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

As healthcare providers, it is our responsibility to protect as many children from disease as possible.

Parents who choose not to have their children vaccinated according to guidelines not only put their children at risk of getting sick, but also indirectly put other children at risk. This is why we feel strongly that the best way to protect the health of all children in our practice is to ensure that everyone follows the recommended schedule*.

If your philosophy differs from ours, we request that you find another Pediatric Practice.

Julia Barriga, M.D., P.A.

*Flu and HPV vaccines will remain optional, however, they are important vaccines and parents should discuss them fully with their Provider before declining them and a Refusal Form will have to be signed and kept in your records.

PARENT COPY

JULIA BARRIGA MD PA
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POLICY: 13 year old and Older Privacy Policy
TRANSITION TO ADULT HEALTH CARE 9-1-19

Julia Barriga, M.D., P.A.'s Teen Transition to Adult Health Care Policy follows the following Policy:

13 Years Old to 17 Years Old Patients

Patients beginning at age 13 years, part of a patient's medical visit will generally be in private, and the parent/guardian may be asked to step out of the exam room if the adolescent requests it. The patient may ask for the parent/guardian or nurse to be present in the exam room. Discussions of certain sensitive issues, such as sexual and mental health and substance use, will remain confidential and will not be shared with the parent/guardian unless the adolescent consents. Medical records documenting the corresponding portions of the medical exam and discussion also will be treated as confidential, to the extent required by law, and will be released to a parent/guardian or other person only with the patient's written authorization.

This Policy would not apply for adolescent patients who have developmental disabilities or other special health needs, it may be necessary and appropriate to modify these policies to accommodate their needs. We welcome patients and parent/guardians to discuss social needs with us, so that we may plan reasonable accommodations together.

Julia Barriga, M.D., P.A will inform the parent/guardian of any life-threatening situation or behavior involving any patient younger than age 18 years, whether disclosed by the patient or becoming evident through medical examination. In this case, we will inform the patient that we have a legal obligation to disclose this information to the parent/guardian.

18 Years Old Patients

Patient 18 years and older: Patients 18 years and older are adults under the law. Patients under age 18 who have been emancipated (through marriage, pregnancy, etc.) are also considered adults under the law.

Julia Barriga, M.D., P.A. will respect these patients right to make their own health care decisions and manage their own health care, unless a court has determined that they are not able to do so and has appointed a legal guardian. Please provide us a copy of the court's decree or equivalent documentation, if you have been appointed the legal guardian. Please provide us a copy of the court's decree or equivalent documentation if you have been appointed the legal guardian of your adult child, so that we may conform to the terms of you guardianship.

Julia Barriga, M.D., P.A. will respect the right of patients age 18 years and older to privacy regarding their health information and records. Providers will meet with and examine these patents privately unless the patient requests that the parent or other person be present. A young adult patient may authorize a parent or other person to receive medical information or records by signing a release of information.

Insurer's privacy policies: Please be aware that young adults and children who are insured under a parent's family policy might receive statements from the insurer at the parent's address. Contact the insurance to learn about their Privacy Policies. Julia Barriga, M.D., P.A. has no control over their privacy policies.

Transitioning from pediatric to adult health care

Julia Barriga, M.D., P.A. serves patients from birth to 18 years of age. After patient turns 18 years old and before they turn 19 years old, patients should transition to an adult primary care provider (usually a Doctor, practicing Family Medicine or Internal Medicine), as well as adult specialist providers for any medical specialty care the patient may receive. We encourage you to start collecting information about adult health care providers well before this age, usually around age 18 years. Remember to check with your Insurance Company.

We are available to discuss health care transition with patients and families. We are committed to partnering with you throughout the process to assure a smooth transition.

Once you select your adult provider, please sign a Medical Records Release Form promptly so we may send your medical records to this provider. You may use Julia Barriga, M.D., P.A.'s release form at www.juliabarrigamd.com website or the form from the adult provider's office. Please be aware that Julia Barriga, M.D., P.A. disposes of medical records according to state law. This generally means that we retain records for seven years after the last date of service or until age 18 years, whichever is longer.

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OFFICE POLICIES CONSENT ACKNOWLEDGEMENT 9-2-19 office copy

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 _____
7. Patient Name _____ Date of Birth _____
8. Patient Name _____ Date of Birth _____

This page represents a Summary of all Policies delineated for Julia Barriga, M.D.,P.A.

1. HIPPA (Health Insurance Portability and Accountability Act): I hereby acknowledge that I have been presented with a copy of Julia Barriga, M.D.,P.A. Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand I am not required to agree to (Julia Barriga, M.D.,P.A. requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.
Parent/Guardian_____

2. Julia Barriga, M.D.,P.A. Financial Policy: I have read, understand, and will comply with the Financial Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or in previous occasions, Julia Barriga, M.D.,P.A. is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.
Parent/Guardian _____

3. Appointment Policy/Office Policies, NO- SHOW Policy : I hereby acknowledge that I have been presented with a copy of Julia Barriga, M.D.,P.A. Office Appointment Policies handout and understand my responsibilities. I have read and understand them.
Parent/Guardian _____

4. Patient Guidelines and Consent for Use of Patient Portal: I hereby acknowledge that I have been presented with a copy of Julia Barriga, M.D.,P.A. Patient Guidelines and Consent for Use of Patient Portal. Communications policies and understand my responsibilities.
Parent/Guardian _____

5. Vaccine Policy. I hereby acknowledge that I have been presented with a copy of Julia Barriga, M.D.,P.A. Vaccine Policy. And I choose to follow the Policies. Parent/Guardian _____

6. 13 year old and older Privacy Policy. I hereby acknowledge that I have been presented with a copy of Julia Barriga, M.D.,P.A. 13 year old and older Privacy Policy and I choose to follow the Policies. Parent/Guardian _____

7. Consent for treatment and Examination. I voluntarily give authorization for the medical treatment to the providers at Julia Barriga, M.D.,P.A. This permission is given for patient(s) listed to receive any medical/surgical procedure, x-rays, drug, or laboratory test, medication or exam, as may be deemed necessary by the providers.

8. I authorize the release of medical records to my insurance company. In the event that. Julia Barriga, M.D.,P.A. files to my insurance, I authorize benefits to be paid directly to . Julia Barriga, M.D.,P.A.

The office policies and protocols will be updated periodically as the practice grows and changes will be made accordingly. These updates will be available on our website as well as in our office.
I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of Julia Barriga, M.D.,P.A. policies and protocols, or I have declined to read. I also acknowledge I have been given copies of all the policies mentioned above, if requested, and I was given the opportunity to ask any questions.

Print Parent/Guardian Name: _____ Signature: _____ Today's Date_____

Print Witness Name: _____ Signature: _____ Today's Date_____

OFFICE COPY

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS 8-26-19
by other than the Parent or Guardian

Patient's Full Name: _____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Patient's Full Name:_____ Date of Birth:_____

Individual (s) authorized to bring children (listed above) for treatment (including Mom and Dad)
Every Person bringing children MUST PRESENT A PICTURE ID AT EVERY VISIT
(Individual must be at least 18 years old)

Name:_____ Phone_____ Relationship:_____

Name:_____ Phone_____ Relationship:_____

Name:_____ Phone_____ Relationship:_____

Name:_____ Phone_____ Relationship:_____

Name:_____ Phone_____ Relationship:_____

Signature(s)

I as the parent/ legal guardian authorize the Individual(s) (listed above) to bring my child/children (listed above) to Julia Barriga, M.D.,P.A. to receive medical services. I am also aware that this Individual should be responsible for any payments due at the time of service or previous balances.

Please make sure the designated individual knows about the current condition of the patient and that he/she can transfer all the information provided on the visit to the parent or guardian.

PARENT / GUARDIAN NAME_____ LEGAL RELATIONSHIP TO PATIENT_____

Phone Number to reach you if needed during the visit :_____

PARENT / GUARDIAN SIGNATURE _____ DATE _____

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PATIENT PORTAL USER AGREEMENT AND INFORMED CONSENT

reviewed 8-26-19

PARENT'S INFORMATION(This parent/ guardian will receive appointment confirmation, reminders and the EMAIL ADDRESS provided to us becomes your Patient Portal Login)

OFFICE COPY

We will link ALL your children (listed below) to your Patient Portal Account and in the Patient Charts

If any of your children have a different family dynamic, custody, etc, Please let us know.

Parent Last Name: _____ First Name:_____ Relationship to Child:_____
Telephone:_____ Do all children (below) reside with Parent: ___YES, ___ NO

Address (if not provided elsewhere)_____

Portal Email address : _____(Portal email access address)

Child's name: _____ DOB _____

Child's name: _____ DOB _____

Child's name: _____ DOB _____

Child's name: _____ DOB _____

Child's name: _____ DOB _____

Child's name: _____ DOB _____

Portal Temporary password if needed: _____ Parent's Signature: _____

Patient portal basics

Julia Barriga M.D.,P.A. understands the need for communication between health care professionals and patients. Julia Barriga M.D.,P.A. is committed to providing patients and other authorized personnel the ability to use a secure and confidential patient portal that provides the following functionality:

1 Access to medical records
2. Ability to contact the appointment desk.
3. Secure communication with health care professional.

The Patient Portal utilizes technology to deliver secure communications between patients and Julia Barriga M,D,.P.A.
The term "patient portal" refers to the part of Julia Barriga MD,PA's information system that provides access to patients' health information and allows for secure communication, including prescription, referral and appointment requests.
"Electronic communication" means e-mail or text messaging with patients outside of a patient portal.

Patient portal policy

The following policies and limitations apply to the use of Julia Barriga M.D.,P.A. patient portal.

1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.
2. Correspondence via patient portal is supplemental to physician/patient encounters. Julia Barriga M,D,.P.A. will not provide patient portal-based diagnosis and treatment.
3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information cannot be discussed through the patient portal.
4. Other electronic communication with the health care professional, such as non-patient portal email or text messaging is prohibited.
5. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.
6. Communications should be responded to within 2 business days. You agree not to use this portal if you need a response sooner or on an urgent basis. If your need is urgent you must contact the practice directly.
7. You agree not to share your password with anyone and that you are solely responsible for protecting your password.
8. You agree that access to the site is provided on an "as is available" basis and that our practice cannot guarantee you will be able to access the portal at any time. Internet based communications are inherently insecure since no technology guarantees privacy or security of information sent over the internet. You agree to use caution when providing information via this portal, and acknowledge that keeping messages secure is your responsibility.

Conditions of participation

Access to Julia Barriga M.D.,P.A. is restricted to the above-named patient. This service is optional, and we reserve the right to suspend or terminate the service and/or your access to it at any time. If the practice suspends this service, you will still have access to copies of your medical record and other health information, upon request.
The patient acknowledges that he/she agrees to comply with the Julia Barriga MD,PA. 's, Patient Portal Policy outlined above.

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Patient/ Family Registration Form

8-22-19

OFFICE COPY

PRIMARY CONTACT PERSON FOR FAMILY (this will be the **person to receive appointment reminders**)

Relationship to patient(s):_____

First Name: _____ Last Name:_____ Birth Date: _____/_____/_____

Address: _____ Apt:____ City: _____ State: _____ Zip: _____

Email: _____ **(primary email)**

Cell Phone: _____ Home Phone: _____ Work Phone _____(select primary phone)

Do you live with patient? ___Yes ___No , Primary Language Spoken: __English, __Spanish, __Other:_____

Preferred method of contact: Appointment Reminders: ___Text Message ___ Cell Phone ___ Home Phone ___ Email

Recalls: past due shots , physicals exam: ___ Text Message ____Cell Phone ___ Home Phone ___Email

SECONDARY CONTACT PERSON FOR FAMILY

Relationship to patient(s):_____

First Name: _____ Last Name:_____ Birth Date: _____/_____/_____

Address: _____ Apt:____ City: _____ State: _____ Zip: _____

Email: _____ **(primary email)**

Cell Phone: _____ Home Phone: _____ Work Phone _____(select primary phone)

Do you live with patient? ___Yes ___No , Primary Language Spoken: ___English, ___Spanish, ___Other:_____

Preferred method of contact: Appointment Reminders: ___Text Message ___ Cell Phone ___ Home Phone ___ Email

Recalls: past due shots , physicals exam: ___ Text Message ____Cell Phone ___ Home Phone ___Email

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) _____

In order to obtain more accurate Family Medical History requirements, if contacts listed above are NOT the BIOLOGICAL PARENTS, we now necessitate BOTH BIOLOGICAL PARENTS (if known) to be listed **(fill in any and all information if known):**

Biological Mother: _____ Birth Date: ____/____/_____

Biological Father: _____ Birth Date: ____/____/_____

If either biological parent listed above 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: _____

LIST ONLY CHILDREN IN FAMILY THAT THE ABOVE PARENTAL INFORMATION APPLIES TO
(If children have a different family dynamic then above - they must be on a different sheet)

	First Child	Second Child	Third Child	Fourth Child
First Name				
Middle Name				
Last Name				
Birth Date	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Sex	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female
Primary Language	___ English ___ Spanish List other:	___ English ___ Spanish List other:	___ English __ Spanish List other	___ English ___ Spanish List other:
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined
Race **(Check all that apply)**	___ Native American ___ Asian ___ Black or African-American ___ Hawain / Pacific Islander ___ White ___ Declined	___ Native American ___ Asian ___ Black or African-American ___ Hawain / Pacific Islander ___ White ___ Declined	___ Native American ___ Asian ___ Black or African-American ___ Hawain / Pacific Islander ___ White ___ Declined	___ Native American ___ Asian ___ Black or African-American ___ Hawain / Pacific Islander ___ White ___ Declined
Who is your preferred Provider?	___ Barriga ___ Morgan ___ Muniz	___ Barriga ___ Morgan ___ Muniz	___ Barriga ___ Morgan ___ Muniz	___ Barriga ___ Morgan ___ Muniz

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INSURANCE INFORMATION

9-2-19

Financial Guarantor

(This is the person that will receive Billing Statements in the mail. Parents must agree on this and work arrangements out among themselves for payment issues)

Financial Guarantor's Full Name_____ Relationship to patient: _____

Financial Guarantor's DOB:_____ Financial Guarantor's Social Security #_____ Phone_____

Financial Guarantor's Address _____.

Do you live with patient? ___Yes ___No, ___I have read, understood and agree to the above financial policy for payment of dues.

Financial Guarantor's Signature_____ Today's Date _____

List below only children in family that the below information applies to

(If children have a different family dynamic than below - they must be on a different sheet)

	First Child	Second Child	Third Child	Fourth Child
Patient's Name as it appears on Insurance Card				
Insurance Carrier Name				
Subscriber ID				
Relationship to Subscriber	__ Self ___ Child	__ Self ___ Child	__ Self ___ Child	__ Self ___ Child
Group Number				
Group Name				
Insurance Carrier Address				
Insurance Carrier Telephone				
Primary Care Doctor listed on Card				

Insurance Card Must be present to be scanned

For Commercial Insurance Carriers: please fill out information of the Primary Subscriber (mom, dad or guardian)

Subscriber last name: _____ Subscriber first name: _____

Sex: _____ Date of Birth: _____ Patient Relation to subscriber: _____

Insurance Carrier: _____ Subscriber ID: _____

Group Number: _____ Group Name: _____

Employer Name:_____

Patient responsibility (If you do not know, leave it blank): PCP visit copay: _____ Well visit copay: _____ Co-insurance : _____ Yearly Deduct__

SECONDARY Insurance Coverage **(if Patient has 2 Insurances, Commercial Insurance is Primary and Medicaid(Assistance Insurance) is Secondary) (Process claims We need information of both Insurances and they both need to be Assigned to JULIA BARRIGA MD PA as PCP)**

Subscriber last name: _____ Subscriber first name: _____

Sex: _____ Date of Birth: _____ Patient Relation to subscriber: _____

Insurance Carrier: _____ Subscriber ID: _____

Group Number: _____ Group Name: _____

Employer Name:_____

Patient responsibility (If you do not know, leave it blank): PCP visit copay: _____ Well visit copay: _____ Co-insurance : _____ Yearly Deduct__

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____ Birth date: _____ Maiden/previous/other names: _____
(Please print) (Please print)

THIS WILL AUTHORIZE THE FOLLOWING PROVIDERS

	Provider or Practice Name	Address	Telephone	Fax
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____

TO RELEASE INFORMATION SELECTED BELOW TO:

JULIA BARRIGA, M.D.,P.A.
5001 E. BUSCH BLVD., TAMPA, FLORIDA, 33617 Phone (813) 984-8846, Fax (813) 984-8827.
DSM: barrigamd@juliabarrigamdpa.opdirect.net

INFORMATION REGARDING:

☐ All medical records	☐ Operative reports	☐ Mental health records	☐ Audiological	☐ ER Reports
☐ Ear, Nose, Throat	☐ Consultations	☐ History and physical	☐ Education (IEP)	☐ Medical Reports from: _____to_____
☐ Neurologic	☐ Specialist Reports	☐ Physical form	☐ Treatment plan	
☐ Ophthalmology	☐ Orthopedic	☐ X-Ray and Lab Reports	☐ Immunizations	
☐ Allergies	☐ Other _____			

PURPOSE OF RELEASE (CHECK ALL THAT APPLY):

☐ Treatment/Referral ☐ Insurance purposes ☐ Personal use ☐ Change of physician ☐ Continuity of Care

IF YOU ARE CHANGING PHYSICIANS, PLEASE MARK THE REASON (CHECK ALL THAT APPLY):

☐ Prefer different office location	☐ Age of children	☐ Physician not in your network
☐ Problems with office staff	☐ Inadequate appointment availability	☐ Moving out of town
☐ Prefer different physician	☐ Other (specify) _____	

INFORMATION TO OMIT (CHECK ALL THAT APPLY):

☐ Mental health records ☐ HIV records ☐ Substance abuse (Alcohol/Drugs) records ☐ Other _____

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider the release of the information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall valid for six months from the date signed below. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I authorize the use and disclosure of the medical records and health care information indicate d above (please print):

Signature: _____ Print Name: _____
(Patient must sign if 19 years of age or over; otherwise parent, or legal representative)

Relationship to patient if not signed by patient: _____

Current address: _____ _____
Street City State Zip

Current home phone: (_____)_____ Current work phone: (_____)_____

Today's date: _____ This authorization will expire on: _____
(specify an expiration date or event)

PLEASE NOTE: THERE WILL BE A CHARGE $1.00/PAGE FOR THE FIRST 25 PAGES, AND $0.25 THEREAFTER_DR. TO DR FREE

(NOTE: The person signing this authorization is to be provided a copy of this form. If the records being released are for a patient who is 19 years of age or over at the time of the record request, the patient must sign this form.)

FOR INTERNAL USE ONLY
Form reviewed by MA_____ Date:_____.
Authorization: Faxed_____, Mailed ____ Emailed____ CD____ Date:_____ Ma:_____
Medical Records Obtained Date:_____ Ma_____

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Medical History : 4 years old and older **8-21-19**
ANAMNESIS

Please complete this form in its entirety and return it BEFORE 1ST VISIT
WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES

Patient's First Name: _____**Last Name:**_____ **Date of Birth:** ____/_____/_____

City and State where your child was born? _____ Is child adopted or fostered? Y___ N___

Family Medical History

(Biological Family, members related by blood)

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather List or explain condition if possible.

Familiy Medical History	**NO**	**YES**	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Asthma/lung disease									
Allergies									
Anemia									
Bleeding disorders									
Cancer									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Obesity									
Diabetes or other endocrine problem									
GI disease / disorder									
Liver disease									
Kidney disease									
Bed-wetting (after age 10)									
Neurological disorder including ADHD/ADD									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Mental Illness									
Vision impairment or eye disorder									
Hearing impairment: Childhood hearing loss									
Alcohol Abuse									
Tobacco Abuse									
Drug Abuse									
Immune problems, recurrent infections or HIV-AIDS									
Tuberculosis									
Other issues:									

I attest that all the medical history information is true and correct to the best of my knowledge: **Print Name**_____

Signature: _____ **Relationship to patient:** _____ **Today's Date:** _____/_____/_____

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Past Medical History

Patient's First Name: _____**Last Name:**_____ **Date of Birth:** ____/_____/_____

Past Medical History	No	Yes	If Yes, Explain
Anemia or bleeding problems			
Eye conditions / wear corrective lenses			
Blood transfusion			
Problems with ears or hearing			
Frequent ear infections or sinus infections			
Snoring (does child snore when sleeping)			
Pharyngitis / tonsillitis			
Allergic rhinitis or other allergy			
Outdoor allergens			
Indoor allergens			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Dental decay			
High blood pressure			
Abdominal pain/ GER reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other Urologic problem			
Bed-wetting (after age 5)			
Overweight, Obesity			
Diabetes			
Thyroid or other endocrine problems			
Frequent headaches			
Seizures, developmental delays, ADD/ADHD or other neurological disorders			
History of Family Violence			
Mental health concerns			
Emotional problems : Anxiety, Depression, ODD, OCD			
Use of Tobacco			
Use of alcohol or drugs			
Chronic or recurrent skin problems: acne, eczema, other			
Orthopedic problems			
Hospitalizations			
Surgeries			
Serious accidents or injuries			
Other infection illnesses: HIV, STDs , TB			
Chicken Pox Disease			
If female, have menstrual periods started?			
If female, any problems with periods?			
Pregnancy			
Other significant issues:			

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Social History

Patient's First Name: _____**Last Name:**_____ **Date of Birth:** ____/_____/_____

Household : Please list all those living in the child's home (include parents, siblings, extended family, step-family, Grandparents, others).

Name and Last Name	Birth date	Relationship to child	Health Problems

Social History	**No**	**Yes**	
Does patient live with both mother and father in same house?			
Non-intact home : explain custody status. explain below			Lives with:
Does non-custodial parent have visitation rights? explain below			
Are there Siblings?			Live in same house?
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			
Other issues:			

Parent's Marital Status: __Married __Divorced __Separated __Never Married __Other

If parent's are not living together or if the child does not live with parents, what is the child's custody status?

_____

What is the visitation status of the non-custodial parent(s)?

_____

Daytime Status: __Home __Daycare __School __Afterschool Care, Other_____

School Name:_____ **Daycare Facility Name**_____

Mother: Highest level of education obtained: __Elementary, __Middle School, __ High School, __Technical School, __College, __Masters or Doctorate.

Occupation:_____. How do you learn best: __Verbal communication, __ Written communication, __Visual communication.

Father: Highest level of education obtained: __Elementary, __Middle School, __ High School, __Technical School, __College, __Masters or Doctorate.

Occupation:_____. How do you learn best: __Verbal communication, __ Written communication, __Visual communication.

Guardian_____: Highest level of education obtained: __Elementary, __Middle School, __ High School, __Technical School, __College, __Masters or Doctorate.

Occupation:_____. How do you learn best: __Verbal communication, __ Written communication, __Visual communication.

Any Other Concerns:_____

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Developmental History

Patient's First Name: _____**Last Name:**_____ **Date of Birth:** ____/_____/_____

Developmental History	**No**	**Yes**	If Yes - explain
Do you have any concerns about your child's physical development?			
Do you have any concerns about your child's attention span?			
Has he/she failed or repeated a grade?			
How is your child's behavior in school?			
What kind of grades does he/she make in academic subjects?			
Is he/she in a special or resource classes?			
When did your child: Sit up: mos. Crawl: mos. Walk: mos.			
First sentence (age) Toilet trained (age)			

ALLERGIES

PATIENT ALLERGIES	**No**	**Yes**	If Yes - explain
Does this child have any known Drug Allergies?			
If you answered YES - Is your child allergic to:			
Penicillin: Amoxicillin, Augmentin			
Cephalosporins: Omnicef, Keflex, Rocephin, Ceclor, Suprax			
Sulpha: Septra/Bactrim			
Zithromax or Erythromycin			
Other Antibiotics or medications? Give name:			Reaction:
Peanuts or other nuts – Give name or Group:			Reaction:
Milk			
Eggs			
Seafood			
Other Foods – give name here:			Reaction:
Bees / Wasps			
Indoor Allergens (pets, molds, dust)			
Outdoor Allergens (trees, weeds, pollens)			
Latex			
Other Allergies:			Name:

Current Medications

Please list current Medication child is taking, including vitamins, herbal, supplements or any over the counter medications.

Medication Name	**Dosage**	**Frequency (times a day)**	**Prescriber (Doctor)**

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Continuity of Care

Patient's First Name: _____Last Name:_____ Date of Birth: ____/_____/_____

Pharmacy Information

Pharmacy Name	Address	Telephone	Fax

Specialist Care and Mental Health Care

Please list Specialist's visits in the last 10 years

Name of Specialist	Specialty	Address	Telephone	Fax	How often do you visit this specialist?	Last visit Date

Dental Care

Is your child established with a Dentist? __No, __Yes, (if yes, fill below)

Dental Facility	Address	Telephone	Fax	How often do you visit your dentist?	Last visit Date