



WELCOME TO SUNSHINE PEDIATRICS!

Sunshine Pediatrics is thrilled to welcome you and your kids to our practice. Children are a blessing and we are honored to care for them with you on their journey through life from cradle to college.

New Parents: The big day!

If you are planning on delivering your baby at a birth center or home birth with one of our affiliated mid-wives, simply tell them you have chosen Sunshine Pediatrics as your pediatrician. This allows for proper documentation to be forwarded to Sunshine Pediatrics concerning the birth of your baby. Please call the office **within 24 hours** of your baby's birth to schedule an appointment with one of our providers. Prepare to be seen within 48 hours of delivery.

If you are planning a hospital birth or ultimately end up delivering at a hospital, simply tell the hospital staff you have chosen Sunshine Pediatrics with Dr. Richard Rodriguez as your newborns pediatrician. This allows the proper documentation to be forwarded to Sunshine Pediatrics concerning the birth of your baby. Once discharged from the hospital, please contact our office to be scheduled for an appointment with one of our providers. Prepare to be seen within 3-5 days of delivery (unless specified per the hospital).

Office Hours:

Monday, Wednesday, Friday

8am to 5pm

Tuesday & Thursday *varies with provider availability*

8am to 7pm

5pm to 6pm is **reserved** for walk-ins

6pm to 7pm is **reserved** for established patient well-visits

Well-child appointments and sick-child appointments are available every day.

Please schedule any well-child visit 24 hours prior to requested time.

Sick visits can be made for same-day appointments.

Appointments:

- Please arrive 15 minutes before each appointment to complete the check-in process
- There is a 15 minute grace window if you are running late. After that, your appointment will be rescheduled at a \$35 fee. Please allow for a 24 hour notice in any changes to the appointment.
- 12 visits during the first 2 years of life; we ask that you come to all of them, even if your child is well.

After hours – EMERGENCY/URGENT matters only

- Call the office, follow the prompts, and leave a detailed message. Your call will be returned within 30 minutes. REPEAT PHONE NUMBER please.
- *Any non-emergent issues can be subject to fee.* After hour phone calls are NOT for insurance questions, appointment making/cancelling, prescription refills, etc.

Newborns:

- MEDICAID is open to newborns. We accept Humana and Sunshine Health.
- We recommend mother's to seek out lactation services. Please ask your provider for more information.

Insurance:

- We accept both Medicaid and commercial insurance.
- Call your insurance the day the baby is born to add baby to a policy.
 - Sunshine Pediatrics is outpatient setting so a 30 day rule does not apply to this office.
- \$175 will be collected at time of visit until baby has active insurance (in-network) in our system. The refund will be issued once we receive payment from insurance.
- If child is put on an HMO we are not in-network with, **no refund will be issued.**
- Follow up with your employers human resources.

Vaccine Friendly:

- Sunshine Pediatrics recommends that you vaccinate you child, but if you decide not to, we respectfully honor your decision.
- Know your own vaccine schedule and understand each vaccine.
- Please see attached vaccination policy.

Forms:

- \$5 (each) for forms given outside of your well-visit; keep a master copy for your records.
- If someone other than the legal guardian is bringing a child, we need a notarized form.
 - Available on our website or in office.
- If transferring to our practice, we ask for medical records to be faxed or given to us BEFORE any appointment is scheduled.
 - Medical release/request form available on our website or in office.



Patient Registration

(Please print)

Patient:

Last Name _____ Patient First Name _____ Middle Initial _____

Sex: M _____ F _____ Date of Birth _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip Code _____ Home phone _____

Race/Ethnicity: Caucasian African American Hispanic Asian American Other

Preferred Language _____ Referred By _____

Siblings:	Name	Sex	DOB	SS#
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Physician _____ Pharmacy Name and Number _____

Mother:

Last Name _____ First Name _____ Date of Birth _____

Mailing Address (list if different) _____

City _____ State _____ Zip Code _____ Cell phone _____

Social Security # _____ Marital Status _____

Email Address _____

Father:

Last Name _____ First Name _____ Date of Birth _____

Mailing Address (list if different) _____

City _____ State _____ Zip Code _____ Cell phone _____

Social Security # _____ Marital Status _____

Email Address _____

Who is financially responsible for the patient (Guarantor)? _____

Emergency Contact

Name _____ Relationship _____ Number _____

Insurance Information

Primary Insurance

Name of Insurance Company _____ Phone Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

Insured's ID/Policy # _____ Group _____

Main Policy Holder _____ Policy Type: HMO PPO PPC Other _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Print Patient Name _____ Date _____

I hereby authorize the release or use of my/or the patient's individually identifiable health information ("protected health information") and medical record information by Sunshine Pediatrics of Central Florida (the "practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining the patient or discussing the patient's care, treatment or medical condition with you, by signing this consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction (s); however, if we do agree, in writing, to your/the patient's requested restriction(s), such restrictions are then binding on the Practice.

I have been provided the opportunity to review the Practice's Notice of Privacy Practices in the waiting room and I understand I may receive a copy if I request it.

Signature (parent/guarantor) Print Name (parent/guarantor) Date

I acknowledge and agree that the Practice may disclose my/the patient's protected health information and medical record information to the following individuals (other than parent): **(please initial line and write in name of individual)**

Spouse(other than child's parent) _____ Grandparent _____
 Legal Guardian _____ Other _____

I agree that the Practice may also disclose the following types of information contained in the patient's medical record.

<input type="checkbox"/>	General Medical Information	<input type="checkbox"/>	Drug/Alcohol Abuse
<input type="checkbox"/>	Financial Information	<input type="checkbox"/>	Labs/Diagnostic Testing
<input type="checkbox"/>	Psychiatric Information	<input type="checkbox"/>	Pregnancy Information if patient is under 18 years old

I agree and consent to the Practice releasing information to me in the following alternative manners **(please initial the appropriate spaces below):**

Via regular mail Via telephone Via home answering machine Via email

The Practice may refuse to treat you if you the patient's authorized representative, do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patients authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Signature (parent/guarantor) Print Name (parent/guarantor) Date

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to any evaluation or treatment that the assigned healthcare provider may deem necessary.

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Sunshine Pediatrics of Central Florida. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

We bill only primary insurance we are contracted with and the patient is expected to know what coverage they have. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, I am responsible for payment in full.

Currently, we do not bill secondary insurances. In the event you have two insurances, we can provide you with any documentation necessary for you to submit a claim to your secondary insurance.

FINANCIAL POLICIES

Payment for all medical care is due at time of service.

In the case of divorced parents, responsibility and payment shall be that of the guarantor bringing the child in for treatment. Payment for co-payments, deductibles, co-insurance or any other balance not paid by your insurance company is owed prior to treatment.

There is a \$35 returned check fee for any checks returned unpaid through Sunshine Pediatrics' bank. I understand that, in the case of default, I am responsible for any costs incurred in the collection of patient account, currently 35% of the balance, as well as reasonable attorney fees and court costs.

During the course of your treatment, separate charges for laboratory, hospital or other services not offered directly by this office may occur. Our office is not responsible for billing these services. You may receive separate bills from these facilities. If you have questions regarding their charges, please contact these facilities directly.

I understand and agree to comply with Sunshine Pediatrics of Central Florida financial policy.

Signature (parent/guarantor)

Print Name (parent/guarantor)

Date

OFFICE POLICIES

We provide an after-hours telephone service to our patients for cases of medical emergencies. **If you are needing to schedule or cancel an appointment, speak to our billing department or a nurse. Please do so during regular business hours of 8:00am to 5:00pm.** Abuse of the after-hours service for anything other than an emergency may result in a **non-negotiable fee.**

For prescription refills, have your pharmacy fax a refill request to our office and allow 3 days for processing. Please do not call the after-hours telephone or office nurse for refills.

As a courtesy to both our providers and other patients, we ask that you contact our office immediately if you are going to be late to your scheduled appointment. If you arrive more than 15 minutes late to your scheduled appointment time, your appointment will be forfeited and rescheduled.

PATIENT INFORMATION

A standard charge for transferring medical records is required by law. Please be advised requesting the transfer of medical records can take up to 5 days to process. For a doctor to doctor transfer of records, there is no fee associated for the first time of transfer. After that, the transfer of medical records will cost \$1 per page.

For school & daycare shot/medical forms, a flat fee of \$5 is required for all school, daycare, shot and/or medical forms at the time of pick-up. These forms are often referred to as blue and/or yellow forms. As a courtesy, these forms will be filled out at no charge during the time of a well exam.

For patient referrals, please allow 5 days as a doctor referral can take up to 3 days to process the correct insurance authorization. If a referral is pending authorization it may be necessary to reschedule an appointment.

NO SHOW/SAME DAY CANCELLATION/WALK-INS POLICY

Our office reserves the right to charge the following fees to reschedule your appointments or procedure.

If you are not on time for your appointment, the appointment will be rescheduled and a fee will apply.

Excessive (more than 4) NO SHOW, LATE ARRIVALS or SAME DAY CANCELLATIONS of appointments can result in your DISCHARGE from the practice.

Appointment Type	Amount	Notice Needed
Office Visit (sick)	\$35	24 hours
Office Visit (well or behavioral)	\$50	48 hours

This charge is not covered by insurance and therefore will be the responsibility of the patient/parent.

Signature (parent/guarantor)

Print Name (parent/guarantor)

Date



SUNSHINE PEDIATRICS OF CENTRAL FLORIDA

RICHARD RODRIGUEZ, M.D.

210 LOOKOUT PL, MAITLAND, FL 32751

PHONE 407-215-0400 FAX 407-215-0402

MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Sunshine Pediatrics. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible – no later than 24 hours prior to your scheduled appointment. This gives us time to schedule for other patients who may be waiting for an appointment.

Please see our appointment cancellation / no show policy below:

1. A **\$35.00** no show fee will be applied to any sick visit missed appointment not cancelled with a 24 hour notice.
Well visits/Med checks/Behavioral Visits need a 48 hour cancellation notice or **\$50.00** no show/same day cancel fee will apply.
2. At the 2nd no show, you will receive a call or email from the office manager to give a reminder about a 3rd no show dismissal policy.
3. At the 3rd no show, the patient will receive a dismissal letter with a medical records form to find a new pediatric practice.

As a courtesy, when time allows, we make reminder messages for appointments. If you do not receive a reminder message, the above policy will still remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience these circumstances, please contact our office manager.

You may contact Sunshine Pediatrics Monday – Friday from 8am to 5pm at the number above. (Please leave a voicemail if you are calling over the weekend to cancel a Monday appointment for a no charge cancellation. If a voicemail is left on Monday morning, the policy remains).

I have read and understand the MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY and agree to its terms.

Parent/Guardian Signature: _____

Date: _____

Relationship to Patient: _____



SUNSHINE PEDIATRICS OF CENTRAL FLORIDA

RICHARD RODRIGUEZ, M.D.

210 LOOKOUT PL, MAITLAND, FL 3251

PHONE 407-215-0400 FAX 407-215-0400

INFORMED CONSENT PURSUANT TO FLORIDA STATUES SECTION 456.51 CONSENT REQUIREMENTS/EXPLANATION OF SCOPE OF CARE

The American Academy of Pediatrics (AAP) recommends that all children and adolescents have an annual well exam visit where screenings and a complete physical exam are performed. Once component of a complete physical exam is inspection and palpation of the external genitalia to ensure normal, age-appropriate development and to document that there are no abnormalities. We will verbally inform you/the patient prior to doing this part of the exam, as we know there is sensitivity, but we need to ensure each patient has been evaluated appropriately. Additionally, if a child or adolescent presents with complaints that could be attributed to the genital area or rectum, we may need to examine the genitals and/or complete a rectal exam to ensure an accurate diagnosis. Florida has passed a new law that requires any health care practitioner that is examining or treating a patient's pelvic region to obtain a written consent. **Though we do NOT perform examination of the ovaries, uterus, and fallopian tubes in our offices, given the broad definition of "pelvis examination" in the recently passed Florida legislation, in an abundance of caution, we are choosing to obtain the consent of each patient or their legally authorized representative for examination of external genitalia. This consent applies regardless of gender.** Our exam, procedures, and way of practice *has not* and *will not* change regardless of the new law. We will continue how we have always performed our physical exams but comply with the new requirement of consent.

CONSENT FOR EXAMINATION OF EXTERNAL GENITALIA

By signing below, the patient (or the patient's legal representative) acknowledges that he/she has been given the opportunity to ask questions about the external genitalia examination before signing the Informed Consent and that the patient (or the patient's legal representative) has voluntarily agreed to the external genitalia examination by a health care provider. If the patient lacks the capacity to sign this Informed Consent, this form will be signed by the person authorized to consent for the patient.

Under Florida Law, prior to performing a pelvic examination, consent must be obtained. While we do not perform internal pelvic exams in our office, the components below are included in the Florida Law and may be performed at this examination:

- External genitalia examination, including the penis, scrotum, vagina, and/or labia
- Examination of the perineal area or perianal area or rectum
- Taking of a rectal temperature in an infant
- Evaluation of labial adhesions or penile foreskin adhesions

The RISKS to the examination include (but are not limited to): discomfort.

The RISKS associated with failing or refusing to undergo the examination elements above include: the inability to obtain a diagnosis and/or delay in diagnosis of a medical condition, the inability for the health care provider to have accurate and complete information necessary to appropriately treat the patient, and potential for infection for situations in which the provider is unable to take a rectal temperature.

The **REASONABLE ALTERNATIVES** include a refusal for the intervention assessment. In such case, shared decision making between the patient and his/her provider is vital to ensure health and wellbeing.

The **BENEFITS** include ability to obtain a diagnosis of a medical condition and the ability for health care providers to have accurate and complete information necessary to appropriately treat the patient.

This consent is in legal good standing and has no expiration, until otherwise revoked and a refusal is signed and on file. If you have any questions, please talk with your Sunshine Pediatrics health care provider

I acknowledge that this consent was given freely voluntarily. By signing below, I confirm that I have read, fully understand and consent to Sunshine Pediatrics of Central Florida conducting a pelvic exam. I also acknowledge that I understand the information in this form, including the purpose, risks, and benefits of the pelvic exam, and that I have had my questions answered.

Patient Name: _____ Date: _____

Signature of parent/guardian/legally authorized representative, or patient over the age of 18: _____

Note: Minors that request examination & treatment for sexually transmissible disease may provide consent to such treatment in accord with FL Law

Note: If you are a minor, & your physician believes that you would suffer health hazards if maternal health & contraceptive information & services of a nonsurgical nature are not provided to you, your physician may provide such services to you without parental consent in accordance with FL Law



Sunshine Pediatrics Vaccination Policy

The providers in this office recommend the immunization schedule of the Centers for Disease Control and Prevention which is also the schedule endorsed by the American Academy of Pediatrics. There is no evidence that this immunization schedule is not in the best interest of most infants. However, the providers do understand that parents are concerned with giving so many vaccinations. As providers, we stress the importance of parents being informed of evidence-based healthcare information and safety for their child. It's our job to inform parents about available protection for your child against preventable diseases. Once we've done our best to inform parents, it's the parent's job to make decisions about their child's preventative healthcare. Because of our understanding of parents' concerns, if a parent is more comfortable following an alternate vaccine schedule, we are willing to work with the parents. We believe in informed choice, personal responsibility and respecting the parent's decision.

THIS BEING SAID, be aware that we cannot falsify or violate FLORIDA LAW:

- If you choose not to vaccinate or to follow a delayed schedule, you must sign the American Academy of Pediatrics "Refusal to Vaccinate" form at each and every well child visit.
- We cannot give you a FL 680 form unless your child is completely up-to-date according to the CDC/AAP immunization schedule.
- We do not and cannot issue a medical exemption from vaccines unless we have clear scientific documentation of a medical exemption necessity.
- We do not and cannot issue religious exemptions. You must go to your county health department to be issued a religious exemption.
- PLEASE do not ask us to violate or falsify FLORIDA LAW. Pressuring us to violate or falsify FL law can result in your child(ren) being discharge from our care.

If you are doing a delayed or alternative schedule from the CDC/AAP's recommended schedule, we can provide you with a 687 form which basically is a record of the vaccinations your child has received. This form is only a record; it is not FL 680 that certifies that the child is up-to-date on their vaccinations per CDC/AAP recommendations and State of Florida Regulations.

To further clarify the difference between a FL 680 form and FL 687 form: the FL 680 is certified by the healthcare provider that the child is up-to-date with the State of Florida Regulations (recommended schedule of the CDC/AAP), and the FL 687 is just a record of the vaccinations your child has received. Most daycare, pre-schools, public and private schools under State of Florida Regulations require the FL 680 and will not accept the FL 687.

I understand that Sunshine Pediatrics' electronic medical record system automatically uploads your child's immunizations record to Florida SHOTS system.

If it is the choice of the parent to decline or delay vaccines of the CDC/AAP schedule a parent must sign the American Academy of Pediatrics Refusal to Vaccinate Form (can be found on our website) each time a scheduled vaccine is declined. I further understand that this policy is non-negotiable and non-compliance will result in immediate discharged of the patient from the practice.

I also understand a copy of this policy is on the Sunshine Pediatrics' website www.mysunshinepediatrics.com along with other information about Florida State Regulations, the CDC/AAP recommended immunization schedule and other helpful information regarding vaccinations.

I acknowledge I have read this policy and fully agree to abide by it.

Child's name (print): _____ DOB _____

Parent/Guardian Signature: _____

Date: _____

PATIENT HISTORY

PATIENT NAME: _____ DOB: _____

BIRTH HISTORY

ADOPTED?	Y / N	ASSITED CONCEPTION?	Y / N
MULTIPLE BIRTH?	Y / N	GESTATIONAL DIABETES?	Y / N
HOSPITAL NAME: _____		HIGH RISK PREGNANCY?	Y / N
TERM (WEEKS): _____		INDUCTION OF LABOR?	Y / N
BIRTH WEIGHT: _____		MATERNAL USE OF ALCOHOL?	Y / N
BIRTH LENGTH: _____		MATERNAL USE OF DRUGS?	Y / N
BIRTH CONDITION (HEALTHY?):	Y / N	MATERNAL USE OF TOBACCO?	Y / N
PLEASE EXPLAIN IF NO: _____		SURGERIES ON BABY?	Y / N
DELIVERY: _____	C-SECTION / VAGINAL	CIRCUMCISION? (BOYS ONLY)	Y / N
BREAST MILK / FORUMLA (TYPE): _____		JAUNDICE?	Y / N
HEPATITS B GIVEN?	Y / N	GBS STATUS?	+/-
VITAMIN K GIVEN?	Y / N	ERYTHROMYCIN GIVEN?	Y / N

FAMILY HISTORY

BIOLOGICAL MOTHER:	BIOLOGICAL FATHER:
ALLERGIES: _____	ALLERGIES: _____
MEDICATIONS: _____	MEDICATIONS: _____
HEALTH CONCERNS: _____	HEALTH CONCERNS: _____
DRUG/ALCOHOL USE: _____	DRUG/ALCOHOL USE: _____
SMOKER? _____	SMOKER? _____
ALLERGIES: _____	ALLERGIES: _____
DEVELOPMENTAL DELAYS: _____	DEVELOPMENTAL DELAYS: _____
ASTHMA? _____	ASTHMA? _____
ANEMIA? _____	ANEMIA? _____
OTHER: _____	OTHER: _____

EXTENDED FAMILY HISTORY

PLEASE LIST ANY FAMILY MEMBERS WITH THESE HEALTH CONCERNS in relation to patient
(MGM=MATERNAL GRANDMOTHER, MGF=MATERNAL GRANDFATHER, PGM=PATERNAL GRANDMOTHER, PGF=PATERNAL GRANDFATHER, MA=MATERNAL AUNT, PA=PATERNAL AUNT, MU=MATERNAL UNCLE, PU=PATERNAL UNCLE, ETC...)

KIDNEY/LIVER DISEASE: _____	HIGH CHOLESTEROL: _____
STROKE: _____	HIGH BLOOD PRESSURE: _____
CANCER: _____	HEART PROBLEMS: _____
ASTHMA: _____	DIABETES: _____
ALLERGIES: _____	HYPO/HYPER-THYROID: _____
SUDDEN DEATH: _____	MENTAL ILLNESS: _____
DEVELOPMENTAL DISABILITY: _____	REFLUX: _____
SEIZURES: _____	ANEMIA: _____
OTHER: _____	

SOCIAL HISTORY

WHO LIVES IN HOME: _____ PETS IN HOME: _____
SMOKERS IN HOME? _____ Y / N



WELL-VISIT POLICY

Date: _____

Patient: _____

The policy of this office is that your child needs to be current with all required well visits REGARDLESS of vaccination status as per the AAP schedule. Failure to keep any of the routine well visits will be cause for discharge from our practice. NO EXCEPTIONS.

The schedule will be given to you or you can access it on the AAP website.

Please see attached wellness visit schedule and CDC vaccination schedule. You can also access it on the CDC and AAP websites for further information.

We appreciate your cooperation with our policies as we strive to provide the best possible care for you child.

By signing below, I am stating that I have read and understand this notice.

Thank you,

Management/Sunshine Pediatrics

Signature_____ Print name_____

Sunshine Pediatrics of Central Florida, PL

Richard Rodrigues, M.D.

210 Lookout Place

Maitland, FL 32751

Phone: 407.215.0400 Fax 407.215.0402



KEEP FOR YOUR RECORDS

WELL VISIT SCHEDULE

BIRTH – NEWBORN VISIT (1-5 DAYS)

2 WEEKS

2 MONTH

4 MONTH

6 MONTH

9 MONTH

12 MONTHS

15 MONTHS

18 MONTHS

2 YEARS

30 MONTHS

3 YEARS

4 YEARS

ANNUALLY UNTIL AGE 18

These visits are recommended by the American Academy of Pediatrics (AAP) and this office for routine screening, disease prevention and wellness.