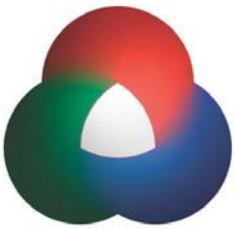

Cannizzaro Integrative Pediatric Center

Welcome!

Thank you for choosing Cannizzaro Integrative Pediatric Center. Our goal is to treat the **whole child** using the best of natural and integrative medical therapies. We strive to provide excellent care in a professional, warm and healthy environment. We look forward to meeting with you and your child and being able to provide you with compassionate patient care.

In order to maximize your time with our providers, please fill out all forms **completely** and bring them with you or submit them electronically prior to the day of your appointment. This is invaluable information for our team. If you are unable to submit all of your paperwork prior to your appointment day, please be sure to **arrive at least 10 minutes** prior to your appointment time to complete the registration process. This will enable you to get your full scheduled time with the physicians.

If you have medical records that you want our physicians to review, please fill out the provided form and submit it to your previous provider. Make sure you request the turn around time from that provider to ensure we will have your records before your initial visit. Your medical records may be sent by email or fax.

Phone: 321-280-5867
Fax: 407-774-1877
Email: nursemel@mycipc.com
Mail: 357 Wekiva Springs Rd, Longwood, FL 32779

I have read, understand and agree to the following. Please initial in each space provided below.

( ) 1. Consent for Treatment, Financial Policy Authorization & Acknowledgements

( ) 2. HIPAA Rules and Regulations

( ) 3. Acknowledgement of Cannizzaro Integrative Pediatric Center's office policies

You are acknowledging that you have read, understood, and agree to our office policies.

Parent Signature:_____Date: _____

Parent Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Office Personnel Signature: _____

CONSENT FOR TREATMENT, FINANCIAL POLICY AUTHORIZATION & ACKNOWLEDGEMENTS

AUTHORIZATION OF TREATMENT

I,_____, hereby authorize medical treatment of my minor child(ren) (listed below) within the scope of practice afforded by the licensed healthcare professionals, other clinical and non-clinical staff at Cannizzaro Integrative Pediatric Center (CIPC).

Children (Name and Date of Birth):_____

_____

_____

_

NOTICE AS TO NATURE OF SERVICES

I seek the medical and health care services of Cannizzaro Integrative Pediatric Center (CIPC), its employees and staff. I understand that this medical practice may use some diagnostic and treatment methods that may be considered holistic, complementary or alternative. Some of these methods have not been accepted by "mainstream" medicine. I understand that the principles of this practice are based on Naturopathy, a primary health care system, in which we believe that the body has an inherent ability to heal itself given the right tools. Treatment modalities provided by Cannizzaro Integrative Pediatric Center (CIPC) are based on functional and science-based evidence. I understand that allopathic (or traditional) medical practices will also be utilized and integrated into my care by a medical physician or designated licensed practitioner.

Some of the characteristic qualities of medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. We will evaluate these factors and seek to help the patient and parent change negative lifestyle patterns and establish more positive ones regardless of age or type of medical problem.

2. Although prescription and over-the-counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs. If deemed necessary, I understand that medical prescriptions will be given under the guidance of a licensed medical practitioner.

3. For some patients, we recommend homeopathy, based on appropriate history. It is based on the principle of "like cures like," and uses extremely tiny concentrations of animal, vegetable or mineral substances to stimulate the body's healing mechanisms. Although homeopathy is fairly well established in some European countries, India and other countries worldwide, it is generally not at all accepted by consensus in mainstream medicine in the United States.

4. Because Cannizzaro Integrative Pediatric Center looks for imbalances in the body and for trends that if not addressed may result in illness, tests are sometimes ordered that may be considered by consensus of mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status, such as blood levels of vitamins and minerals, hormone levels, heavy metals, chronic viruses and bacteria or food allergies.

5. Cannizzaro Integrative Pediatric Center feels that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause maybe triggered or perpetuated by common environmental substances, many of which are man-made. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. We will attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.

6. Cannizzaro Integrative Pediatric Center believes in the whole family being involved in their children's health care and encourages questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. Consultations are encouraged with consensus of mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

7. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

8. Cannizzaro Integrative Pediatric Center believes that true healing occurs with a strong mind, body and spirit connection. We provide additional services such as stress reduction, emotional healing, acupressure, acupuncture and massage.

Office Based Care

I understand this practice exclusively office-based and not affiliated with a hospital. If I become so ill that I require hospitalization, I will be under the care of the hospitalist on call. The providers will work in conjunction with the hospitalist as permitted. I also understand that it is my responsibility to inform CIPC of any hospital admissions, any knowledge of any diagnoses my child has received, as well as any treatments they have had or are undergoing for current conditions, and that I should keep their physicians and any practitioners I see informed on an ongoing basis.

REVOCATION OF AUTHORIZATIONS

These authorizations will remain active unless revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

NUTRITIONAL SUPPLEMENTS

I understand that Cannizzaro Integrative Pediatric Center (CIPC) will make nutritional supplements and other recommended products available. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of patients. I am in no way obligated to purchase these products from this office. I am free to purchase any recommended supplements or other products from any source that I choose.

INSURANCE CLAIM MANAGEMENT

Cannizzaro Integrative Pediatric Center is actively working to contract as in-network providers with all insurance companies**.** There are some insurance plans that will only send out invites once a year as needed in there determined market. It is advised that I contact my insurance provider to inquire on the network status of the office. The office tax identification number and provider's National Provider number can be obtained from the office receptionist. An encounter will be submitted to your insurance company in a timely manner. My treating practitioner(s) will not respond to insurance requests for information, and are not obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.
I am responsible for the payment of fees deemed necessary by my insurance company for the services provided by Cannizzaro Integrative Pediatric Center at the time of service or when my insurance provider determines my patient financial responsibility. I am entitled to know the cost of all services and procedures in advance and I will ask if they are not told to me.

FINANCIAL RESPONSIBILITY

I understand and agree to the following policies regarding financial and insurance responsibilities. **I am responsible for paying my membership fees annually or quarterly.** I understand that quarterly commitments are paid in monthly increments and automatically renew. A notice will be emailed in the patient portal one month prior to renewal. I know it is my responsibility to contact the office to cancel my membership if I choose to at that time or prior to the renewal date. A payment method is required to keep on file I know I am responsible for keeping that information up to date. I am responsible for charges incurred for all treatment rendered. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). Cannizzaro Integrative Pediatric Center will not be obligated to take action on my behalf against an insurance carrier to negotiate my insurance claim.

Full payment is expected at the time of services rendered.

In addition to the fee for the office visit, the cost for lab work or other specialized testing deemed appropriate to my case will be applied to my balance.

Our practice is committed to providing the best treatment for patients. All appointments are considered confirmed at the time they are made. I will receive one courtesy email as a reminder of the appointment. Because a substantial amount of time has been set-aside for me, I may be charged a $50.00 fee for a missed appointment. I understand that I need to call the office 48 business hours in advance if I cannot keep the appointment in order to avoid this charge.

PATIENT ACKNOWLEDGEMENT

I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. I have read, understood and agree to the foregoing. I understand that I have the right to review this consent with a lawyer if I choose before accepting any medical services from Cannizzaro Integrative Pediatric Center. I have executed this consent freely and willingly understand its provisions. I recognize that

Cannizzaro Integrative Pediatric Center will rely upon my signing of this document in accepting my child as a patient. I acknowledge receipt of a copy of this consent if I have requested it.

I do hereby acknowledge that by signing this statement of understanding that I acknowledge and understand that some, and perhaps all, of the medical, preventative, nutritional, and diagnostic services provided at Cannizzaro Integrative Pediatric Center on or after the date of my signing this statement may be innovative, non-traditional or unconventional. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies). I also understand that these unconventional services may be viewed by third party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under any medical insurance program. I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to Cannizzaro Integrative Pediatric Center

I understand that my signature signifies consent for any and all treatments offered and given to me or my minor child at Cannizzaro Integrative Pediatric Center.

Signature of Patient or Responsible Party: _____ ***DATE:*** _____

Patient Name(s): _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICES RENDERED

I have read, understand and agree to the following:

Initials

( ) 1. Because a substantial amount of time has been set aside for me, I will be charged $50.00 for missed appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.

( ) 2. I understand that I am providing Cannizzaro Integrative Pediatric Center with my credit card information below that Cannizzaro Integrative Pediatric Center will keep on file in order to secure my appointment time, and charge my membership fees as well as fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). I also agree that Cannizzaro Integrative Pediatric Center has my authorization to charge my card in the event that I do not give them adequate notice to cancel or reschedule my appointment as per office policy and for my agreed upon membership fee payment plan. I understand that my credit card information will only be used as stated above.

If your CC was already entered on the Portal, please just add the last 4 digit and sign

Name on Credit Card: _____ Account Number: _____

Card Code: _____ Expiration Date: _____ ☐MC ☐Visa ☐Amex ☐Discover

Signature of Patient/Responsible party: _____ Date: _____

Witness (Printed Name and Signature): _____ Date: _____

CIPC: OFFICE POLICIES & PROCEDURES FOR PATIENTS

FOLLOW-UP APPOINTMENTS:

- Please be sure to arrive 20 minutes before your scheduled appointment. This will enable us to sign you in, perform vitals and ensure you get your allotted time with the doctors.
- Because of the complexity of most cases, treatment protocols may need frequent adjustments in the beginning. Therefore we may require monthly office visits in the first 4-6 months or more often as deemed necessary by your practitioner in order to facilitate wellness.
- Questions are always welcome. Most of the labs and testing ordered by at the Cannizzaro Integrative Pediatric Center are more specialized. The discussion of these labs and test results are usually in-depth and lengthy. Therefore, a follow-up appointment is always scheduled 2-4 weeks after the initial visit. If an office visit is not possible, a telephone appointment may be scheduled, which will be billed in the same manner to an in office follow-up visit – according to complexity and time spent.
- Results will be discussed only during a scheduled office or phone appointment.

TELEPHONE/VIDEO APPOINTMENTS:

- As a courtesy to those who are not able to come into the center we offer phone/video appointments that are billed at the same rate as an office visit.

MISSED APPOINTMENTS:

- It is understandable if life circumstances cause you to reschedule your appointment.
- Please cancel or reschedule your appointment 48 business hours prior to your scheduled time. We do not double book. As your appointment time is set aside specifically to focus on your individual needs, it impacts our office if cancellations occur in less than 48 hours.

LATE ARRIVALS

- If you arrive more than 10 minutes after your scheduled appointment time, it may be necessary to reschedule. However, the missed appointment fee will still apply.
- If you choose to keep your appointment, your visit time will be shortened accordingly.
- Please call us if you are running late.

COMMUNICATION AND PHONE POLICIES

- Because of HIPPA regulations we communicate only through our office telephones and Hello Health EMR email communication. Please be sure to call our office or email through your Hello Health medical record with any questions.
- During office hours, please call the office and leave a message. Someone from the office will get back to you the same day.

PRESCRIPTION REFILLS:

- At the time of the office visit, you will be given prescriptions with the appropriate number of refills to last until your next follow up visit.
- Please make sure you have all the prescriptions you need before you leave the office.
- Prescription medications such as those for blood pressure, diabetes, pain, weight loss and thyroid conditions need to be monitored closely. An office visit is required at a minimum every 3 months or as indicated by your physician to evaluate your care, order labs and approve additional refills.
- Failure to make and keep scheduled appointments will make it difficult to continue your care and will result in having refills denied.
- Absolutely NO prescriptions for controlled medications (like ADHD meds) will be called into the pharmacy. You will have to be seen in the office by one of our doctors.
- Refills of prescription medications require at least a 48 hour notification. Please ask your pharmacy to fax our office a refill request at (407)774-1877
- If you have not been seen in our office within 6 months, prescriptions will not be refilled without an office visit.

LAB PROCEDURES AND RESULTS:

- It is imperative that all lab work ordered by the practitioner be completed within the time frame discussed. This ensures that the results are available for discussion during your next scheduled appointment and eliminates the need to reschedule as it may become difficult to accommodate your family's schedule needs.
- Because of the wide variety of testing and companies we use, the receipt of results can vary from several days to several weeks. We routinely do not call you when they arrive unless the practitioners need to speak to you immediately. We will let you know the status of lab results when we call to confirm your appointment.
- Allow two full weeks for the results to arrive at our facility.
- In order to ensure the best understanding of your lab results and to answer all of your questions, a follow-up appointment is required. Not all results will be discussed over the phone.
- Our staff is not allowed to discuss results over the phone, unless the physician has already reviewed and signed off on them.
- We ask that you wait until your appointment to request a copy of your labs to avoid any confusion about the results.
- Fasting blood work requires that you have no food by mouth for 12 hours before your blood draw. Drinking water is encouraged on the of your lab draw. Prescription medications are allowed unless otherwise directed by your physician.

NUTRITIONAL SUPPLEMENTS:

- Nutritional supplements can be refilled by calling our office prior to pick up, or can be shipped directly with a credit card payment.
- Please allow 3-5 business days from the time you order for delivery.
- You do not need an office visit to refill nutritional supplements.
- In most cases you will need to continue on your current regimen until your next visit.
- Supplements cannot be returned after 30 days of purchase date.
- Only unopened supplements will be refunded at full price within 30 days of purchase.
- No refunds will be made in cash or back to your credit card. If a credit is necessary, it will be applied to your account to be used in the office towards other supplements or services.
- Supplements that are open and then stopped either by your physician or yourself for any reason cannot be returned.

MEDICAL RECORDS RELEASE

- A signed release is required before any information in your chart can be mailed/faxed to you, another physician or third party.
- Your records are available to you 24 hours a day/7 days a week through your online electronic medical record. If you require the office to print your records, the cost of copying of your medical records for yourself will be a minimum of $10.
- Records are sent to another physician at no charge.
- One copy of your labs is given to you at your follow up visit. Additional copies will be available through your online electronic medical record.
- If you are having records sent to our office, we prefer to have them mailed or emailed to our office. Faxed copies are sometimes difficult to read.

PAYMENT POLICY

- Please make sure that your credit card is up to date on the portal.
- Payments are due in full at the times of service.

I have read and understand the office policies.

Parent

initials ( )

RELEASE OF CONFIDENTIAL INFORMATION

This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act of 1996, also known as Kennedy-Kassebaum Act. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present and future. Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstances, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company you already signed for the release of relevant records if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax or mail or give verbal knowledge of your medical history to the specialist.

(Initials)
_____This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

1.) Healthcare providers involved in your care

2.) Insurance companies to secure payment

3.) Laboratories involved in your care

4.) Attorneys with your permission

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse, significant other, or adult children. Please indicate if you would like us to speak with your spouse/significant other, or adult child if and when the need arises. Note: if you decide to revoke your permission at any time, we will need a written revocation.

You have my permission to discuss any medical matters pertaining to my health with:

- **NAME**_____**Relationship** _____
- **NAME**_____**Relationship** _____
- **NAME**_____**Relationship** _____

*Signature:*_____*Date:*_____

By HIPAA standards, we are not allowed to leave results of your lab tests, x-rays, diagnostics, medications, etc., related to your specific health condition on your voicemail, answering machine, fax, etc. However, if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us to leave your information on your messaging systems. Please choose one of the options below. Note: if you would like to revoke your option at any time, we will need your written notification.

(*Initials)*

_____Appointment reminders and any information regarding my treatment may be called to my
☐HOME Phone ☐CELL Phone ☐Other_____

_____A copy of "Notice of Privacy Practices" is available for your review.

Today's date: _____

Your Email:_____

Patient's full name: _____ **M** or **F** D.O.B. _____

Address:_____

Street City State Zip

Responsible Party Information

Parent Name:_____(M / F) D.O.B._____SSN_____

Address (if different from above):_____

Street City State Zip

Home Phone:_____Cell: _____

Employer:_____Work: _____

Parent Name:_____(M/ F) D.O.B._____SSN_____

Address (if different from above):_____

Street City State Zip

Home Phone:_____Cell: _____

Employer:_____Work: _____

Parents' Marital Status (please circle one)

Married Single Divorced Widowed

Emergency Contact

_____

Name Relation Phone

Primary Insurance Information

Insurance Company: ____

_____ Policy ID/Subscriber Number:

_____Group Number:_____

Insured Name (and DOB and SSN if not provided already above):_____

ADDITIONAL SIBLINGS (NAME & DOB):_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

O 2 years prior from last date seen
O Dates Other: _____
O Specific Information Requested:

_____

The purpose of disclosure is:

O Change of Insurance or Physician
O Continuation of Care (e.g., VA Med Ctr)
O Referral
O Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Cannizzaro Integrative Pediatric Center **Address:** 357 Wekiva Springs Rd

City, State, Zip: Longwood Florida 32779 **Please fax records.**

Fax: (407) 774-1877 **Phone:** (321) 280-5867

I understand I may 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 health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Refusal to Vaccinate

Child's Name:_____Child's DOB:_____

Parent's/Guardian's Name(s):_____

My child's healthcare provider, Cannizzaro Integrative Pediatric Center has advised me that my child (named above) should receive vaccinations recommended by the State of Florida and the CDC.

I have read the Center for Disease Control and Prevention's (CDC) Vaccine Information Sheet(s) explaining t h e vaccines and the disease(s) they prevent. I have had the opportunity to discuss these with my child's healthcare provider, who has answered all my questions regarding the recommended vaccine(s). I understand the following:

- The purpose of and need for the recommend vaccine(s)
- The risks and benefits of the recommend vaccine(s)
- If my child does not receive the vaccine(s), the consequences may include:
  - Contracting the illness, the vaccine could prevent
  - Transmitting the disease to others
  - The need for my child to stay out of daycare or school during the disease outbreaks
- My health care provider, the American Academy of Pediatrics, the American Academy of Family Physicians and the Center for Disease Control and Prevention have discussed all the vaccine(s) be given

Nevertheless, I have decided to decline OR Delay the vaccine(s) recommended for my child, as indicated below, by initialing the appropriate box under the column titled "declined."

Vaccination	Declined/ Delay (initial)	
Hepatitis B Vaccine		
Diphtheria, Tetanus, acellular Pertussis (DTaP and Tdap) Vaccine		
Haemophilus influenza type B (Hib) Vaccine		
Pneumococcal conjugate Vaccine		
Polio Vaccine (IPV)		
Measles, Mumps, Rubella (MMR) Vaccine		
Varicella (Chickenpox) Vaccine		
Meningococcal Vaccine		
Hepatitis A Vaccine		
Other:_		

I know that failure to follow the recommendations about vaccination may endanger the health of my child and others that my child might come in contact with.

I know that I may re-address this issue with my health care provider at any time, and that I reserve the right to change my mind and accept vaccination for my child anytime in the future.

I acknowledge that I have read this documentation in its entirety and fully understand all that I have read.

Parent's/Guardian's Signature:_____Date:_____