

Jonathan Badilla M.D., P.A.
Normandy Pediatrics
10250 Normandy Boulevard, Suite 201, Jacksonville, FL 32221
(904) 652-0870

New Patient Welcome Letter

Thank you for choosing Normandy Pediatrics as your Medical Home, your primary care center. Our team is dedicated to give your child the best healthcare possible.

We have become what known as the **Patient Centered Medical Home**.

*What is a **Patient Centered Medical Home**?*

Patient Centered means the patient and the family come first. We will provide complete healthcare, which is focused on all aspect of the child's health and well-being ranging from vaccinations and academic development to specialty care and acute and chronic care. This process is patient/parent- driven, together with the provider.

Medical Home begins with our practice, where our professional staff and providers can direct the care of the child. With a medical home, the quality of care improves, and the child/family experience improves.

Patient Centered Medical Home is a team approach to providing total health care where you are part of a group that includes the provider, our professional staff, specialists, and any support services needed. The healthcare team will coordinate all your health care needs. At the end of every office visit we will give you a copy of the child's diagnoses, the child's plan of treatment, any medication sent via eScript and a date for the child's next appointment. If there are any questions at check-out, all you need to do is ask. The staff is committed to the health care of the patient.

The **Patient Centered Medical Home** allows the patient/parent to become involved in health care decisions. So, what can the patient/parent do to help?

Be an active partner in your care

Learn what is needed to maintain a healthy environment for your child

Follow the plan that the provider and patient/parent agreed on

If you have questions, ask

The patient portal is www.dr-connect.com/badillapeds/. This portal allows you to send messages to the child's team, view upcoming appointments, request prescription refills, view test results, view notes about your child's visits, and review your child's plan and treatment.

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PRACTICE INFORMATION SHEET

OFFICE HOURS:

Our office is available Monday through Friday 8:00am to 5:00pm. Our office is closed from 12:00pm to 1:00pm for lunch but phones are rolled to the answering services and may be reached at (904) 652-0870 during these hours. Our physicians are available "after hour" 24 hours per day/365 days per year by calling our phone number and following the prompts. If you need an appointment, prescription refill or test results, please call during regular business hours or you may visit the web portal at any time.

URGENT CARE:

WALK IN urgent care is available for all of our registered patients. This service is available Monday through Friday 8:00am to 5:00pm. Our goal is to provide urgent medical care for acute illness within 30 minutes of your arrival.

APPOINTMENTS:

Normandy Pediatrics is committed to providing quality care to our patients. To ensure timely continuity of care, we encourage patients to schedule appointments in advance at the time of patient's check-out. When calling for an appointment, please provide your name, date of birth, telephone number, chief complaint/ reason for the visit, as well as any **updated contact or insurance information**.

While we strive to schedule appointments appropriately, emergencies can and do occur in Primary Care. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

To ensure quality of care, Normandy Pediatrics, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit).

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of our patients please be courteous and call Middleburg/ Normandy Pediatrics promptly if you are unable to attend your appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment, we require that you call within 24 hours of your scheduled appointment time. Appointments are in high demand at Normandy Pediatrics, and your early cancellation will give another patient the ability to have access to timely medical care.

We also encourage the patient to utilize the patient portal at www.dr-connect.com/badillapeds/ which allows the patient to retrieve test results, office visit summary along with patient's plan of treatment.

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WEB PORTAL

We have a web portal so you can access your child's information from any computer.

You will be able to:

- Edit demographic information for you and your child
- Send and receive messages from your provider
- Request and view appointments
- Request refills and more!

Website: www.dr-connect.com/badillapeds/

Username: _____

Password: _____

(Protect your password, Protect your child)

How to log in:

1. Type in web address
2. Sign in with your username and password we gave you
3. You may change the password once you're logged in

If you have multiple children and don't remember the username or password, just let us know and we can also give you their information.

If you have any problems, please feel free to give us a call at 904-652-0870.

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PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date: _____

Patient Name: _____ Nickname: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Email: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Birth Hospital: _____ Primary Language: _____

Primary Phone: _____ Secondary Phone: _____

Pharmacy Name & Address: _____

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

If Patient is a Minor, Please Complete this Section:

Father's Name: _____ Social Security #: _____ Date of Birth: _____

Father's Employer: _____ Employer's Phone: _____

Mother's Name: _____ Social Security #: _____ Date of Birth: _____

Mother's Employer: _____ Employer's Phone: _____

Does the patient have health insurance? (Please check one.) Yes No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: _____

Secondary Insurance Carrier(s): _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Gender: M F Subscriber Social Security #: _____ Subscriber I.D. #: _____

Subscriber's relationship to patient (mother, father, grandmother, etc.): _____

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Jonathan Badilla M.D., P.A. / Normandy Pediatrics. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature shall be as valid as the original.

Do you consent for us to get your child's medication history from his/her previous providers? Yes No

Signature: _____ Date: _____

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Normandy Pediatrics

PCMH Patient-Provider Agreement

Name:

Date of Birth:

A Patient-Centered Medical Home is a trusting partnership between a provider-led healthcare team and an informed patient/guardian. It includes an agreement between the provider and the patient/guardian that acknowledges the role of each in the total health care program.

As your primary care provider we will:

- Learn about the patient, your family, life situation, and health goals and preferences. We will remember the patients' health history every time you seek care and suggest treatment that makes sense to you.
- Take care of short-term illness, long-term chronic disease, and the patient's all-around well-being.
- Keep guardian up to date on all the patient's vaccines and preventive screening tests.
- Connect guardian with other members of the patients care team (specialists, behavioral healthcare, etc.) and coordinate the patients care with them.
- Be available to the patient after hours for their urgent needs (per Practice Information sheet)
- Notify the patient/guardian of test result in a timely manner.
- Communicate clearly with patient/guardian so they understand the patient's condition (s) and their care plan.
- Listen to the patient/guardians questions and feelings. Normandy Pediatrics will respond promptly to you in a way you understand.
- Help make the best decisions for the patients care.
- Give the patient/guardian information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

We trust you, as our patient/guardian, to:

- Know that you are a full partner in your child's care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using and questions you may have.
- Let us know when your child sees other health care providers so we can help coordinate the best care for the patient.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand the patient's health condition, ask questions about their care, and tell us when you don't understand something.
- Learn about the patient's condition (s) and what you can do to help them stay as healthy as possible.
- Follow the plan that we have agreed is best for the patient's health.
- Take medications as prescribed.
- Call if you do not receive the patients test results within 2 weeks.
- Contact us after hours only if the patient's issue cannot wait until the next day.
- If possible, contact us before taking the patient to the emergency room or urgent care.
- Learn about health insurance coverage and contact Normandy Pediatrics if you have questions about the patient's benefits.
- Pay your share of any fees.
- Give us feedback to improve our care for your child.

We look forward to working with you as your child's primary care provider in their patient-centered medical home.

Provider Signature:

Date:

Patient/Guardian Signature:

Date:

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FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Normandy Pediatrics.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, and all major credit cards. Returned checks are subject to a \$25.00 service fee and you will lose your privilege to write checks.

HMO/PPO INSURANCE COVERAGE

CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Normandy Pediatrics with a copy of my current insurance card and. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I will notify Normandy Pediatrics immediately upon any change to my insurance. We will file your insurance if we are under contract with your insurance company. I understand that all charges not covered by my insurance are my responsibility. If the insurance company fails to pay Normandy Pediatrics in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Normandy Pediatrics.

AUTOMOBILE ACCIDENTS

We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment. We do not file with third party payers for motor vehicle or other accidents. We do not make arrangements with any attorneys to hold your billing until a court case is settled. PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, urine drug screenings, etc.) will not be included in the charges for Normandy Pediatrics. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Normandy Pediatrics will send my lab specimens to a laboratory that accepts my insurance.

NO SHOW POLICY (Please initial)

_____ There will be a \$35.00 charge if you fail to show for your scheduled office appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

PRIVACY POLICY

I have received a copy of Normandy Pediatrics' privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Jonathan Badilla M.D., P.A. dba Normandy Pediatrics. In the event I receive payment directly from my insurance company for services rendered by Normandy Pediatrics, I agree to endorse any check received to Normandy Pediatrics.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of our *Privacy Policy*. To ensure our records are accurate, please sign this form and return to the receptionist.

I certify that I received a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information.

Signature: _____ Date: _____

PRACTICE INFORMATION SHEETS

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in Normandy Pediatrics' PRACTICE INFORMATINO SHEETS FOR PATIENTS form.

Print Name: _____

Signature: _____ Date: _____

Thank you,
Normandy Pediatrics Staff

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PHYSICAL AND SHOT RECORDS

To obtain a certified copy of the Blue and Yellow form (Physical & Shot Record) you will be charged a fee of \$3.00 CASH for both or \$2.00 CASH for one. The only payment method accepted for this transaction is CASH.

By signing below you understand this office policy and that payment is due *before* receiving the forms.

(Forms are no longer required to be colored blue and yellow)

Print Name: _____

Signature: _____ Date: _____

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DESIGNATION OF ANOTHER PERSON TO CONSENT FOR TREATMENT

I, as the parent/legal guardian of the patient, give _____,

Permission to take my child, _____

To Normandy Pediatrics for:

	YES	NO
Immunizations	_____	_____
Pick Up Medications	_____	_____
Receive Instructions	_____	_____
General Medical Care	_____	_____
Leave Message on Machine	_____	_____

Expiration (check ONE):

- This designation will remain in effect until I revoke it by providing written notification to Normandy Pediatrics.
- This designation is valid only during the following time frame:

Effective From: _____ *Effective To:* _____

Print Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____