



# PEDIATRIC CARE CENTER

## OPEN 24 HOURS, 7 DAYS A WEEK

**JACKSONVILLE (904) 519-6555**  
8117 Point Meadows Drive • Jacksonville, FL 32256

**JACKSONVILLE BEACH (904) 249-3373**  
274 Third Avenue South • Jacksonville Beach, FL 32250

[24hourkidcare.com](http://24hourkidcare.com)

### **General Information**

Our Point Meadows location is open 24 hours a day, 7 days a week to provide true round-the-clock care to your family! Our Beaches location is open Monday – Friday from 7:30am - 8:00pm and Saturday and Sunday from 9:00 am – 5:00 pm. Our Orange Park location is open Monday- Friday from 7:30 am – 8:00 pm. Remember you are a patient of the practice, not a specific location so you may be seen at any of our offices. If you call the office after hours or on a weekend, your phone call will be routed to the location that is open at that time.

After 8pm our office is staffed with both a Pediatric Registered Nurse and Medical Assistant to answer your phone calls and care for your family. In the event your child needs to be seen after 8pm the nurse will assess and treat your child in direct communication with the provider on call. One of our doctors is always available overnight to come into the office if necessary.

Please call the office prior to coming in, especially during the night and on weekends. This call will allow our staff to prepare for your appointment and ensure your needs are met efficiently.

### **No Show Policy**

If you are unable to keep your scheduled appointment please be sure to call our office to reschedule. That available time slot can be given to another sick child who needs to be seen. Please be advised that we have had to begin a new policy due to repeated no-show appointments. A no-show appointment is a missed appointment when no phone call was made to our office to advise our staff that you are unable to keep your appointment. If a family has three (3) no-show appointments we will unfortunately have to discharge the family from the practice.

### **Referral Policy**

From time to time it will be necessary for 24/7 Pediatric Care Center to refer your child to an outside lab, facility, and/or specialist for further testing/treatment.

While we make every attempt to insure this facility/physician is in-network with your insurance company, it is ultimately your responsibility to make sure this is the correct facility for your plan. Please make sure you check with your insurance company before going to any specialist/facility for treatment.

### **Financial Policy**

Your insurance is a contract between you and your carrier. While we will make every effort to obtain payment for the services we provide from your insurance carrier, it is your responsibility to understand your plan benefits and to pay for all services rendered.

Copays will be collected prior to your office visit. We accept cash, check, Visa, Mastercard, and Discover.

Returned checks are subject to a \$25 service charge.

### **Authorization of Assignment of Benefits and Release of Medical Records**

I authorize 24/7 Pediatric Care Center

- to bill my insurance company directly for services and direct payment of benefits to Jacksonville Beach Pediatric Care Center.
- to release all medical information, including but not limited to, information relating to psychiatric evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS and AIDS related diagnosis, if such information exists, to all my insurance carriers or other third party payers as may be required or requested for the processing of claims for insurance or other purposes.



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## **HIPAA Notice of Privacy Practices**

**This notice describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, and for other purposes that are permitted or required by law. It also describes your rights to access and to control your PHI. PHI is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services. Please review this notice carefully.**

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to obtain approval for the hospital admission.

We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and other business activities. For example, we will use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your insurance. We will also call you by name in the waiting room when your physician is ready to see you and will use your PHI on occasion to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situation without your authorization. Such as Public Health issues as required by law, communicable disease issues, health oversight, such as, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, also research, criminal activity, military activity, national security, and workers' compensation. We may make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the use or disclosure indication in the authorization.

**Your rights:** You have the right to inspect and copy your PHI. However, under federal law you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes stated above. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

If you believe your privacy rights have been violated by us, or have any objections to this form you may file a complaint by notifying our Compliance Officer in writing or in person at this office.

This notice was published and became effective September 23, 2013.



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## Patient Acknowledgement

Your signature below is an acknowledgement of receiving the following procedures, policies and practices of 24/7 Pediatric Center and that you have read them, understand them and agree to them.

*Su firma a continuación es un reconocimiento que ha recibido todos los siguientes procedimientos, políticas y prácticas de 24/7 Centro Pediátrico y que usted ha leído, comprendido y llegar a un acuerdo con ellos.*

1. General Information/Información General
2. Referral Policy/Regla de Refererridos
3. Financial Policy/Regla Financiera
4. Authorization of Assignment of Benefits and Release of Medical Records  
Autorización de Asignación de Beneficios y Autirización para Acceder a los Registros Medicos
5. HIPAA Notice of Privacy Practices/HIPAA Aviso De Privacidad

Print Child's Name: \_\_\_\_\_  
Imprima nombre del niño/a

Print Parent/Guardian Name: \_\_\_\_\_  
Imprimia padre/ Guarda nombre

Signature/Firma: \_\_\_\_\_

Date/ Fecha: \_\_\_\_\_

*Original to Patient Chart  
Copy to Patient*