Children's Center for Cancer & Blood Diseases

FLORIDA HOSPITAL MEDICAL GROUP

2501 N. Orange Ave., Suite 589
Orlando, FL 32804
407-303-2080

HIPAA INFORMATION

As of 04/14/2003

Patient Name: _____

Children's Center for Cancer & Blood Diseases
FLORIDA HOSPITAL MEDICAL GROUP

PLEASE READ AND SIGN

Dear Parents/Patients,

Be aware if you have blood work drawn in our office, you may receive a bill from an "outside laboratory" due to your insurance plan. Not all plans cover laboratory tests 100%.

Please be aware of what YOUR policy covers.

Please ask the nursing staff WHERE YOUR LABS ARE BEING SENT. BE SURE IT IS THE CORRECT LABORATORY FOR YOUR CURRENT INSURANCE PLAN.

Out staff try their best to have this information correct, however, it is the parents/patients responsibility to ask WHERE the labs are being sent.

If you receive a bill from a laboratory and you have a secondary insurance you with to file, you can provide this information yourself on the laboratory's invoice in the space provided (it is usually on the back). Send the completed form, with a request to re-file the claim with the secondary insurance company back to the reference laboratory's billing department or you can call the lab with this information.

Thank you,

I have read and understand the above statements regarding the laboratory process for the Children's Center for Cancer and Blood Diseases.

_____ _____ _____

Signature Patient Name Date

Children's Center for Cancer & Blood Diseases

FLORIDA HOSPITAL MEDICAL GROUP

Clifford Selsky, Ph.D, M.D.
Fouad Hajjar, M.D.
Ada De la Osa, ARNP-BC
Shari Feinberg, CPNP, CPON

Parent/patient office conduct policy

In an effort to maintain a comfortable environment for parents, patients and staff in Dr. Selsky, Dr. Hajjar and Dr. Gordon's office, we have the following policy.

I understand:

I understand that I am responsible for my behavior and anyone who accompanies me to the office of Dr. Selsky, Dr. Hajjar and Dr. Gordon. Any inappropriate behavior or language (i.e. shouting, using profanity, making threatening gestures, etc.) directed to the physicians and/or any of the staff members will not be tolerated in the office or during telephone conversations and may result in discharge from this practice.

I understand:

I understand that as a parent/guardian or patient of this medical practice, I agree to abide by all office policies.

I understand:

The undersigned has read and understands the above statements and willingly agrees to help maintain a professional and comfortable environment in the office of Dr. Selsky, Dr. Hajjar and Dr. Gordon.

_____

Signature of Parent/Guardian/Patient or Authorized Representative