

2. PERSONAL INFORMATION FORM

PATIENT INFORMATION:

ACCOUNT# _____ PATIENT SS# _____
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME TELE: (____) _____ DOB: _____ GENDER: _____ MALE _____ FEMALE

PARENTS EMAIL ADDRESS (MUST ENTER): _____

MEDICAID LETTER GIVEN BY/DATE: _____

MOTHER'S INFORMATION (OR GUARDIAN) YOUR RELATIONSHIP TO PATIENT: _____
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____
ADDRESS: _____
(IF DIFFERENT FROM ABOVE)
CITY: _____ STATE: _____ ZIP CODE: _____
HOME TELE: (____) _____ DOB: _____ SPOUSES NAME: _____
EMPLOYER: _____ OCCUPATION: _____ *(IF DIFFERENT FROM FATHER)*
WORK #: (____) _____ EXT: _____ CELL #: (____) _____
SS# _____ MARITAL STATUS: _____ COPY OF DRIVERS LICENSE INITIAL _____

FATHER'S INFORMATION (OR GUARDIAN) YOUR RELATIONSHIP TO PATIENT: _____
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____
ADDRESS: _____
(IF DIFFERENT FROM ABOVE)
CITY: _____ STATE: _____ ZIP CODE: _____
HOME TELE: (____) _____ DOB: _____ SPOUSES NAME: _____
EMPLOYER: _____ OCCUPATION: _____ *(IF DIFFERENT FROM MOTHER)*
WORK #: (____) _____ EXT: _____ CELL #: (____) _____
SS# _____ MARITAL STATUS: _____ COPY OF DRIVERS LICENSE INITIAL _____

EMERGENCY CONTACT (DIFFERENT FROM ABOVE) YOUR RELATIONSHIP TO PATIENT: _____
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____ CELL#: (____) _____

CHILD(REN) NAME(S) _____ DOB _____ DOB _____
_____ DOB _____ DOB _____

MAY WE LEAVE A MESSAGE REGARDING APPT. ON ANSWERING MACHINE? Y__ N__ IF NO THEN WHERE _____

WHOM MAY WE THANK FOR YOUR REFERRAL?
PRINT FULL NAME: _____ SOURCE: _____
ARE THEY A PATIENT HERE? YES NO *(i.e. another physician, friend, insurance, yellow pages, etc.)*

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D. F.A.A.P., and Associates

3. AUTHORIZATION CONTACT FORM

1) I (we) **AUTHORIZE** the following people to **BRING** my child(ren) into your office for treatment:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

2) I (we) authorize Babies and Beyond, Pediatrics, P.A. to **SPEAK** to the following people regarding my health or child's health (i.e. spouse, child, etc. including phone number). Relationship (i.e. parent, guardian, grandparent).

Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____

3) Note: If there are any special parental or custodial relationships such as custody with one parent only, legal custody/guardianship with non-parent, etc, please explain:

Parent/Guardian Sign

Date

Note: If more than one child, make copies of this document and put it in the other children's chart.

"Committed to Providing Compassionate and Quality Care for Babies, Toddlers, & Teens"

224 Mariner Blvd. Spring Hill, FL 34609
Phone (352) 686-9779 Fax (352) 686-5998

Babies and Beyond Pediatrics, P.A.

Primary Language spoken in home: (✓ one)
 English Spanish
 Other: _____

4. New Patient Intake History Form

Pt. Name: _____ DOB: _____
 Patient resides with: _____ Legal Guardian is: _____ Relationship to Child: _____
 Marital Status of Child's Parents: Married Divorced Single—Never Married

Birth History

Hospital born at: _____ Obstetrician: _____ Pediatrician in Nursery: _____
 Type of delivery (✓ one): Vaginal Delivery C-Section Delivery Age: Preterm (# 37 wks) _____ wks
 If C-Section delivery, why? _____ Fullterm (≥ 38 wks)
 Birth Weight: _____ Birth Length: _____ Discharge Weight: _____
 Did the baby have any problems at or immediately after birth? _____

 List age: Held up Head: _____ Cooed or laughed: _____ Sat up: _____ First Word: _____ Walked: _____

Patient Health History

Child's Previous Pediatrician: _____ City/State: _____ Phone #: _____
 Date of last exam: _____ Results: _____
 Any serious short or long-term illness? No Yes If yes, what and when? _____

 Any operations or hospitalizations? No Yes If yes, what and when? _____

 Does any family member smoke? No Yes If yes, who? _____ In the home? No Yes
 Are immunizations up to date? No Yes
 Any medication allergies? No Yes If yes, what med and what was the reaction? _____

HAS THE CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING: (CIRCLE YES OR NO)

Yes No AIDS/HIV	Yes No Chicken Pox	Yes No Hearing Problems	Yes No Pneumonia
Yes No Anemia	Yes No Constipation	Yes No Heart Problems	Yes No Rheumatic fever
Yes No Asthma	Yes No Convulsions	Yes No Hepatitis	Yes No Sinus problem
Yes No Bed Wetting	Yes No Diabetes	Yes No Kidney Disease	Yes No Speech Problem
Yes No Birth Defects	Yes No Diarrhea	Yes No Lead Poisoning	Yes No Thyroid Disease
Yes No Bladder problems	Yes No Drug/Alcohol abuse	Yes No Liver Disease	Yes No Tuberculosis
Yes No Bleeding Excessive	Yes No Ear Infections	Yes No Measles	Yes No Urinary Disease
Yes No Cancer	Yes No Epilepsy	Yes No Mononucleosis	Yes No Vision Problems
Yes No Cerebral Palsy	Yes No Fainting		

Family History

Has any member of the family or close relative had any of the following? Please circle yes or no. If yes, indicate which family member and age if asked.

Yes No Arthritis _____	Yes No Hyperactivity _____	Yes No Seizure _____
Yes No Asthma _____	Yes No Hemophilia _____	Yes No Substance Abuse _____
Yes No Cancer _____	Yes No High Blood Pressure _____	Yes No Stroke _____
Yes No Diabetes _____	Yes No Immuno suppressed _____	Yes No TB _____
Yes No Heart Problems _____ Age _____	Yes No Kidney Disease _____	Yes No Migraine _____
Yes No High Cholesterol _____	Yes No Mental Disorder _____	Yes No Other _____

Name of person completing form: _____ Relationship to patient: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

Babies & Beyond Pediatrics

5. OFFICE POLICIES

- Please notify us of any changes to your INSURANCE STATUS, PHONE NUMBER and/or ADDRESS.
- CANCELLATIONS must be made 24 hours in advance of appointment to avoid a No-Show charge.
- All payments are expected at time of service.
- Please allow 72 HOURS for school forms, sport forms and/or referrals to be completed.
- A doctor is always available 24 hours a day 7 days a week for all emergencies.

(PLEASE CALL OUR OFFICE BEFORE GOING TO AN AFTER HOURS FACILITY OR EMERGENCY ROOM, UNLESS IT IS A LIFE THREATENING SITUATION).

- SATURDAY HOURS are available from 8:45 a.m. to 12:00 noon.
- Some PRESCRIPTIONS can be filled in our office.
- Patient will be seen by their APPOINTMENT TIME NOT BY WHEN THEY ARRIVE.
- As a courtesy, our nurses can perform LAB WORK but your CO-PAY /% will apply.

6. UNIQUE SERVICES OFFERED AT BABIES AND BEYOND PEDIATRICS

On Call Program

If you need to speak to one of our doctors, please call the office phone number which will connect you to our answering service. The service is instructed to take a brief history and get an accurate phone number and spelling of the patient and callers name. If the Doctor /Nurse has not called you back within 20 minutes please call the service again and re-verify the phone number that you gave them. The answering service are non- medical professionals who are instructed not to give any advice. When a parent or guardian leaves a message with our answering service, the service immediately contacts the On – Call Doctor/Nurse by sending an electronic message. A Doctor/Nurse from our group is always on-call and available to speak with you 24 hours a day, 7 days a week, 365 days a year no matter what time it is!!!

Stay Fit Kidz Weight Loss/Gain Program

A comprehensive program to fight obesity, while creating healthier children and teens. An extensive Medical/Nutritional/Psychological Assessment by a Board Certified Pediatrician. A small group exercise program (lose body fat, add strength and muscle mass). One on one nutritional counseling and impletation. Clinically proven vitamins and weight loss/gain supplements for children and teens.

Stay Fit Adult Weight Loss Program

HCG: If you are unfamiliar with the HCG diet, HCG (Human Chorionic Gonadatropin), is a hormone produced during pregnancy. The purpose of the HCG hormone is to rally the metabolism of systemic fat. Typically, as a species, the human body is pre-disposed to retain calories in the form of fat reserves as a survival mechanism for long winters or famine; conditions that rarely exist today. This is why dieting is such an uphill battle; not only are we struggling our own poor eating habits, but a genetic predisposition to retain fat. HCG is the solution. When a women becomes pregnant, the growing baby requires a 24/7 calorie source. In response, the placenta of the mother begins to produce HCG, which “unlocks” her stored fat to provide the calories necessary for proper development of her unborn child. If the HCG hormone is supplemented in the absence of a pregnancy, the dieter can sustain themselves on their own stored fat, resulting in healthy weight loss.

Naturalistic: This a 3 month (90) day comprehensive Medical/Holistic approach to weight loss (17 years & up). It combines Medication(s), Natural Weight Loss Supplements, Nutrition and Exercise. During this 90 day program you will start eating every 2-3 hours throughout the day. It is important to maintain a certain amount of calories to adequately burn fat and not lose lean muscle. Eating your meals in a 5-6 meal per day format will help balance your insulin response and improve metabolism.

Stay Fit Adult Hormone Replacement Therapy

Testosterone is much more than a sex hormone. There are testosterone receptor sites in cells throughout the body, most notably in the brain and heart. Youthful protein synthesis for maintaining muscle mass and bone formation requires testosterone. Testosterone improves oxygen uptake throughout the body, helps control blood sugar, regulates cholesterol and maintains immune surveillance. The body requires testosterone to maintain youthful cardiac output and neurological function. Testosterone is also a critical hormone in the maintenance of healthy bone density, muscle mass and red blood cell production. If you feel based on your symptoms that you may have low testosterone or you want to decrease your body fat and increase your muscle tone then ask our office for a patient medical questionnaire, consent and HIPAA forms and a 4-day food log and set up an appointment to draw your labs at our office.

→ *opider - 1 Cancer care*

Expertise in Child and Adult Mental Health Disorders: i.e. Depression, Bipolar, ADHD, OCD

Also expertise in: Autism, Asthma, Allergies, Sleep Disorder, Acne and Obesity.

In Office

EKG, Pulmonary Function Test, Skin Testing and Sinus Endoscopy (scope into nose to diagnose Sinus Infections, No need for X-rays or CT Scans). Available for purchase: Vitamins, Protein Shakes, Fish Oil etc.

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D., FAAP and Associates

8. AUTHORIZATION TO RELEASE MEDICAL RECORDS (SEND TO)

◆ Date of Request: / /

Your previous physician's name, practice's name or name of ER/Hospital recently visited:

City: State: Zip:
Phone: () Fax: ()

Dear Doctor/Hospital: _____ **Attn: Medical Records Dept.**

The following ◆ has asked that medical records be released and forwarded to our office as soon as possible. *Parent/legal guardian*

Patient Name(s): ◆ ◆ Date of Birth:
◆ ◆ Date of Birth:
◆ ◆ Date of Birth:

In order for us to fully evaluate this patient's health and make informed decisions, the parent has approved our request for copies of all relevant records in your file. Please be sure to include radiology reports, lab results, consultation reports, emergency room reports and any hospitalizations from the time they have been a patient in your practice or at your hospital.

*Thank you for expediting this request.
Please send the records to our office at the address below:*

224 Mariner Blvd.
Spring Hill, FL 34609
Ph: 352-686-9779
Fax: 352-686-5998

◆ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, (Initial) psychiatric, HIV testing, HIV results, or AIDS information.

I hereby authorize the release of all necessary medical records to Babies and Beyond Pediatrics for as long as I remain a patient there. I wish them to be forwarded as soon as possible. I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time upon written notice except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". This form must be received within 90 days of signing and is valid for 90 days after receipt.

◆ ◆ ◆ Relationship to patient: one
Parent/Legal Guardian Print Name Parent Legal Guardian
(Signature if patient is a minor) Grandparent Other
◆ Name of Insurance: ◆ Name of Ins. Policy Holder:
◆ Ins. Policy Holder SSN: ◆ Ins. Policy Holder DOB:
◆ Patient's address: ◆ City
◆ State ◆ Zip ◆ Phone:

NOTE: keep original in chart

SIGNATURE OF WITNESS: _____

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D., FAAP and Associates

8. AUTHORIZATION TO RELEASE MEDICAL RECORDS (KEEP IN CHART)

PLEASE FILL OUT HIGHLIGHTED AREAS ONLY

◆ Date of Request: / /

Your previous physician's name, practice's name or name of ER/Hospital recently visited:

City: State: Zip:
Phone: () Fax: ()

Dear Doctor/Hospital: _____ Attn: **Medical Records Dept.**

The following ◆ has asked that medical records be released and forwarded to our office as soon as possible. *Parent/legal guardian*

Patient Name(s): ◆ ◆ Date of Birth:
◆ ◆ Date of Birth:
◆ ◆ Date of Birth:

In order for us to fully evaluate this patient's health and make informed decisions, the parent has approved our request for copies of all relevant records in your file. Please be sure to include radiology reports, lab results, consultation reports, emergency room reports and any hospitalizations from the time they have been a patient in your practice or at your hospital.

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Parent/Legal Guardian Print Name Parent Legal Guardian
(Signature if patient is a minor) Grandparent Other

◆ Name of Insurance: ◆ Name of Ins. Policy Holder:

◆ Ins. Policy Holder SSN: ◆ Ins. Policy Holder DOB:

◆ Patient's address: ◆ City:

◆ State ◆ Zip ◆ Phone:

NOTE: keep original in chart

SIGNATURE OF WITNESS: _____

Babies and Beyond Pediatrics, P.A.
Russell T. Bain, M.D., F.A.A.P. and Associates

9. Insurance Companies We Are Contracted With

Aetna - HMO, PPO, MC, Traditional and Indemnity
Amerigroup
Amerigroup Healthy Kids
Avmed
Baycare
Beechstreet
Cigna - HMO, PPO & POS
CMS
CMS Healthy Kids
Coventry (Formerly First Health and Southcare)
Evolutions
Florida Blue (BCBS) - (PPO, HMO, Traditional, Network Blue and Blue Options)
Humana - HMO, PPO & POS
Medicaid
Medipass
Multiplan (Formerly PHCS)
Pedicare
Pedicare Healthy Kids
Prestige Medicaid
Simply Healthcare
Staywell Medicaid
Sunshine Healthcare
United Healthcare - HMO, PPO & POS
United Healthcare Medicaid
United Healthcare Healthy Kids
Universal Healthcare
Tricare Standard (Not Prime)

NOTE: If insurance is not listed on here it may be affiliated with one of the above networks. Please call the insurance company if you are not sure.

Babies and Beyond Pediatrics, P.A.

7. Financial policy: Patients with contracted insurance or with no insurance (self pay)

We are totally committed to providing you and your family with the highest quality pediatric care while at the same time making sure you receive your maximum allowable benefits according to your insurance plan. In order for this to occur, we need your assistance and complete understanding of your insurance benefits and our financial policy.

Payments:

Payment is due at the time service is rendered. We accept cash, checks or major credit cards (Visa, Master Card, Discover and American Express). If circumstances arise that cause a parent to be unable to pay, please notify the receptionist **before** your visit. We do not have the ability to do payment plans.

NOTE: We encourage all routine well physicals to be rescheduled until the visit can be paid in full.

Return Check Policy:

There is between a \$25.00 bounced check fee for returned checks, depending on the face value of the check. We can not accept another check until the bounced check and bounced check fee is paid in full. If more than one check is returned, we will no longer be able to accept any further checks.

Our Fees:

Our charges are generally considered to fall within the acceptable ranges by ***most*** insurance companies...and will be covered up to the *maximum allowance* determined by your insurance carrier.

Patient Balances:

In some instances we cannot be certain of the exact amount allowed by a particular insurance company for each visit, thus resulting in a refund to you or money owed to us. Refunds and statements are sent out on a monthly basis. If you do not understand your statement, please call our billing department at 352-684-8112. Patient balances > 30 days may be subject to collections and small claims court fees.

Insurance Coverage:

I. General Information:

A. In order to accept and file your insurance the following must occur.

1. We need you to provide us with your child's insurance information and card.
2. We must be able to verify that your child is enrolled in the policy and what your benefits are. If we cannot verify your insurance benefits before your visit then we cannot accept your insurance for that visit. We will extend to you a discount off the total charges and give you a copy of your bill for you to send in for reimbursement.
3. It is your responsibility to provide us with **up to date and accurate** insurance information. Failure to do so may result in your being held responsible for all charges plus any additional fees associated with insurance filing.

B. If you do not understand the details of your insurance coverage [i.e.: the amount of / or what visits your co-pay applies to, if all ages are covered in full for well care (some are not), what your deductible is and when does it apply (sick and/or well visits, labs or procedures)], please ask us to explain your benefits ***before*** your initial visit.

II. Deductibles:

If your deductible has not been met, you will pay what your insurances contracted allowable fee is for each charge. Once your deductible is met you will be required to pay a **percentage off of your insurances contracted allowable fees.**

OVER

III. Percentages:

If you have an insurance policy that states you pay a percentage, this will be off your insurances contracted allowable fees.

IV. PPO Patient only:

We will file your insurance claim. If payment is not received within 60-90 days you will receive a statement advising you to contact your insurance company to help get the claim paid, otherwise the balance will become your responsibility.

V. No Insurance Coverage:

If you have no insurance for your child or one that we do not accept, our policy is to extend a discount off our standard charges **only if** the entire visit is paid in full at the time services are rendered.

VI. No Show Policy:

We understand that there are times when emergencies may arise and you are unable to give proper notice, we would sincerely appreciate when possible, that all future appointments requiring cancellation be done at least 24 hours in advance of said appointment so we may utilize this time for other ill patients.

Same day sick appointment was missed thus a \$50.00 no show charge will be assessed.

First no show without 24 hr cancellation. (no charge)

First no show, **if confirmed by speaking to parent or guardian** and NO 24 hour cancellation, a \$25.00 no show charge will be assessed.

Second no show without 24 hr cancellation, thus a \$75.00 no show charge will be assessed.

Third no show without 24 hr cancellation, a \$100.00 no show charge will be assessed and possible termination from the practice.

INFORMED CONSENT

1. My signature below indicates my consent to any and all of the medical services provided to my child(ren) by the office/doctors of Babies & Beyond Pediatrics, P.A.
2. I authorize my insurance company to pay Babies and Beyond Pediatrics P.A. directly for all services rendered.
3. I have read and understand the financial policy of this office and agree that I am responsible for any balances that result from services rendered for my child(ren) by Babies and Beyond Pediatrics, P.A.
4. In addition, I also understand that whomever brings my child(ren) to this office is responsible for payment in full at time services are rendered.
5. I authorize the release of any medical information necessary for the care of my child(ren) and to process the claim.

Name of Responsible Party

Signature of Responsible Party

Relationship to Patient

Today's Date

Witness sign (receptionist)

Today's Date

PS: If you have any questions about the information you have just read or any uncertainty regarding your insurance coverage please do not hesitate to ask us.

Note: If more than one child, make copies of this document and put it in the other children's chart.

Babies and Beyond Pediatrics, P.A.

Russell T. Bain, M.D. F.A.A.P., and Associates

10. HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" 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 care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information 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.

Treatment: We will use and disclose your protected health information 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 protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight; Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security: Workers' Compensation, Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and 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.

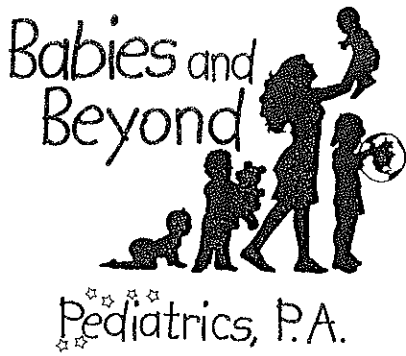
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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-OVER-

"Committed to Providing Compassionate and Quality Care for Babies, Toddlers, & Teens"

224 Mariner Blvd. Spring Hill, FL 34609
Phone (352) 686-9779 Fax (352) 686-5998



October 30, 2014

Russell T. Bain, M.D., F.A.A.P.
James M. Davis, M.D., F.A.A.P.
Norman Becker, M.D., F.A.A.P.

To: Parents of Babies and Beyond Pediatrics

From: Dr. Russell Bain

We need your help!!!

We do our best to get our patients in the same day when they are sick and try to call 48 hours before to remind our patients of their upcoming appointments. We are having a major problem with people not showing up for their appointments and not calling especially the parents who made a sick appointment that day. We need our patients to call before and cancel their appointment. We understand occasionally emergencies happen but this has not been the case. When we call we get responses like I got busy or oh well. The doctor's time has to be respected.

Effective immediately if a patient **no shows the same day** they make an appointment and don't respectfully call to cancel there will be a \$50 mandatory no show charge. If a patient no shows for an upcoming appointment there will be a \$50 mandatory no show charge. **We can't possibly call all of our patients and remind them of their upcoming appointments. Please write down your appointment time.**

Respectfully,

The Doctors & Staff of Babies and Beyond Pediatrics

224 Mariner Boulevard
Spring Hill, FL 34609
(352) 686-9779
(352) 686-5998 Fax

Print Parent/Guardian Name

Sign

Date