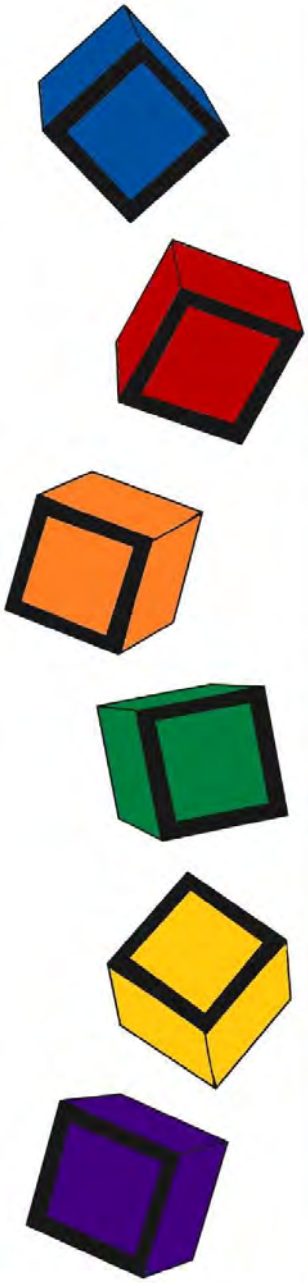
TAMPA CHILDREN'S ENT
Ear, Nose and Throat Specialists

Karin S. Hotchkiss, M.D., F.A.C.S.
Joshua R. Mitchell, M.D.
Jennifer H. Millett, A.P.R.N.
Jenna M. Gilboy, A.P.R.N.
Cecilia Camacho, Au.D., CCC-A
Katherine Pawlowski, Au.D.



Dear Parent,

Your child is scheduled for an auditory processing evaluation at Tampa Children's ENT. Please make sure your child is well rested and has eaten normal meals the day of his/her appointment. You may also bring a few snacks for your child to eat during breaks in testing. If your child gets cold at doctor's offices, please bring a sweater for your child to wear at the appointment to ensure he/she is comfortable during testing.

Please complete the enclosed paperwork and checklists to the best of your ability and bring them with you to your child's appointment. These checklists will not be used for the diagnosis of an auditory processing deficit, but will help the audiologist understand your child's difficulties and your concerns. It will also help the audiologist make recommendations specific to your child's needs.

If your child has been diagnosed with any attention issues and is currently taking medication to manage the attention issue, it is very important that your child take this medication on the day of testing to ensure that he/she can focus throughout the testing. If your child cannot sustain attention long enough to complete the testing, the audiologist may not be able to determine if your child has an auditory processing disorder.

If your child has had completed a speech and language evaluation and/or a psychoeducational or neuropsychological evaluation, please bring a copy of these evaluations with you or fax them to 813-262-1335 prior to your child's appointment. If possible, it is extremely beneficial to have these evaluations completed prior to the auditory processing evaluation.

Please note that your child must be 7 years of age or older, have a normal IQ (intelligence), be English speaking, and have normal hearing in both ears. Your child's hearing will be tested prior to the auditory processing evaluation to confirm that he/she has normal hearing on the day of testing. An auditory processing evaluation cannot be completed on children with any of the following diagnoses: severe developmental delay, Autism, Asperger's, Pervasive Developmental Disorder, or hearing loss. If you have questions regarding your child's candidacy for an auditory processing evaluation, please call 813-262-1330 and ask to speak with the audiologist prior to your child's appointment.

I look forward to working with you and your child!

Sincerely,

Pediatric Audiology Team

2814 W. Virginia Ave
Tampa, FL 33607

6901 Simmons Loop
MOB Suite 208
Riverview, FL 33578

(813) 262-1330
FAX (813) 262-1335

www.tampachildrensent.com

## Patient Information

Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ SSN: _____-_____-_____ Gender: ◯ M ◯ F

Email Address: _____ **Preferred Language:** _____

**Race:** ◯ African American/Black ◯ White **Ethnicity:** ◯ Hispanic

◯ American Indian or Alaskan Native ◯ Asian ◯ Non-Hispanic

◯ Native Hawaiian or Pacific Islander ◯ Declined

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

Primary Phone (____)____-_____ Secondary Phone: (____)____-_____

Primary Care Physician: _____ Physician Phone: (____)____-_____

School: _____ Grade: _____

Additional Providers to Receive Reports:

Provider: _____ Provider Phone: (____)____-_____

Provider: _____ Provider Phone: (____)____-_____

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**Who has legal custody/guardianship of the patient?**

◯ Parents ◯ Grandparents/Other Relative (specify): _____

◯ Mother Only ◯ Foster Parent: _____

◯ Father Only ◯ State Custody/Other (specify): _____

### Mother's Information

Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ SSN: _____-_____-_____

**If different from child:**

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

Primary Phone (____)____-_____ Secondary Phone: (____)____-_____

Place of Employment: _____ Occupation: _____ Work Phone: (____)____-_____

### Father's Information

Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ SSN: _____-_____-_____

**If different from child:**

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

Primary Phone (____)____-_____ Secondary Phone: (____)____-_____

Place of Employment: _____ Occupation: _____ Work Phone: (____)____-_____

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### Emergency Contacts (please provide 2)

Name: _____ Phone: (____)____-_____ Relationship: _____

Name: _____ Phone: (____)____-_____ Relationship: _____

# Patient History

Who referred you child for an auditory processing evaluation: _____

Reason for Testing: _____

_____

_____

## Birth History

How many weeks was your child at birth? _____weeks

Where was your child born? _____

Please list any complications with pregnancy or delivery: _____

Did your child stay in the NICU? ◯Yes ◯No If yes, for how long? _____

Did your child pass the newborn hearing screening? ◯Yes ◯No

If no, which ear? ◯Both ◯Left ◯Right

Was your child jaundiced? ◯Yes ◯No

If yes, what treatment was used? ◯Photo Therapy ◯Blood Transfusions ◯Sunlight

Did your child receive IV antibiotics? _____ If yes, when: _____

## Medical History

**Additional space is provided at the end of the document for any information that doesn't fit below.**

**Please list past medical problems or diagnoses. Check here if NONE** ☐

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

**Please list any specialist physicians caring for your child. Check here is NONE** ☐

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

**Please list any hospitalizations. Check here if NONE** ☐

Date of Hospitalization: ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization: ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization: ____/____/____ Reason for Hospitalization: _____

## Medications

**Please list all current medications your child is taking. Check here if NONE** ☐

Medication Name: _____ Dose: _____ Reason: _____

Medication Name: _____ Dose: _____ Reason: _____

Medication Name: _____ Dose: _____ Reason: _____

Is your child is taking medication for attention difficulties? ◯Yes ◯No

Have you noticed a change in attention since he/she started the medication? ◯Yes ◯No

## Family History

Please list all members living in the child's household (i.e. mother, father, etc.).

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

Name: _____ Age: _____ Relationship: _____ Related Diagnosis:_____

**Related Diagnoses may include ADHD, PDD, ODD, Hearing loss, etc.**

## Developmental History:

What hand does your child write with? ◯ Right ◯ Left ◯ Ambidextrous

What age did your child crawl? _____

What age did your child walk? _____

When did your child say his/her first word? _____

Were there any delays in your child's development? ◯ Yes ◯ No

If yes, explain:_____

## Audiological History

Do you feel that your child hears well? ☐ Yes ☐ No

Do you think that your child has a problem listening or understanding? ☐ Yes ☐ No

Does anyone in the family have a hearing loss? ☐ Yes ☐ No

If yes, who: _____

Are you or someone else concerned about your child's speech? ☐ Yes ☐ No

Has your child been diagnosed with Autism, Asperger's, or Pervasive Developmental Disorder? ☐ Yes ☐ No

Has your child been diagnosed with a syndrome? ☐ Yes ☐ No

If yes, what syndrome: _____

Has your child had any ear infections? ☐ Yes ☐ No

If yes, how many: _____ Date if the last infection: ____/____/____

Has your child had ear surgery (including ear tubes)? ☐ Yes ☐ No

If yes, when: ____/____/____

Does your child report noises in their ears? ☐ Yes ☐ No

If yes, which: ☐ Ringing ☐ Beeping ☐ Clicking ☐ Roaring

Does your child report feeling dizzy or off balance? ☐ Yes ☐ No

Does your child complain of pain in the ears? ☐ Yes ☐ No

Is your child bothered by background noise or does he/she have difficulty hearing when it's noisy? ☐ Yes ☐ No

## Educational History

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, which grade? _____ Why? _____

Does your child have any difficulty at school? ☐ Yes ☐ No

If yes, please explain: _____

_____

What subjects does your child struggle with?

_____

What subjects does your child excel at?

_____

Has your child been tutored? ☐ Yes ☐ No

If yes, explain: _____

Is your child receiving special school support (i.e. special ed, pull out services, classroom modifications, etc)?

☐ Yes ☐ No

Please list all school services: _____

_____

Does your child have a learning disability? ☐ Yes ☐ No

If yes, explain: _____

Is there a family history of learning problems? ☐ Yes ☐ No

If yes, explain: _____

## Evaluation Record:

Please note previous evaluations that your child has had:

| Testing | Yes | No | Age Evaluated | Normal Results | Abnormal results |
|---|---|---|---|---|---|
| Hearing | ☐ | ☐ | | ☐ | ☐ |
| Neurological | ☐ | ☐ | | ☐ | ☐ |
| Psychological | ☐ | ☐ | | ☐ | ☐ |
| Speech and Language | ☐ | ☐ | | ☐ | ☐ |
| Vision | ☐ | ☐ | | ☐ | ☐ |
| Occupational (fine motor) | ☐ | ☐ | | ☐ | ☐ |
| Physical (gross motor) | ☐ | ☐ | | ☐ | ☐ |

## Therapy History

Does your child receive any school or private therapy services (i.e. speech, physical, occupational)? ☐ Yes ☐ No

**Please list any school or private therapy services:**

Therapy Provided:_____ Facility: _____ Duration: _____

Therapy Provided:_____ Facility: _____ Duration: _____

Therapy Provided:_____ Facility: _____ Duration: _____

## Behaviors and Characteristics

### Indicate (X) if your child exhibits any of the following:

- ☐ Sensitive to loud sounds
- ☐ Difficulty understanding or is confused in noisy places
- ☐ Difficulty following an/or understanding TV shows
- ☐ Easily upset by new situations
- ☐ Difficulty following directions
- ☐ Does opposite of what is asked
- ☐ Restless, difficulty sitting still
- ☐ Overly active
- ☐ Short attention span
- ☐ Easily distracted
- ☐ Daydreams
- ☐ Forgetful
- ☐ Asks for repetition
- ☐ Reverses words, numbers, or letters
- ☐ Anxious
- ☐ Lacks Motivation
- ☐ Does not complete assignments
- ☐ Easily Frustrated
- ☐ Tires easily
- ☐ Dislikes school
- ☐ Clumsy
- ☐ Prefers to play with older children
- ☐ Prefers to play with younger children
- ☐ Seeks attention
- ☐ Disruptive
- ☐ Shy
- ☐ Lacks self-confidence

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**Please list any additional information you would like the audiologist to know.**

**Vision Questionnaire:**

- ☐ Blur when looking at near
- ☐ Headaches with near work
- ☐ Words run together when reading
- ☐ Burning, itching, watery eyes
- ☐ Falls asleep when reading
- ☐ Sees worse at the end of the day
- ☐ Skips/repeats lines when reading
- ☐ Head tilt/close one eye when reading
- ☐ Frowns, scowls, or squints to see blackboard
- ☐ Avoids near work/reading
- ☐ Omits small words when reading
- ☐ Writes up/down hill
- ☐ Misaligns digits/columns of numbers
- ☐ Holds reading too close
- ☐ Trouble keeping attention on reading
- ☐ Poor handwriting / hand-eye coordination
- ☐ Rubs eyes during or after visual activity
- ☐ Complains of blur while reading or writing
- ☐ Confuses words with similar beginnings or endings
- ☐ Uses finger or marker when reading
- ☐ Loses place often when reading
- ☐ One eye turns (in, out, up, or down)
- ☐ Complains of letter or lines “floating,” “running together,” or ”jumping around”

# FISHER'S AUDITORY PROBLEM CHECKLIST

Please place a check mark before each item that is considered to be a concern by the observer:

☐ 1. Has a history of hearing loss.

☐ 2. Has a history of ear infection(s).

☐ 3. Does not pay attention (listen) to instruction 50% or more of the time.

☐ 4. Does not listen carefully to directions–often necessary to repeat instructions.

☐ 5. Says "Huh?" and "What?" at least five or more times per day.

☐ 6. Cannot attend to auditory stimuli for more than a few seconds.

☐ 7. Has a short attention span. (If this item is checked, also check the most appropriate time frame)

☐ 0-2 minutes ☐ 5-15 minutes ☐ 2-5 minutes ☐ 15-30 minutes

☐ 8. Daydreams – attention drifts – not with it at times.

☐ 9. Is easily distracted by background sound(s).

☐ 10. Has difficulty with phonics.

☐ 11. Experiences problems with sound discrimination.

☐ 12. Forgets what is said in a few minutes.

☐ 13. Does not remember simple routine things from day to day.

☐ 14. Displays problems recalling what was heard last week, month, year.

☐ 15. Has difficulty recalling sequence that has been heard.

☐ 16. Experiences difficulty following auditory directions.

☐ 17. Frequently misunderstands what is said.

☐ 18. Does not comprehend many words-verbal concepts for age/grade level.

☐ 19. Learns poorly through the auditory channel.

☐ 20. Has a language problem, (morphology, syntax, vocabulary, phonology).

☐ 21. Has an articulation (phonology) problem.

☐ 22. Cannot always relate what is heard to what is seen.

☐ 23. Lacks motivation to learn.

☐ 24. Displays slow or delayed responses to verbal stimuli.

☐ 25. Demonstrates below average performance in one or more academic areas.

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked ____ x 4 = ____

# C. H. A. P. S.

## Children's Auditory Performance Scale

*by Walter J. Smoski, Ph.D., Michael A. Brunt, Ph.D., J. Curtis Tannahill, Ph.D.*

Child's Name_____ Age (years_____ months_____) Date Completed_____

Name of Person Completing CHAPS_____ Relationship to Child _____

### PLEASE READ INSTRUCTIONS CAREFULLY

Answer all questions by comparing this child to other children of similar age and background. Do not answer the questions based only on the difficulty of the listening condition. For example, all 8-year-old children, to a certain extent, may not hear and understand when listening in a noisy room; this would be a difficult listening condition for all children. However, some children may have more difficulty in this listening condition than others. You must judge whether or not THIS child has MORE difficulty than other children in each listening condition cited. Please make your judgment using the following response choices.CIRCLE a number for each item. For ages 7 and above.

| LISTENING CONDITION | LESS DIFFICULTY | SAME AMOUNT OF DIFFICULTY | SLIGHTLY MORE DIFFICULTY | MORE DIFFICULTY | CONSIDERABLY MORE DIFFICULTY | SIGNIFICANTLY MORE DIFFICULTY | CANNOT FUNCTION AT ALL | |
|---|---|---|---|---|---|---|---|---|
| **NOISE** (TOTAL CONDITION SCORE: 0) | | | | | | | | |
| If listening in a room where there is background noise such as TV, music, others talking, children playing, etc., this child has difficulty hearing and understanding compared to other children of similar age and background | | | | | | | | |
| 1. When paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 2. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 3. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 4. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 5. When not paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 6. When involved with other activities, i.e., coloring, reading, etc | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 7. When listening with a group of children | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| COMMENTS: | | | | | | | | |
| **QUIET** (TOTAL CONDITION SCORE: 0) | | | | | | | | |
| If listening in a quiet room (others may be present, but are being quiet), this child has difficulty hearing and understanding compared to other children of similar age and background. | | | | | | | | |
| 8. When paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 9. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 10. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 11. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 12. When not paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 13. When involved with other activities, i.e., coloring reading, etc. | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 14. When listening with a group of children | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| COMMENTS: | | | | | | | | |
| **IDEAL** (TOTAL CONDITION SCORE: 0) | | | | | | | | |
| When listening in a quiet room, no distractions, face-to-face, and with good eye contact, this child has difficulty hearing an understanding compared to other children of similar age and background. | | | | | | | | |
| 15. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 16. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 17. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| COMMENTS: | | | | | | | | |
| **MULTIPLE INPUTS** (TOTAL CONDITION SCORE: 0) | | | | | | | | |
| When, in addition to listening, there is also some other form of input, (i.e., visual, tactile, etc.) this child has difficulty hearing and understanding compared to other children of similar age and background. | | | | | | | | |
| 18. When listening and watching the speaker's face | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 19. When listening and reading along when material is read aloud by another | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 20. When listening and watching someone provide an illustration, such as a model, drawing, information on the overhead projector or chalkboard, etc. | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| COMMENTS: | | | | | | | | |

## LISTENING CONDITION

### AUDITORY MEMORY SEQUENCING

TOTAL CONDITION SCORE: 0

| | LESS DIFFICULTY | SAME AMOUNT | SLIGHTLY MORE | MORE DIFFICULTY | CONSID. MORE | SIGNIFIC. MORE | CAN'T FUNCTION | |
|---|---|---|---|---|---|---|---|---|
| If required to recall spoken information, this child has difficulty hearing and understanding compared to other children of similar age and background | | | | | | | | |
| 21. Immediately recalling information such as a word, word spelling, numbers | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 22. Immediately recalling simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 23. Immediately recalling multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 24. Not only recalling information, but also the order and sequence of the information | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 25. When delayed recollection (1 hour or more) of words, word spelling, numbers, etc. is required | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 26. When delayed recollection (1 hour or more) of simple instructions is required | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 27. When delayed recollection (1 hour or more) of multiple instructions is required | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 28. When delayed recollection (24 hours or more) is required | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |

COMMENTS:

### AUDITORY ATTENTION SPAN

TOTAL CONDITION SCORE: 0

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| If extended periods of listening are required, this child has difficulty paying attention, that is, being attentive to what is being said compared to other children of similar age and background. | | | | | | | | |
| 29. When the listening time is less than 5 minutes | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 30. When the listening time is 5-10 minutes | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 31 When the listening time is over 10 minutes | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 32. When listening in a quiet room | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 33 When listening in a noisy room | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 34. When listening first thing in the morning | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 35. When listening near the end of the day, i.e., before supper time | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |
| 36. When listening in a room where there are also visual distractions | +1 | 0 | -1 | -2 | -3 | -4 | -5 | Select |

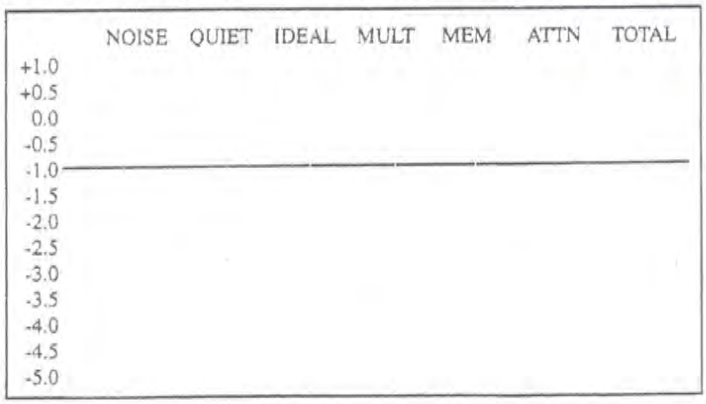
COMMENTS:

**SCORING:** The CHAPS can be scored two ways. Add the circled responses for each condition and place the sum in the Total Condition Score box in under each listed listening condition. Be careful to note "+" and "-" values when adding. Transcribe these sums as indicated below and determine the average score for each listening condition. The Total Condition Scores can be compared to the indicated PASS and FAIL ranges and the appropriate box checked. In addition, the average condition scores can be plotted on the graph to display performance as compared to the normal range. See the CHAPS manual for more complete validity and interpretation information.

| LISTENING CONDITION | TOTAL CONDITION SCORE | | | AVERAGE CONDITION SCORE | | |
|---|---|---|---|---|---|---|
| NOISE | 0 | ÷ 7 | = | 0 | Pass | Risk |
| QUIET | 0 | ÷ 7 | = | 0 | Pass | Risk |
| IDEAL | 0 | ÷ 3 | = | 0 | Pass | Risk |
| MULTIPLE | 0 | ÷ 3 | = | 0 | Pass | Risk |
| MEMORY | 0 | ÷ 8 | = | 0 | Pass | Risk |
| ATTENTION | 0 | ÷ 8 | = | 0 | Pass | Risk |
| TOTAL | 0 | ÷ 36 | = | 0 | Pass | Risk |

**TOTAL CONDITION SCORE:**
PASS RANGE +36 to -11
AT-RISK RANGE -12 to -130

**CHAPS Listening Condition Analysis: Transfer Average Condition Scores by entering "X" on graph (round 0.5 scores up to next decimal).**



# Reading Insert Grades 1st-3rd

1. Does the child have difficulty with sound/symbol correspondence (i.e. /a/ as in apple)?

   ☐ Yes ☐ No If yes, list examples:

   _____

   _____

2. Does the child confuse letters that look alike (i.e. b/d/p, w/m. h/n, f, t)?

   ☐ Yes ☐ No If yes, list examples:

   _____

   _____

3. Does the child have confusion perceiving letters that have similar sounds (i.e. /f/ vs. /v/, /p/ vs. /b/)? ☐ Yes ☐ No If yes, list examples:

   _____

   _____

4. Does the child have difficulty remembering common sight words (was, the, and, she)?

   ☐ Yes ☐ No

5. Does the child have difficulty segmenting words in sounds (i.e. cat-/k/ /a/ /t/)?

   ☐ Yes ☐ No

6. Does the child have difficulty blending individual sounds to make words?

   ☐ Yes ☐ No

7. Does your child have difficulty with rhyming words (Tell me a word that rhymes with bat)?

   ☐ Yes ☐ No

8. Does the child have reading and spelling errors that indicate difficulty sequencing sounds (i.e. blast read or spelled blats)?

   ☐ Yes ☐ No

9. Does the child demonstrate omission of grammatical endings when reading and writing (-s, -ed, -ing)?

   ☐ Yes ☐ No

10. Does your child have difficulty remembering spelling of words over time?

    ☐ Yes ☐ No

# Reading Insert Grades 4th-8th

1. Is there a history of dyslexia in your family?
   ☐ Yes ☐ No
2. Does the child have significant difficulty reading and spelling multisyllabic/longer words? Omits whole syllables (i.e. complicated spelled as complated or adolescents spelled as adolesense)?
   ☐ Yes ☐ No
3. Does the child have reduced awareness of word structures (prefix, root, and suffixes)? (i.e. leaves if endings on words –ed, -s, -es, difficulty understanding prefixes (pre-, sub-), difficulty understanding root words and suffixes (i.e. declare/declaration))
   ☐ Yes ☐ No
4. Does the child demonstrate frequent misreading of common sight words?
   ☐ Yes ☐ No
5. Does the child have difficulty learning new information from print because of word reading errors?
   ☐ Yes ☐ No
6. Does the child have difficulty understanding print because of underlying oral language problems with vocabulary and or grammar?
   ☐ Yes ☐ No
7. Does the child have significant difficulty writing due to spelling and organization problems?
   ☐ Yes ☐ No
8. Is the child slow in their rate of reading (how fast or slow the child reads)?
   ☐ Yes ☐ No

Please have your child's teacher complete the following 2 pages

# S.I.F.T.E.R.

## SCREENING INSTRUMENT FOR TARGETING EDUCATIONAL RISK

by Karen L. Anderson, Ed.S., CCC-A

STUDENT _____ TEACHER _____ GRADE _____

DATE COMPLETED _____ SCHOOL _____ DISTRICT _____

The above child is suspect for hearing problems which may or may not be affecting his/her school performance.
This rating scale has been designed to sift out students who are educationally at risk possibly as a result of hearing problems.
Based on your knowledge from observations of this student, circle the number best representing his/her behavior.
After answering the questions, please record any comments about the student in the space provided on the reverse side.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. What is your estimate of the student's class standing in comparison of that of his/her classmates? | UPPER | 5 | 4 | MIDDLE | 3 | 2 | LOWER | 1 | ACADEMICS |
| 2. How does the student's achievement compare to your estimation of her/her potential? | EQUAL | 5 | 4 | LOWER | 3 | 2 | MUCH LOWER | 1 | |
| 3. What is the student's reading level, reading ability group or reading readiness group in the classroom (e.g., a student with average reading ability performs in the middle group)? | UPPER | 5 | 4 | MIDDLE | 3 | 2 | LOWER | 1 | |
| 4. How distractible is the student in comparison to his/her classmates? | NOT VERY | 5 | 4 | AVERAGE | 3 | 2 | VERY | 1 | ATTENTION |
| 5. What is the student's attention span in comparison to that of his/her classmates? | LONGER | 5 | 4 | AVERAGE | 3 | 2 | SHORTER | 1 | |
| 6. How often does the student hesitate or become confused when responding to oral directions (e.g., "Turn to page . . ")? | NEVER | 5 | 4 | OCCASIONALLY | 3 | 2 | FREQUENTLY | 1 | |
| 7. How does the student's comprehension compare to the average understanding ability of her/her classmates? | ABOVE | 5 | 4 | AVERAGE | 3 | 2 | BELOW | 1 | COMMUNICATION |
| 8. How does the student's vocabulary and word usage skills compare with those of other student s in his/her age group? | ABOVE | 5 | 4 | AVERAGE | 3 | 2 | BELOW | 1 | |
| 9. How proficient is the student at telling a story or relating happenings from home when compared to classmates? | ABOVE | 5 | 4 | AVERAGE | 3 | 2 | BELOW | 1 | |
| 10. How often does the student volunteer information to class discussions or in answer to teacher questions? | FREQUENTLY | 5 | 4 | OCCASIONALLY | 3 | 2 | NEVER | 1 | CLASS PARTICIPATION |
| 11. With what frequency does the student complete his/her class and homework assignments within the time allocated? | ALWAYS | 5 | 4 | USUALLY | 3 | 2 | SELDOM | 1 | |
| 12. After instruction, does the student have difficulty starting to work (looks at other students working or asks for help)? | NEVER | 5 | 4 | OCCASIONALLY | 3 | 2 | FREQUENTLY | 1 | |
| 13. Does the student demonstrate any behaviors that seem unusual or inappropriate when compared to other students? | NEVER | 5 | 4 | OCCASIONALLY | 3 | 2 | FREQUENTLY | 1 | SCHOOL BEHAVIOR |
| 14. Does the student become frustrated easily, sometimes to the point of losing emotional control? | NEVER | 5 | 4 | OCCASIONALLY | 3 | 2 | FREQUENTLY | 1 | |
| 15. In general, how would you rank the student's relationship with peers (ability to get along with others)? | GOOD | 5 | 4 | AVERAGE | 3 | 2 | POOR | 1 | |

## TEACHER COMMENTS

Has this child repeated a grade, had frequent absences or experienced health problems (including ear infections and colds)? Has the student received, or is he/she now receiving, special services? Does the child have any other health problems that may be pertinent to his/ her educational functioning?

### The S.I.F.T.E.R. is a SCREENING TOOL ONLY

Any student failing this screening in a content area as determined on the scoring grid below should be considered for further assessment, depending on his/her individual needs as per school district criteria. For example, failing in the Academics area suggests an educational assessment, in the Communication area a speech-language assessment, and in the School Behavior area an assessment by a psychologist or a social worker. Failing in the Attention and/or Class Participation area in combination with other areas may suggest an evaluation by an educational audiologist. Children placed in the marginal area are at risk for failing and should be monitored or considered for assessment depending upon additional information.

### SCORING

Sum the responses to the three questions in each content area and record in the appropriate box on the reverse side and under Total Score below. Place an **X** on the number that corresponds most closely with the content area score (e.g., if a teacher circled 3, 4 and 2 for the questions in the Academics area, an X would be placed on the number 9 across from the Academics content area). Connect the **X**'s to make a profile.

| CONTENT AREA | TOTAL SCORE | PASS | | | | | | MARGINAL | | FAIL | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACADEMICS | | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 |
| ATTENTION | | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 |
| COMMUNICATION | | 15 | 14 | 13 | 12 | 11 | | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 |
| CLASS PARTICIPATION | | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 |
| SOCIAL BEHAVIOR | | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 |

**Child's Name:** _____ **Date of Birth:** _____


## Florida Pediatric Associates, LLC
## Patient Portal Agreement Form

******DO NOT use the Patient Portal for emergencies, CALL 911******

For urgent problems, please call our office at **(813) 262-1330**

The Patient Portal is a secure web portal that allows you as a patient's parent or guardian to access your child's personal health information. It also allows you to communicate with our office via secured messaging. Our Patient Portal Web address is: ***https://portal.floridapediatrics.com/tcent***

**Important Information:**

- Our hours of operation are **8:30 AM – 5:00 PM Monday – Friday**. We encourage you to use the Patient Portal at any time. However, messages are held for us until we return the next business day.
- Messages are typically handled within two business days. If your Provider is out of the office that day, your request may be held until your doctor returns to the office. You must call our office at **(813) 262-1330** if you have an urgent matter to discuss.
- Staff members other than your Provider may be involved in receiving your messages and routing them to the Provider or other staff personnel to address.
- If you are not receiving emails from us, please check your JUNK email folder before contacting our office.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify our office should your password be stolen.
- We strive to keep all of the information in your child's medical record correct and complete. If you notice information in your child's record that is incomplete or inaccurate, you agree to notify our office immediately by phone or secured message. In addition, you also agree not to provide false or misleading information.
- You agree to not hold Florida Pediatric Associates, LLC or its subsidiaries responsible for any network infractions beyond our control.
- We offer the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your expressed written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

The information on our portal is maintained by Florida Pediatric Associates, LLC. You may contact our Patient Portal Administrator at 727-456-4258 with your questions or concerns (non-patient care related) regarding the patient portal or send a secured message using the link provided on the portal.

I have read, understand and agree to the above information regarding the Florida Pediatric Associates, LLCs, Patient Portal:

**Signature:** _____

**Print Name:** _____

**Email Address:** _____

***Portal Registration Completed by:*** _____ ***Assigned PIN #:*** _____

# Consent to Leave Message on Voicemail

Patient Name: _____ DOB: _____

Tampa Children's ENT staff can contact you by telephone – at your request - with information such as laboratory results, or instructions from your doctor. Our office can leave detailed medical information on your answering machine with your consent.

By signing this "Consent to Leave Voicemails", you consent to TCENT leaving a voice mail message containing detailed medical information on the phone number(s) listed below. This information can include, but not be limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, medical information (diagnosis, medications, test results, etc.) and the name of the practice or hospital where you/the patient received services. Additionally, you agree that it is your responsibility to contact the office should you have any questions or concerns about or not understand the information left.

Which phone number(s) may we leave messages that contain the above referenced medical information?

_____

_____

May we leave detailed messages that contain medical information with a family member or representative of your choice? If so, please identify them below.
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that TCENT cannot require me to sign this consent form in order to receive treatment.

I understand that I have the right to revoke this consent at any time by sending a written request to Tampa Children's ENT. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

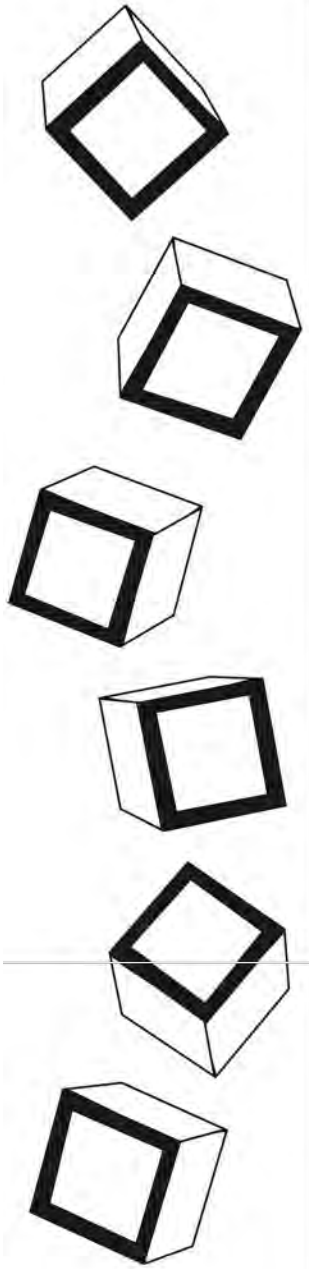
I understand that I am entitled to a copy of this completed consent form.

Name (print): _____ Relationship to patient: _____

Signature: _____ Date: _____

TAMPA CHILDREN'S ENT

Ear, Nose and Throat Specialists



2814 W. Virginia Ave
Tampa, FL 33607

6901 Simmons Loop
MOB Suite 208
Riverview, FL 33578

(813) 262-1330
FAX (813) 262-1335

www.TampaChildrensENT.com

## Office Policies

**Patient Name**: _____ **D.O.B.**: ____/____/_____

Thank you for choosing Tampa Children's ENT. It is our goal to provide you with the best possible care. Please review our policies and guidelines outlined below. Your cooperation with our policies will enable us to serve you in the best possible manner.

**Office Payment Policy**

Payment is expected **in full** at the time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and/or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made **prior to your appointment**. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services **in full**. Obtain insurance authorization and/or referrals (if necessary) prior to your visit to avoid delays or rescheduling.

If you have a billing question, please contact our billing office for clarification:
Patient Last Name **A-L** call Elizabeth Forziano 727-322-7935
Patient Last Name **M-Z** call Christy Kelly 727-456-4259

**Diagnostic Testing**

Please complete all prescribed diagnostic testing in a timely manner (7-10 days unless otherwise specified). If your insurance plan denies any lab test, x-ray, surgery, or other diagnostic exam that is prescribed we ask that you notify our office as soon as possible. If an appeal letter is requested we will be happy to provide it, however, your insurance company may still choose to deny coverage even with an appeal letter.

**Late Arrival/Cancellation**

Patients arriving more than **15 minutes** after scheduled appointment time may be rescheduled. Occasionally late arrivals may be seen at the end of the clinic **at the Physician's discretion.** If you call to alert us of your late arrival we will try our best to work you into the day's schedule but cannot guarantee you will be seen that day. We appreciate your compliance with this in order to avoid long waits. Cancellation of office visits and in-office procedures require at least **24 hours notice** or are subject to a **$30.00 charge**. Surgery cancellations other than illness require **72 hours notice** or are subject to a **$100.00 charge**. Excessive "no show" visits without notification may result in the discharge of the patient from this clinic.

**Medical Records/FMLA**

Medical records may be copied upon written request for **$1.00 per page**. There is no charge for medical records sent directly to another health care provider. You may be asked to sign a release of information prior to the records being sent. There will be a **$25.00 charge** for all medical leave papers filled out by this office.

**HIPAA**

Our Notice of Privacy Practices, required by HIPAA, is attached for your review. You may wish to save a copy for your records. This document is also available in our office.

**Assignment of Benefits/Guarantor Agreement**

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A

copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible for any balance not covered by my insurance carrier. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products and services received. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

I acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and understand the office policy for payment and agree to the terms as stated.

_____ _____ **Date**: ____/____/_____

**Signature of Responsible Party** **Relationship to Patient**

# NOTICE OF PRIVACY PRACTICES
# THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**PLEASE NOTE:**
**State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect __JULY 1, 2013__ and will remain in effect until it is amended or replaced by us.**

**It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.**

**You may request a copy of our Notice of Privacy Practices at any time by contacting our Privacy Officer, _*Lee Ann Atkinson*__. Information on contacting us can be found at the end of this notice.**

**OUR COMMITMENT TO YOUR PRIVACY**
We understand that information about you and your health care is personal. We create a record of the care and services you receive from Florida Pediatric Associates, LLC (FPA) and are committed to protecting that information about you.
We are required by law to 1) Make sure health information that identifies you is kept private. 2) Give you this Notice of our privacy practices. 3) Follow the terms of the Notice that is currently in effect.

**ROUTINE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)**
(Please note: for the purposes of this document the terms "you" will pertain to the patient and/or legal guardian if appropriate)
**TREATMENT:** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you. Many of the people who work in our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
**PAYMENT:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with the details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you PHI to bill you directly for services and items.
**HEALTH CARE OPERATIONS:** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may do this, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
**APPOINTMENT REMINDERS:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
**TREATMENT OPTIONS:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives; or communicate with you regarding the scheduling, ordering or results of tests.
**HEALTH RELATED BENEFITS AND SERVICES:** Most uses and disclosures of PHI for marketing purposes and disclosures that constitute sale of protected health information require authorization.
**RELEASE OF INFORMATION TO FAMILY & FRIENDS:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter or aunt take their child to the doctor for treatment. In this example, this person would have access to the child's medical information; *however this person must be listed on the consent for treatment form in the patient's chart and be able to present valid picture ID at the time they present to our office.*
Additionally, a parent may not speak English fluently and may have an interpreter assist them at the appointment, this person would have access to the child's medical information.
**OTHER:** Uses and disclosures not described in this NPP will be made only with authorization from you, the individual.

**USE AND DISCLOSURE OF YOUR PHI IN SPECIAL CIRCUMSTANCES**
**DISCLOSURES REQUIRED BY LAW:** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law; such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in the case of a medical emergency.

**PUBLIC HEALTH:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

**HEALTH OVERSIGHT ACTIVITIES:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**LAWSUIT OR SIMILAR PROCEEDING:** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

**NATIONAL SECURITY:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

# NOTICE OF PRIVACY PRACTICES

**YOUR PRIVACY RIGHTS AS OUR PATIENT**

You have the following rights regarding the PHI we maintain about you:

**CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. At our discretion, we will accommodate all reasonable requests. You are not required to give a reason for your request.

**ACCESS:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit the completed request form. You may contact our Privacy Officer for a copy of this form. Once approved an appointment can be made to review your records, during the process of review no records may be removed from the office. Copies, if requested, *will be $1.00 per page for the first 25 pages and $0.25 per page for every page over 25*. The individual office *may* choose to waive this fee at the discretion of the physician. We will try to accommodate all reasonable requests, however if we deny your request to inspect and/or copy your record you may request a written reason for the denial. You have a right to obtain a copy of your health information within the designated record set maintained in electronic form in electronic format. We will send the electronic form of your health information to you via unencrypted email if you acknowledge the risk of the sending of unencrypted emails.

**AMENDMENT:** You may ask us to amend your health information if you believe it is inaccurate or incomplete, and you may request that the amendment be in effect for as long as it is maintained by our practice. Your request for an amendment, must be in writing (the appropriate form can be requested from office staff) and must include an explanation of why the information should be amended. We will deny your request if you fail to submit your request with supporting explanation in writing. Also, we may deny your request if you ask us to amend information that is not created by us, or is not part of the medical information maintained by us, or if we find that the information we possess is accurate and complete. If we deny your request you will receive the denial in writing; you have a right to appeal the decision – but it must be done in writing.

**RESTRICTIONS:** You have the right to request that we restrict the uses or disclosure of your health information for treatment, payment or healthcare operations purposes. We are not required to comply with any other requests for restrictions, but if we do, we will abide by the written agreement (except in the case of a medical emergency). Additionally, you have a right to request that we place additional restrictions on our use or disclosure of your health information to a health plan. Specifically you have the right to request that we restrict the use or disclosure of health information to a health plan (insurance company) for purposes of payment or operations, IF you pay for the service out-of-pocket IN FULL at the time the service is provided. This request MUST be made in writing (the appropriate form can be requested from office staff). This requirement does not apply to disclosures for treatment, such as disclosures to a referring physician for continuation of care. This office is required to comply with any requests that limit disclosures to a health plan when the service has been paid out-of-pocket and in full by the patient. Such restrictions do not override disclosures that are otherwise required by law. Additionally if initial payment for services, that have a request for restriction applied to them, is returned or invalid; our office will make a good faith attempt to collect payment – if this is unsuccessful we have the right to then submit a claim for these services to the health plan.

**ACCOUNTING OF DISCLOSURES:** All of our patients have the right to request an accounting of all disclosures made. All requests for an accounting of disclosures must be submitted in writing (the appropriate form can be requested from office staff) and include: a time period, that must not exceed 6 years prior to the date of the request and/or be dated prior to April 14, 2003 – as information prior to that date was not required to be tracked. The first list you request within a 12-month period is free of charge. We may charge you for any additional lists requested within the same 12-month period. We will notify you of the costs involved with any additional requests prior to their completion, allowing you to withdraw your request before you incur any costs.

**BREACH NOTIFICATION REQUIREMENTS:** In the event that unsecured protected information about you is "breached", we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform The Department of Health and Human Services and take any other steps that are required by law.

**RIGHT TO FILE A COMPLAINT:** If you believe your privacy rights have been violated, you may file a complaint with our practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit it in writing and to the attention of the Privacy Officer (the appropriate form can be requested from office staff). We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

**RIGHT TO A PAPER COPY OF THIS NOTICE:** You are entitled to receive a paper copy of our Notice of Privacy Practices. To obtain a paper copy of this Notice, contact our Privacy Officer in writing.

**MINORS AND PERSONS WITH LEGAL GUARDIANS:**

Minors and certain disabled adults are entitled to the privacy protection of their health information. Because, by law, they cannot make health decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents and guardians can authorize the use and release of PHI and also hold all rights listed in this notice or the behalf of the minor child or disabled adult.

Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

**We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.**

**HOW TO CONTACT US:**

Please direct any questions about this Notice to our Privacy Officer at 727-456-4244

Privacy Officer address:
Florida Pediatric Associates, LLC
Attn: Privacy Officer
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

Medical Information Department address:
Florida Pediatric Associates, LLC
Attn: Medical Information Department
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

**FLORIDA PEDIATRIC ASSOCIATES, LLC**
**FOUNTAINHEAD PRACTICE MANAGEMENT SOLUTIONS, LLC**
**MAY 2013**