PREMIER PEDIATRICS

Where Kids Come First

TODAY'S DATE_____

HOW DID YOU HEAR ABOUT US? (Circle) Friend, Family Member, Hospital, Google, Insurance Company Website, Other Insurance Company Source, Other Internet Source, School, Other _____

PATIENT INFORMATION

Patient's full name _____ Social Security #_____
Last First M.I.

Address _____ Apt.#_____

City _____ State_____ Zip Code _____

Home Phone ( )_____ Date of Birth_____ Sex: male____ female____

PRIMARY INSURANCE INFORMATION Patient lives with the insured? : Yes_____ No _____

Name of Insurance _____ Insurance Phone _____

Policy # _____ Group #_____

Insured's Full Name _____ Relationship to patient_____

Address _____ State_____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____

Cell Phone ( ) _____ Date of Birth _____ SS# _____

Employer _____ Employer Address _____

Is there any other insurance on this or any of the children listed below? Yes _____ No _____

If yes please list other insurance and the children it covers _____

PARENT/ GUARDIAN (circle one) Lives with patient: Yes_____ No _____

Full Name _____ Relationship to patient_____

Address _____ State_____ Zip Code_____

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____

Cell Phone ( ) _____ Date of Birth _____ SS# _____

Email Address _____ Employer _____

OTHER PARENT/ GUARDIAN (circle one)(If not already listed) Lives with patient: Yes_____ No _____

Full Name _____ Relationship to patient_____

Address _____ State_____ Zip Code_____

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____

Cell Phone ( ) _____ Date of Birth _____ SS# _____

Email Address_____ Employer _____

NAMES AND DATES OF BIRTH OF ALL OTHER CHILDREN COMING TO THE PRACTICE

NAME SAME ADDRESS? DATE OF BIRTH SAME INSURANCE?

. _____

. _____

SIGNATURE OF RESPONSIBLE PARTY_____

PRINT NAME _____

Premier Pediatrics

Pediatric Patient History

Child's name	Age	D.O.B.	M F	Date

Birth & Development

Did the mother have any problems during pregnancy? Yes No

If yes, please explain:

Baby's condition at birth: [ ] Good [ ] Fair [ ] Poor

Birth weight:

Did the baby have any breathing problems at birth? Yes No

Type of delivery: Vaginal C-section

Did the baby become jaundiced? Yes No

Did the baby go home from the hospital with the mother? Yes No

Birth to One Year

Breast fed: Yes No How long?

Formula: Yes No What kind?

Colic: Yes No How old?

At what age did child sit?

Walk?

Talk?

One Year and Older

Good appetite? Yes No

Habits/Behavior (*Please check ✓*) :

[ ] Nail biting [ ] Thumb sucking
[ ] Nightmares [ ] Bad temper
[ ] Bedwetting [ ] Disobedient
[ ] Speech problems [ ] Holding breath
[ ] Jealous [ ] Irritable
[ ] Can't toilet train [ ] Other

Medical History

General Health: [ ] Good [ ] Fair [ ] Poor

Allergies: Yes No

[ ] To medications? (*Please list*)

[ ] To foods/other? (*Please list*)

Type of allergic reaction:
[ ] Rash [ ] Hives [ ] Respiratory Problems

Hospitalizations/Surgeries/ER Visits (*List reasons & dates):*

Recurring medical problems (*Please check ✓*):

[ ] Diaper rash [ ] Fainting
[ ] Colds/Respiratory infections [ ] Ear infections
[ ] Seizures/Convulsions [ ] Sore throats
[ ] Stomach problems

Childhood diseases (*Please check ✓*):

[ ] Chicken pox [ ] Rubella
[ ] Measles [ ] Scarlet fever
[ ] Mumps [ ] Whooping cough

Immunizations up to date? (*Please check ✓*)

[ ] Complete
[ ] Partial
[ ] None

Family History

Has anyone in the family ever had the following? (*Please check ✓ and state relationship to child*):

[ ] SIDS (Sudden Infant Death Syndrome) _____
[ ] Asthma _____
[ ] Allergies _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Drug/Alcohol abuse
[ ] Epilepsy _____
[ ] Mental illness _____
[ ] Sickle cell disease _____
[ ] Disabilities _____
[ ] Very high cholesterol _____
[ ] Heart attack before age 55 _____

Siblings (*Please list*):

Does anyone in the household smoke? Yes No

Do you or friends/family have a pool? Yes No

Has your child been exposed to lead (i.e., in paint, older home, etc.)? Yes No

Premier Pediatrics, P.A.
10,000 West Colonial Drive, Suite 390
Ocoee, FL 34761

FINANCIAL POLICIES AND PROCEDURES

Signing this form confirms your understanding of the basic financial policies and procedures of Premier Pediatrics, P.A. and your agreement to be financially responsible for all charges incurred. PLEASE READ COMPLETELY.

We will file your primary insurance claim. However, it is your responsibility to provide correct, complete, current, and timely information about your insurance, to notify us of any changes to your insurance prior to your visit, to provide any information requested by your insurance company, and to ensure that your insurance company pays your claim in a timely manner. Failure to provide all the necessary insurance information, including a copy of the insurance card, may require an appointment to be rescheduled.

We do not file secondary insurances. We will help provide you with paperwork to file secondary claims.

It is your responsibility to know your insurance benefits, and to make sure the doctor is a participating provider with your plan. Although we try to assist you by obtaining a basic verification of benefits, the information we are able to obtain from your insurance company is not a guarantee of payment and may not be the most accurate description of your coverage and benefits.

You are responsible for, and agree to pay, all copays, deductibles, co-insurance amounts, previous balances, and non-covered services at the time of service. If for any reason you are unable to pay at the time of service, prior arrangements must be made. If you arrange for someone else to bring your child to an appointment, please also arrange for payment at the time of service. The party bringing the child is responsible for payment.

We do not make special arrangements for divorce situations.

Outstanding balances are due within 30 days unless other arrangements have been made. Late fees and interest may be incurred on all balances not paid within 30 days of the first billing.

When Premier Pediatrics, P.A., is closed for business, we forward our telephone calls to the Tele-Care Nurse Program. There is a fee of $15.00 per call. This fee is subject to change without notice.

We accept Visa, MasterCard, Discover, American Express, and Cash payments. **We do not accept checks.**

There **may** be a $25.00 fee imposed for no-show appointments. We will do our best to call to confirm your appointment the day prior to the visit. However, this call is a courtesy only.

There is a fee for the completion of all forms, this includes FMLA forms, WIC forms, immunization forms, and physical forms not completed at the time of the physical. Fees vary depending on the type of form and are subject to change without notice.

A properly completed and signed records release form is required for medical records to be released. There may be a fee for medical records. The fee is based on the Florida Statutes. The fee must be paid prior to records being released.

If it becomes necessary to place your account with a professional collection agency, or take legal action to collect the balance of your account, you are responsible for all legal/collection/attorney fees. Other fees may apply.

All fees are subject to change without notice and will not be billed to any insurance company.
You may request a copy of this form for your records.

Print Name_____ Date_____

Names of children _____

Signature_____

PREMIER PEDIATRICS

Where Kids Come First

AUTHORIZATION FORM

CONSENT FOR TREATMENT: The undersigned hereby consents to the provision of examination, treatment, medical and laboratory procedures, drugs and supplies to the patient, as ordered or requested by the patient's physician(s) and acknowledges that no guarantee or assurance has been made as to the results of such treatment, procedure, or examinations.

RELEASE OF INFORMATION: I understand that as part of my healthcare, Premier Pediatrics maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The undersigned hereby authorizes Premier Pediatrics and any involved physician(s) to disclose and release all or any part of the patient's record for treatment, payment, and/or healthcare operations.

PATIENT/GUARANTOR AGREEMENT: The undersigned agrees that, in consideration of the services rendered to the patient, they are obligated to pay, and unconditionally guarantees payment of the patient's account(s). It is understood that payment in full is required in a timely basis, regardless of whether any third party payment is pending. In the event of payment default of any unpaid balance, the undersigned assumes responsibility and all terms of Premier Pediatrics Financial Policies and Procedures will apply.

MESSAGES: The undersigned agrees that Premier Pediatrics may leave messages on voice mail or answering machine pertaining to appointments, results, and billing and insurance matters, as well as other matters.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby assigns to Premier Pediatrics, for application to the patient's bill, any benefits or other recovery of any type, arising out of any insurance policy covering the patient or any other party liable to the patient, and authorizes direct payment to Premier Pediatrics of such benefits or recovery. It is agreed that Premier Pediatrics may accept any such payment. The undersigned is responsible for charges not covered by this assignment.

RELEASE OF CONFIDENTIAL INFORMATION FOR BILLING PURPOSES: Disclosure of substance abuse, psychiatric treatment, and HIV information is protected by Federal or State Law. Federal or state law prohibits making any disclosures of confidential information without the consent of the person to whom it pertains, or as otherwise permitted or required by federal or state law.
The undersigned hereby authorizes Premier Pediatrics and any involved physician(s) to release to the patient's insurance company or other third party payer, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding:

(**PLEASE INITIAL** INFORMATION TO BE RELEASED FOR BILLING):

_____ The patient's hospitalization and/or treatment for alcohol or drug abuse.

_____ The patient's hospitalization and/or treatment for mental illness.

_____ The fact that and HIV test was performed and the patient's HIV test result.

This consent will remain in effect only until the insurance claims have been settled: and may be revoked prior to that time, except to the extent that action has already been taken in regards to the claims.

I HEREBY CERTIFY THAT I HAVE READ AND/OR HAVE HAD THE FOREGOING INFORMATION EXPLAINED, THAT I HAVE RECEIVED A COPY UPON MY REQUEST, AND THAT I AM THE PATIENT, OR THAT I AM DULY AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Signature _____ Date _____

Patient/parent/Legal Guardian/Other Authorized Representative

Premier Pediatrics

Where Kids Come First

NOTICE OF PRIVACY PRACTICES

To Our Patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintain the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. Your can request that our practice 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. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of you health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human services. To file a complaint with our practice, contact: Practice Administrator, Premier Pediatrics, 10,000 W. Colonial Dr. Suite 390, Ocoee, FL 34761. All complaints must be in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices

Signature _____ **Print Name**_____

Date_____ **Patient Name**_____

Medical Records Release

Premier Pediatrics
10,000 West Colonial Drive, Suite 390
Ocoee, FL 34761
407-290-2394
Fax 407-521-3640

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information
Please allow a minimum of two business days to process your request.
I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.
I have read and understand the following statements:
1. I may revoke this authorization at any time by notifying Premier Pediatrics in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Premier Pediatrics will not condition my treatment, payment, enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form, if requested
6. I further agree to pay charges to provide the information requested per the Florida Statutes
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____. If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

I understand and agree to the provisions of this form on behalf of the individual patient indicated below. I have signed my name individually as the parent of the patient, as the patient , or as the legal guardian of the patient. If I am the legal guardian, I have attached a copy of the court order designating me as the guardian of the patient.

Patient's Legal Name: _____

Date of Birth: _____

Patient/Parent/Legal Guardian Phone Number:_____

I authorize Premier Pediatrics to: Disclose to: _____

or

Obtain from: **(previous doctor)** _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ **FAX**: _____

The purpose of this request:
Personal Request_____ Treatment (Continued Care)_____

Other:_____

Please furnish the following information specified below for the following dates:_____
Circle one:
shot record only, Complete chart, Other: _____

Parent/Guardian/Adult Patient **Signature:** _____

Print Name:_____

Date :_____

Per Florida Statute 456.057 and Department of Health Chapter 64B8-10.003 reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: For the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be 25 cents per page.

Premier Pediatrics

Where Kids Come First

Complete this form if you wish to grant permission for an adult other than the parents or legal guardians to bring the child to a medical appointment. This permission is necessary for grandparents, step-parents, caregivers, or any adult other than the parents or legal guardians. Please be advised that the authorized adult must present valid photo identification when bringing the child for a medical appointment.

Date_____

I give my permission for (name of adult) _____

to authorize treatment for (name of child) _____.

I also authorize Premier Pediatrics to discuss my child's protected health information with the above named adult.

This permission is for the time period of _____ through _____.

Print Your Name _____

Relationship to child _____

Signature_____

Mark Gilchrist, MD ◆ Stephanie Crum, MD

Board Certified Pediatrics

10,000 West Colonial Dr., Suite 390 • Ocoee, FL 34761

(407) 290-2394 • Fax (407) 521-3640