Patient Registration Form

Patient Information:

NAME: _____ Preferred Name: _____

SEX: M / F DATE OF BIRTH: _____ / _____ / _____ Social Security Number: _____

NAME: _____ Preferred Name: _____

SEX: M / F DATE OF BIRTH: _____ / _____ / _____ Social Security Number: _____

NAME: _____ Preferred Name: _____

SEX: M / F DATE OF BIRTH: _____ / _____ / _____ Social Security Number: _____

Contact Information:

MOBILE PHONE: _____ USA: ___Yes ___ No

HOME PHONE: _____ WORK PHONE: _____
EMAIL: _____

PATIENTS ADDRESS: _____

City: _____ State: _____ Zip Code: _____

PREFERRED METHOD OF COMMUNICATION: _____Mobile Phone _____Home Phone

_____Work Phone _____Email _____Mail

PREFERED LANGUAGE: _____

ETHNICITY: _____: Hispanic or Latino _____: Not Hispanic or Latino

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Medical Insurance:

PLAN NAME AND TYPE: _____ or _____Self Pay

Insurance ID: _____ Group ID: _____

Effective From: ___ / ___ / ___ Effective to: ___ / ___ / ___

Person responsible for Insurance:

GUARANTOR NAME: _____ RELATIONSHIP: _____

ADDRESS: _____Same as Patient or: _____

City: _____ State: _____ Zip Code _____

DATE OF BIRTH (Guarantor): _____ / _____ / _____ SEX: M / F Primary

How or where did you hear about SuperKids Pediatrics?

_____

Father	**Mother**
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Address: _____	Address: _____
_____	_____
Cell #: _____	Cell #: _____
Occupation: _____	Occupation: _____
Work Phone: _____	Work Phone: _____
Social Security: _____	Social Security: _____
Driver's License #: _____	Driver's License #: _____

Previous Primary Care Provider: _____

Phone: _____

Address: _____

Additional Siblings:

Name: _____ Date of Birth: ____/_____/_____ Sex: M/F

Name: _____ Date of Birth: ____/_____/_____ Sex: M/F

Name: _____ Date of Birth: ____/_____/_____ Sex: M/F

PREFERED PHARMACY USED: _____ PHONE: _____

LOCATION/ADDRESS: _____

The undersigned hereby authorizes the release of any information relating to treatment, healthcare options and all claims or benefits, submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize the above mentioned insurance company (ies) to pay and hereby assign directly to SuperKids Pediatrics all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that even though SuperKids Pediatrics has agreed to participate with my insurance company, I am ultimately responsible for all charges related to my children's care.

Parent / Guardian

Print: _____

Sign: _____

Date: _____

PEDIATRIC HEALTH QUESTIONNAIRE

Patient's Name:_____ Date: _____

Age: _____ Date of Birth:_____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Who does the child live with? _____ Pets at home: _____

Birth History:

Complications during pregnancy? Yes No

Was the baby Premature? Yes No

Any complications after birth? Yes No (jaundice, breathing, feeding problems, infections)

Hospitalizations/Illnesses:

Please, list below any hospitalizations, surgeries and/or serious injuries. Age

_____ _____

_____ _____

_____ _____

Present Medications: Please, list below any medication (prescription medication, over the counter medication, herbs) your child is now taking or takes often.

Name Dosage

_____

_____

_____

Previous Medications: Please, list below any previous medication (prescription medication, over the counter medication, herbs) your child used to take on a regular basis.

Name Dosage

_____

_____

_____

Is your child allergic to any medication, food or things from the environment? Yes No

If Yes, please list: _____ .

What kind of reaction does it provokes? Runny nose, rash, anaphylaxis, GI symptoms, difficulty breathing, other: _____

Family History:

Is there a family history of: (circle Yes or No)

Asthma	Yes	No	Heart Disease	Yes	No
Allergies	Yes	No	Tuberculosis	Yes	No
Seizures	Yes	No	Diabetes	Yes	No
Deafness	Yes	No	Mental Retardation	Yes	No
Cancer	Yes	No	Slow Learner	Yes	No
High Cholesterol	Yes	No	Mental Illness	Yes	No
Thyroid	Yes	No	Substance Abuse	Yes	No

Immunizations: Is your child up to date for her/his age? Yes No

Developmental/Social:

Have you ever feel your child is slow in development?	Yes	No
Does your child get along well with other children?	Yes	No
Problems with Speech/language?	Yes	No
Problems with Social skills?	Yes	No
Problems with Motor skills?	Yes	No

Name of child's school: _____ Grade: _____

Are there any school problems or concerns? If yes, please explain:

_____

_____

Teen concerns:

Smoking:	Yes	No
Alcohol:	Yes	No
Social/Recreational Drug use:	Yes	No
Sexual Issues:	Yes	No

Filled out by: _____ Relationship:_____
Signature:_____ Date: _____ Phone #:_____

Clinician Signature: _____ Date: _____

SuperKids Pediatrics Office Policies

9121 N Military Trail Suit 102, Palm Beach Gardens, FL 33410
Phone: 561-619-2460 ~ Fax: 844-886-3192

Appointment Policy

It is our intention to provide your children the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

In the Office

• **Arrive early**. Please remember that all insurances require that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim.

• **Schedule an appointment by calling 561-619-2460**. Walk-in patients are offered the first available appointment.

• **Schedule same-day appointments for ill visits.** Appointments are used on a first-available appointment basis.

• **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to reschedule your child's visit.

• **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment.

• **Late arrivals (>15 minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment may or may not be on the day the appointment was missed.

• **The no-show charge will be waived if you contact the office before your appointment.**

• **Appointments for additional children should be made by phone prior to coming to the office**. If you would like another child to be seen, please schedule appointments for both children by phone prior to coming to the office.

• **Turn off cell phones in the office and examination rooms.**

After-hours Call Service

• **Please limit after-hour calls to urgent issues only. For emergencies call 911**. For refills, appointment requests, and other no urgent matters, you may leave a message or call the office during regular hours. Please also do the following when using this service:

- When leaving a message, please speak slowly.

- Be sure to leave a callback number.
- Follow the doctor's instructions.

Vaccine Policy Statement

We will offer our patients immunizations following the Centers of Disease Controls and Prevention and American Academy of Pediatrics recommended schedule. We firmly believe that all children and young adults should receive all the recommended vaccines. However, we are more than happy to spend time with you in discussing available science behind each intervention, concerns, myth busting, defining different care paths, and how vaccines relate to diseases and preventive care.

Alternative Vaccine Schedule

You may wish to pursue an alternative schedule, even though this is not recommended by the Center for Disease Control and Prevention's (CDC) and your provider. If you should choose an alternate vaccine schedule for your child, please be aware that your insurance company may not reimburse you for vaccination or administration fees not completed while the "standard" well child check visit is done. In addition, you may be charged a copay for returning for an office visit to receive the vaccines. In all cases, whatever your insurance company does not cover will be your responsibility.

It is standard procedure for physician to submit claims for "illness" related evaluation which are done during a well exam schedule visit. This is not a new billing policy or procedure but rather a standard evaluation of a separate event a may require applicable copay based on the rules of your insurance.

We encourage all families to know as much as they can about their insurance plan, please check with your insurance company before proceeding.

We are here to provide the best care to your children should the need arise. If you have any questions, please do not hesitate to contact the practice manager at SuperKids Pediatrics. As always, we welcome the opportunity to care for your children and appreciate your trust in the services we provide.

I have read and agree to all the provisions of the above Office policies.

Signature of Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SuperKids Pediatrics
9121 N Military Trail Ste 102, Palm Beach Gardens, FL 33410
Phone: 561-619-2460 – Fax 561-828-9311

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

  _____

  _____

_____

Employee signature

SuperKids Pediatrics Financial Policy Patient's Name:_____

Thank you for choosing SuperKids Pediatrics as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that SuperKids Pediatrics will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and SuperKids Pediatrics. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact SuperKids Pediatrics at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 25% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ SuperKids Pediatrics will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify SuperKids Pediatrics if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

ASSIGNMENT OF BENEFITS: We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office. I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: SuperKids Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Parent / Guardian)

Patient Name:_____ Record Number:_____

Patient's Date of Birth:_____ Patient's SSN:_____

Purpose of Release

- ☐ Change in insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other

Type of Information

- ☐ 2 years prior from last seen
- ☐ Complete Medical Record
- ☐ Dates Other: _____
- ☐ Specific Information Request

The Information is to be provided to:

Name of Person/Organization/Facility: SuperKids Pediatrics – Lizaida Medina Candelaria, MD FAAP

Address: 9121 N. Military Trail Ste. 102, Palm Beach Gardens, FL 33410

Phone Number: 561-619-2460

Fax Number: 844-886-3192

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Under HIPAA with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.