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: _____

Guardian EMAIL: _____

PATIENTS ADDRESS: _____

City: _____ State: _____ Zip Code: _____

Preferred Method of Communication: __ Mobile # __ Home # __ Work # __ Email __ Mail

INSURANCE INFORMATION:

MEDICAL INSURANCE NAME AND TYPE: _____ or _____ No Insurance

Insurance ID: _____ Group ID: _____

GUARANTOR NAME: _____ RELATIONSHIP: _____

ADDRESS: _____Same as Patient or: _____

City: _____ State: ___ Zip Code _____ DATE OF BIRTH (*Guarantor*): __ / __ / __ SEX: M / F

DEMOGRAPHICS:

Preferred Language: _____

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

RACE:

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

Guardian (F or M)	**Guardian (F or M)**
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Address: _____	Address: _____
_____	_____
Cell #: _____	Cell #: _____
Occupation: _____	Occupation: _____
Work Phone: _____	Work Phone: _____
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: _____

How or where did you hear about SuperKids Pediatrics? _____

I consent to using all channels of communication provided and for all purposes. I understand that any charge billed to me by my communications carriers arising from SuperKids Pediatrics communications is my responsibility.

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 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 my insurance company (ies) to pay and hereby assign directly to SuperKids Pediatrics all benefits, if there are any, otherwise payable to me for his/her services. I understand that I am ultimately responsible for all charges related to services to my children.

Parent / Guardian

Print Name: _____ Date: _____

Signature: _____

PEDIATRIC HEALTH QUESTIONNAIRE

(One per patient)

Patients Name:_____ Age: ____ Birth Date:_____

PARENTS:

Name: _____ Age: ____ Relationship: Father / Mother / Other _____

Name: _____ Age: ____ Relationship: Father / Mother / Other _____

Who resides with child? _____ Pets at home? _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Birth History:

Complications during pregnancy? Yes No

Gestational Age: _____

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.

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 provoke? Runny nose, rash, anaphylaxis, GI symptoms, difficulty breathing, other: _____

Family History:

Please indicate family history and child's relationship of:

Asthma	___ Yes: Relation _____	Heart Disease	___ Yes: Relation _____
Allergies	___ Yes: Relation _____	Tuberculosis	___ Yes: Relation _____
Seizures	___ Yes: Relation _____	Diabetes	___ Yes: Relation _____
Deafness	___ Yes: Relation _____	Mental Retardation	___ Yes: Relation _____
Cancer	___ Yes: Relation _____	Slow Learner	___ Yes: Relation _____
High Cholesterol	___ Yes: Relation _____	Mental Illness	___ Yes: Relation _____
Thyroid	___ Yes: Relation _____	Substance Abuse	___ Yes: Relation _____

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

Developmental/Social:

Have you ever felt your child is slow in:
Development? ___ Yes ___ No
Speech/language? ___ Yes ___ No
Social skills? ___ Yes ___ No
Motor skills? ___ Yes ___ No
Does your child get along well with other children? ___ Yes ___ No

Name of child's school / day care (if applicable): _____ 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: _____

ACKNOWLEDGEMENT OF RECEIPT AND NOTICE OF PRIVACY PRACTICES

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 availability and receipt of the Notice.

Authorize Consent to Seek Medical Care

I have the legal right to consent to medical and surgical treatment because I am the parent/legal guardian of the patient(s). I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that the provider at SuperKids Pediatrics and their designated associates or medical assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the providers, nurses, physician assistants, and other health care providers at SuperKids Pediatrics to provide treatment as long as a physician / patient relationship exists, or until I or the office withdraw consent.

I acknowledge that I have received a copy of office's Notice of Privacy Practices and I Consent to Medical Care

_____ _____

Please print your name here *Signature (guardian)*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so**. <u>Please list below names(s) of the individual(s) you authorize our office to discuss care and/or you allow to bring in child for medical services</u>.** Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____ _____

_____ _____ _____

<u>*FOR OFFICE USE ONLY***</u>**

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, it was not possible to obtain an acknowledgement.
☐ We couldn't communicate with the patient.
☐ Other (Specific details provided on chart's patient case) _____

Office Team Name/Signature: _____

Office policy and financial agreement

• **Billing**. I understand that, as a courtesy, SuperKids Pediatrics has agreed to file my claim for services rendered to one insurance carrier. I further acknowledge that it is my responsibility to understand my insurance policy eligibility, coverage and limitations. I understand that SuperKids Pediatrics will collect all patient responsibility and balance at the time of service. I understand that any charge not covered by my insurance policy regardless of reason, is my responsibility. I understand that if my account is not paid in full within 60 days of a statement date, a 25% monthly collection late fee will be added to the outstanding balance, and it will be turned to collection for further processing. I understand that no additional services will be provided for delinquent accounts until they are brought current. I understand that I am ultimately responsible for all professional fees incurred for services and consults performed including but not limited to any co-payment set by my insurance carrier, any unsatisfied deductible or termination of coverage, any amount my insurance carrier deems my responsibility, any amount considered non-covered by my insurance carrier for any reason and any claim not process by my insurance carrier within 60 days of the date of service regardless if I agree with my medical insurance provider outcome. I understand that as a parent or guardian, I will continue to be responsible for all costs incurred for services rendered and fees and any delinquent bill and its payment in full as well as reasonable attorney fees and court costs. I further acknowledge a service charge of $40 for any return checks for any reason.

• **Divorced/Separated Parents**. I understand that SuperKids Pediatrics, specialize in pediatric primary medical care and will thwart any efforts to be used for the purpose of marital disputes. I acknowledge that SuperKids Pediatrics Is not a party to or bound by the divorce decree, custody agreement or other related agreements. The parent or guardian accompanying the patient at the time of service is responsible for patient balance and payment in full before services are rendered. I understand further that both parents will have access to the child's medical record, including patient portal account and visit summary, unless a court order is on file. I understand that providers and supporting staff will not allocate additional time to speak, report or clarify encounter justification or details, at a later time, with a parent that was not in attendance during the visit. I acknowledge the need to book additional appointments to address any concern that was not addressed by me during the actual visit.

• **No show or late arrivals** I UNDERSTAND THAT A $25 DOLLAR FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED AT LEAST WITH 24-HOURS ADVANCED NOTICE. I acknowledge that 10 minutes or more after scheduled appointment, is considered late arrival subject to no show fee. I understand that after a late arrival, the first available appointment may or may not be on the same day as the original appointment.

• **Appointments for additional siblings**. I understand that if I schedule an appointment with one child but request services for an additional sibling, the practice might not be able to accommodate an encounter with the same provider at the same time for my additional child. I understand that I need to schedule appointments ahead of time for all the children in need of service.

• **Insurance & Demographic Information**. I understand that it is my responsibility to update any demographic or insurance information prior to each visit and any consequence arising while billing my insurance. I understand that I need to have my insurance information with insurance card and active

policy at each appointment. It is my responsibility to provide SuperKids Pediatrics and my insurance company with all the information needed to process my claim for services in a timely manner.

• **No electronics, food, or smoking**. I understand that the use of cell phones, recording devices, radios, electronic devices, headphones, or ear plugs is not permitted in the examination rooms. I further understand that no food, drinking, smoking (cigarette or vaping) is allowed in the office.

• **After-hours Call Service**. I will limit after-hour calls to urgent issues only. I understand that for any emergencies I need to call 911. I understand that for refills, appointment requests, and other no urgent matters, I must call the office during regular hours so that they can be appropriately managed by the appropriate care team. I UNDERSTAND, ACKNOWLEDGE AND AGREE THAT AN AFTER HOUR FEE OF $35.00 MAY BE ACCESSED FOR THE CONVINIENCE OF THE AFTER HOURS SERVICE REQUEST.

• **Well Child Care (WCC) requirement**. I understand that WCC visits are a condition for primary care provider-patient relationship with SuperKids Pediatric. SuperKids Pediatrics require full commitment to all recommended WCC visits. These visits include but are not limited to encounters at 1,2,4,6,9,12,15,18, 24 and 30 months of life. One yearly visit thereafter. I further acknowledge that it is standard procedure for physicians to submit claims for "illness" related evaluations addressed during a scheduled well child examination visit.

• **Vaccine Policy Statement**. I understand that SuperKids Pediatrics recommends and firmly believes in the safety and effectiveness of vaccines to prevent serious illness and to save lives. I understand that my provider at SuperKids Pediatrics will discuss available science behind each intervention, concerns, myth busting, and how vaccines relate to diseases and preventive care. I understand that SuperKids Pediatrics does not accept new families who choose not to vaccinate their child. I understand that SuperKids Pediatrics require a limit of 24 months of life for vaccine compliance based on the vaccine schedule recommendations at 24 months. I understand that SuperKids Pediatrics will NOT request a temporary medical exemption on form DH680 from the Health Department for missing immunization based on guardian's vaccine refusal. I further understand the consequences if my child does not receive the recommended vaccine(s). I acknowledge and agree with any additional charges for immunization-only appointments that are not part of a Well Child Visit schedule.

• **Medical Forms and Letters.** I understand that SuperKids Pediatrics will address and provide forms and letters such as but not limited to school entry health forms, sport physicals, medical necessity, immunization, placement plan, and medication at school during the time of my child's visit. I acknowledge a minimum of $5.00 charge for forms requests later and understand the unavailability or unattainability in the case of a lapse in assessment.

I have read, understand and agree with all the provisions above. My signature below forms a legally binding agreement between SuperKids Pediatrics and me.

_____ _____

Name of Guarantor or Responsible Party Date

_____

Signature of Responsible Party

LEFT INTENTIONALLY BLANK

(PLEASE COMPLETE ONE RELEASE OF MEDICAL INFORMATION, FORM BELOW, PER CHILD)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

I hereby voluntarily authorize and request the disclosure of all information which you may possess relating to my examination and illness, including psychiatric, psychological information and information pertaining to AIDS, Human Immune Deficiency Virus Testing and any other medical problem which may be part of my medical records, covering the periods from birth to present.

Purpose of Release

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

Type of Information

- ✓ Complete Medical Record
- ☐ Specific Information Request:

_____

The Information is to be provided to:

Name Organization/Facility: **SuperKids Pediatrics**

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

Phone Number: 561-619-2460

Fax Number: 844-886-3192

_____ _____

Patient's Guardian Signature Date

_____ _____

Printed Name of Patient's Guardian Relationship to Patient

Under HIPAA, with patients' written requests, records must be provided within 30 days of a request.