Central Florida Pediatrics

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Welcome to Central Florida Pediatrics! This packet contains all the information you will need to get your child established with our practice.

Please complete the following forms and bring them with you to your first visit:

- 2023 Financial Statement and Authorizations
- Consent for Care- Complete this form if you intend for anyone other than a parent or legal guardian to have authority to give consent for treatment at our office. ***NOTE: Only a parent or legal guardian can bring a child for their initial visit.***. All forms that are signed by the person that has been given consent for treatment will be considered final, including demographic updates and financial policies.
- Patient Health History- BOTH pages need to be completed.
- Consent for Release of Confidential Records- This form is needed to request copies of medical records from the child's previous physician, place of treatment, if any or the hospital the child was born in.
- Consent for Email and Text- This form allows us to text or email you appointment confirmations.

You will also need to bring:

- A photo identification (i.e. driver's license), with your current address
- Your insurance card- If you have a newborn, you must add the baby to your policy within 30 days.

If you have any questions regarding this information, please contact our office. We look forward to seeing you soon!

Sincerely,
Central Florida Pediatrics

Central Florida Pediatrics

2023 Financial Statement and Authorizations

Financial Responsibility: Payment is due in full at the time services are rendered, regardless of divorce decrees or if the party accompanying the patient is not the parent/guardian. **If payment is not made in full at the time of service, a $25 nonpayment fee will be assessed.** If a check is returned from the bank, a $25 returned check fee will be assessed.

Insurance Plans: We will submit claims to primary insurance companies with which we are participating providers. **We do not bill secondary insurance companies**. It is the parent's responsibility to pay any balances not paid by their primary insurance and file a claim directly with any secondary insurance. We cannot send claims to any insurance company we are not contracted with, including Medicaid and auto insurance companies. Parents/guardians are ultimately responsible for all charges incurred if an insurance company does not pay within 60 days or if the services are not covered on the patient's insurance plan. Our office will attempt to verify the medical coverage as a courtesy; however this is not a guarantee of coverage or payment by the insurance company. It is the sole responsibility of the parent/guardian to understand the patient's coverage, including maximum benefits, copays, or deductibles, as well as provide our practice with current insurance information.

Newborn Enrollment: It is essential that you contact your insurance plan to enroll your newborn onto your policy within the first 30 days of your baby being born. It often takes a few weeks for the baby to show up on the plan as a covered member. After 30 days many insurance carriers do not pay for services provided if the newborn has not been added to the policy. If the newborn is not added within 30 days then full payment for services will be collected at the time of service until the newborn is showing active on your insurance plan.

Account Balances: Our office sends statements once a month for any unpaid balances to the address on file. It is the parent/guarantor's responsibility to update contact information, including addresses and/or phone numbers. Any balance that becomes past due will be considered for referral to a collection agency at which point our practice will no longer provide medical care to the patient and siblings. It is the parent's responsibility to pay all collection fees (typically 40% of balance) and any court fees related to collection of past due balances.

Appointments: Any appointment not cancelled 24 hours prior to the appointment time will be considered a missed appointment and a $25 fee may be assessed. Two or more missed appointments on an account (which consists of all patients in the family), may result in dismissal from our practice. This fee is not covered by insurance plans.

Continuity of Care: All children should be evaluated by their primary care physician, as part of a routine physical, according to current AAP guidelines. We require all of our patients to follow these guidelines so that we can monitor their development and growth. Failure to do so may result in dismissal from our practice.

After Hours Phone Calls: Our office provides a triage service for any concerns that parents/guardians may have after hours. However, there may be a $20 fee per call for use of this service to offset our cost. This fee is not covered by insurance plans. Many insurance companies offer a 24-hour nurse hotline for concerns after our normal office hours.

Saturday Appointments: There will be an additional $25 fee assessed for weekend or evening appointments.

Prescription Refills and Forms: Please contact our office during normal business hours for any prescription refill requests. Allow 24-48 hours for these requests to be completed. Forms will be completed within 48-72 hours of the request, including physical and immunization forms. For completion of any non-routine forms and letters, you may be charged a $25 fee. Medical records will be released within 10 working days after we receive the authorized request.

Consent: I hereby give consent to Central Florida Pediatrics to provide the necessary treatments for my child(ren)'s medical care. I have received a copy of the Privacy Policy. I authorize Central Florida Pediatrics to use or disclose pertinent information to coordinate my child(ren)'s medical care. I authorize payment for covered healthcare services performed to be paid to Central Florida Pediatrics.

I give my permission for Central Florida Pediatrics to leave phone messages regarding my child(ren)'s medical information, laboratory results, test results, or appointment information. If I choose to restrict Central Florida Pediatrics from leaving messages at the phone number on file, I will notify the practice.

PARENT/LEGAL GUARDIAN ACCEPTANCE OF THESE POLICIES

_____	_____
Signature	Date
_____	_____
Print Name	Relationship to Child(ren)
Child's Name: _____	Date of Birth: _____
Child's Name: _____	Date of Birth: _____
Child's Name: _____	Date of Birth: _____

Central Florida Pediatrics

CONSENT FOR CARE

I, _____, the parent/legal guardian of the following patients:

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

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

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

hereby give authorization for the following people to bring my child to Central Florida Pediatrics and to discuss my child's medical conditions, past and present, and give consent for any treatment deemed necessary.

Name: _____ Expires: _____

Name: _____ Expires: _____

Name: _____ Expires: _____

_____ _____
Signature of Parent/Guardian Date

FOR OFFICE USE ONLY:

_____
Print Employee's Name

_____ _____
Employee's Signature Date

_____
Parent I.D. Expiration Date

Central Florida Pediatrics
735 Primera Blvd., Ste 135 • Lake Mary, FL 32746 • (407) 321-0085 • Fax (407) 328-7658
2881 Wellness Avenue • Orange City, FL 32763 • (386) 917-0450 • Fax (386) 917-0457

PATIENT HEALTH HISTORY

Date: _____ Child's Name: _____ D.O.B.: _____

Sex: ☐ M ☐ F Race: _____ Primary Language: _____

PATIENT HISTORY

Birthplace: _____ Hospital: _____ OB: _____

Delivery: ☐ Vaginal ☐ C-Section Full Term: ☐ Yes ☐ No # Weeks_____ Birth Weight: _____

Has the patient ever had (please check all that apply):

☐ Adenoidectomy
☐ Allergies
☐ Anemia
☐ Appendectomy
☐ Asthma
☐ Blood Transfusion
☐ Broken bone(s)
☐ Other _____
☐ Cancer
☐ Chickenpox _____
☐ Concussion/head injury
☐ Chronic ear infections
☐ Diabetes
☐ Ear tubes
☐ Hepatitis
☐ Mental Disorders
☐ Mononucleosis
☐ Nervous Disorders
☐ Neurologic Disorders
☐ Pneumonia
☐ Seizure Disorders
☐ Tonsilectomy
☐ Urinary Infections
☐ Allergic reaction to any medications (list):
_____
_____
_____

Please list previous physicians familiar with child's medical history: _____

FAMILY HISTORY

	Name	DOB	Sex	If living– list all medical conditions	If deceased– list cause of death	Age at death
Father						
Mother						
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			

Has anyone in the immediate or extended family had (please check all that apply):

Illness	Who?	Illness	Who?
☐ AIDS	_____	☐ High Blood Pressure	_____
☐ Blood Disorders	_____	☐ Mental disorders	_____
☐ Cancer	_____	☐ Neurologic disorders	_____
☐ Diabetes	_____	☐ Thyroid problems	_____
☐ Heart Conditions	_____	☐ Tuberculosis	_____
☐ Hepatitis, Type ____	_____	☐ Other _____	_____

Does anyone in the household smoke? ☐ Yes ☐ No

Information provided by: _____ Relation to child: _____

Thank you for providing this information. If there are any items not listed on this form which you feel are pertinent to the care of your child, please feel free to review them during your visit.

PATIENT HEALTH HISTORY - PAGE 2

Child's Name:		DOB:	
Demographic Information			
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer

Guardian / Step parent information (please circle one)		
Last name	First name	DOB
Last name	First name	DOB
Emergency Contact (Other than the parent of the child)		
Last name	First name	Phone number
Last name	First name	Phone number

Medical staff only below this line	
Hospitalizations/ Surgeries	**Allergies**
Specialists	**Medications**

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735 Primera Blvd #135, Lake Mary, FL 32746 ~ Ph: 407-321-0085, Fax: 407-328-7658

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Current phone number: _____

RELEASE MEDICAL RECORDS FROM:
Name: _____
Address: _____
_____
Ph: _____ Fax: _____

RELEASE MEDICAL RECORDS TO:
Name: _____
Address: _____
_____
Ph: _____ Fax: _____

Medical records requested from dates: _____ to _____

Purpose/Need for Information
☐ Changing physicians ☐ Moving ☐ Specialist ☐ Insurance information
☐ At the request of the parent/guardian ☐ Other: _____

Specific Documentation Required:
☐ All medical records ☐ Specialist notes
☐ Immunizations/vaccines ☐ Laboratory reports
☐ Other: _____

I authorize the release of medical records ***with the exception*** of the following (please check all that apply)
☐ Mental health ☐ HIV/AIDS ☐ Drug/alcohol use ☐ Genetic testing

Signature: _____ **Date:** _____
Print name: _____ **Relationship:** _____
Contact phone number: _____

******If parent or guardian is mailing or faxing this form to the office, you must also provide a copy of your picture ID. We cannot release medical records without verifying the signature on the release.***

For office use only Witness: Date:

This request is authorized to include any Federal and/or State protected information under Florida Statues 394.459(9) Psychiatric Information. 397.053/396.112 Drug and/or Alcohol Abuse Information. 381.609 HIV and AIDS related conditions and/or 397.501(3) records of a minor client.

I understand that this authorization will expire one year from the date of signature and/or may be revoked earlier by my request in writing. Revocation has no effect on prior action taken under direction of the signed dated consent for release. If I refuse to sign, my treatment, payment, enrollment or eligibility for benefits will not be affected. All records obtained will be used solely for professional purposes. PHI obtained may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. I understand that a copy of this relase is as valid as the original and I am entitled to a copy after I sign it. I hereby release Central Florida Pediatrics, its employees, staff, & representatives from all liability relating to or arising out of this release of information.

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Consent to Email and/or Text

We now have the ability to email and/or text you which will allow us to streamline communication and take up less of your time with voice calls. Please select one of the following:

☐ **I consent to receive emails and/or text messages for upcoming appointment reminders, notifications of well child exams due, requests to obtain feedback on your experience with our healthcare team or other healthcare communications at the following email and/or cell phone number from Central Florida Pediatrics:**

☐ **I <u>DO NOT</u> consent to receive emails and/or text messages.**

Cell phone number: (_____) _____-_____ Parent initials: _____

Email address: _____ Parent initials: _____

I understand that this consent to receive emails and/or text messages will apply to all future appointment reminders, notifications, feedback requests and general health information for the patients listed below **unless I request a change in writing**:

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

_____ _____

Signature of Parent/Guardian Date

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