PREMIER PEDIATRICS
PATIENT REGISTRATION

Patient Information

Patient's Legal Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
First Middle Last

Address: _____ Apt. _____ Home Phone: (_____)_____

City: _____ State: _____ Zip Code: _____ SS# _____

Race: Select Ethnicity: Select Primary language: Other

Child is living with: (check one) ☐ Both Parents ☐ Father ☐ Mother ☐ Parent & Step Parent ☐ Other _____

Are Parents: (check one) ☐ Married ☐ Single ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Are there any other significant adults involved? If so, who are they? _____

Family Information

Father	**Mother**
Name: _____	Name: _____
SS# _____ DOB _____	SS# _____ DOB _____
Home Phone: (_____) _____	Home Phone: (_____) _____
Work Phone: (_____) _____	Work Phone: (_____) _____
Cell Phone: (_____) _____	Cell Phone: (_____) _____
Email: _____	Email: _____

Emergency Contact Information (A local person other than Parents or Guardians)

Name: _____ Relationship to Patient: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____)_____

We appreciate referrals. Whom may we thank for referring your family to our office? _____

IMPORTANT! Please read and sign the other side of this form.

PREMIER PEDIATRICS

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

Consent is hereby given to perform any and all examinations, tests, procedures and treatments necessary and or advisable; and in an emergency, without the presence of parents or responsible adults. I hereby authorize examination and treatment of the above named child by the physician, any assistants or designees deemed necessary by the physician. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice. If I cannot bring my child (ren) , the persons listed bellow will have the authority to bring in and authorize treatment :

Name:	Relationship to patient:
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Any person, not listed above must have a dated and signed letter of consent from myself, or treatment could be refused or delayed. I understand that in unusual circumstances, efforts will be made to contact me prior to rendering of treatment, but that medical treatment will not be withheld if I can not be reached. This authorization will remain in effect unless so designated that such consent for treatment of a minor is cancelled. I have read all the information on this sheet and have completed all the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Premier Pediatrics, LLC. of any changes to this information in the form of a signed and dated letter.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS

☐ I authorize Premier Pediatrics, LLC. to file insurance claims for services and supplies rendered to and for my/our child (ren).

☐ I authorize Premier Pediatrics, LLC. to release information, including my/our child (ren) medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the Internet.

☐ I authorize that payment of all third party benefits otherwise payable to me be made directly to Premier Pediatrics, LLC.

☐ I assign to Premier Pediatrics, LLC. all payments for medical services and supplies provided to my dependent child(ren).

☐ I understand that I am financially responsible to Premier Pediatrics, LLC. for the above named patient (s). If my insurance company fails to fully compensate Premier Pediatrics, LLC. any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 30 days after notification from Premier Pediatrics, LLC. and or a billing company acting on its behalf.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

☐ I understand that Premier Pediatrics, LLC cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided.

☐ I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

I UNDERSTAND I HAVE A RIGHT TO REVIEW NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THIS NOTICE IS POSTED IN THE LOBBY AND MADE AVAILABLE AT ALL TIMES. THIS NOTICE OF PRIVACY PRACTICES DESCRIBES MY RIGHTS AND INTERNAL MEDICINE PRACTICES' DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. BY SIGNING BELOW, I CERTIFY MY AGREEMENT AND ACCEPTANCE OF THE ABOVE.

Patient Name _____ **DOB** _____

Parent/Guardian Signature _____ **Name** _____ **Date** _____

PREMIER PEDIATRICS, LLC

Office Policy (*Rev 12/01/2019*)

Patient name: _____ ***DOB:*** _____

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully.* If you have any questions, do not hesitate to ask a member of our team.

Office Etiquette:

1) We reserve the right to discharge any patient who is rude or offensive to our staff, providers, or other patients/parents.

2) We must remain neutral in any custody battle situation between parents and will not choose any sides.

Appointments:

1) If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $25 for missed appointments or not canceled appointments within 24 hours.**

2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

4) We will make every effort for you to see the provider of your choice but under certain circumstances it may not be possible. We strive to provide the quickest, quality service with minimal wait time.

Financial Responsibility:

Please note that we provide services to our patients, not to the insurance companies, and our patients are responsible for the payments. If for whatever reasons your child's insurance company denies paying us, you will be required to pay.

Insurance Pay patients:

1) If your child is covered by a commercial insurance plan that we accept, we will file a claim to your carrier. You will be expected to pay any co-pay, co-insurance, non-covered services, and or any deductibles at the time of service. A **$10 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.

2) It is your responsibility to keep us updated with your correct insurance information. If your child is covered under a Medicaid plan, please be aware that you have to choose one of our providers as the primary care physician, this can be done by informing your insurance company and providing them with the correct information. If your child has a secondary insurance that we were not informed of, or the insurance company you designate is incorrect, you will be responsible for payment of the visit.

3) Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment. It is your responsibility to understand your benefit plan with regard to, for instance, covered services including referrals and prior authorizations, and participating laboratories.

4) When your child comes for a well visit and is found to have any sickness/problems and our providers had to address the sick condition by providing counseling and/or prescription and/or specialist referral, it will be considered a "Sick/Well" visit and billed accordingly. The opposite is also true - if your child comes in for a non-life-threatening sick visit and found to be due or overdue for well visit, it will be done also. You are required to pay applicable co-pay/deductibles, for the sick portion of the visit.

Self-pay patients:

1) Self-pay patients are expected to pay for services in FULL at the time of the visit. We offer discounted sliding scale rates for patients without insurance.

2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for possible reimbursement.

Statements/ Previous balance/payment info

1) Except for rare exceptions, generally we do not mail statements but send them electronically. We expect you to pay within **10** business days. There is an 18% annual (1.5% monthly) interest charge for past due balances.

2) If previous arrangements have *not* been made with our billing department, any account balance outstanding longer than 28 days will be charged a **$5 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collections agency and a fee will be charged.

3) A **$30** fee will be charged for any checks returned for insufficient funds and payment is expected within 7 days or it will be turned over to the District Attorney's office.

Well Visit / Immunization:

1) We follow AAP (and your insurance company's) age specific well visits and immunizations guidelines. Well visits must be done irrespective of whether you want to immunize your child or not. ***Frequent missing of well visits may lead to discharge from our practice as this decreases our quality scores with your insurance plan.***

2) We strongly recommend immunization of your children. If you choose not to immunize your child, you are required to sign vaccine refusal forms as requested by our staff and assume all risks associated with non-immunization.

Quality Measures (HEDIS):

1) As per insurance quality guidelines we cannot order a test or send to a specialist as per your request. It must be justified by a medical diagnosis. Also, we are required to report timely well visits, immunizations, BMI and obesity counseling.

2) We are also expected to reduce specialist visits, expensive prescriptions, and unnecessary procedures.

School Excuse:

Excuses are given for the days when the patient is seen or if authorized by our providers to keep the child home for certain days. If we didn't see the child during an acute illness, we cannot give any excuse retroactively for an extended period.

Forms:

1) Forms are completed for those whose accounts are in good standing. Delinquent accounts must be brought current before forms will be released. Forms must be paid for before they are released. Payment is due when the forms are dropped off.

2) Blank forms will not be accepted - you are responsible for completing your child's personal information as much as possible so that our Providers can focus on the clinical part of it.

3) There is no charge for blue or yellow forms given at the time of your child's visit. This is considered part of the visit. However, should you lose your form; there will be a **$1** charge per form to replace them.

4) Any additional school, camp, or sport forms are subject to a **$5** per form fee.

5) We require a **48**-hour turnaround time.

Transfer of Records:

1) If you transfer to another physician, we will send your medical records upon their request with appropriate authorization from you, free of charge.

2) If you are the legal guardian and need a copy of your child's records for yourself, there will be a **$1** per-page fee for the first 25 pages and **0.25** cents.

3) We only provide copies of records (including consultations from specialists) rendered here. For any previous records, you must request them directly from your previous doctor(s).

Referrals:

1) Referrals are done only after the patient has been seen in our office for the condition the referral is being sought.

2) If your child is being managed by a specialist and getting certain medications, formula, or services, without any documents from the specialist we won't be able prescribe them.

Prescription Refills:

1) ADHD stimulant medication refills are done only during monthly office or telemedicine visits. Lost prescriptions are not filled until due time.

2) If we suspect any medication diversion, we will not continue prescribing the same medications.

3) We generally do not prescribe narcotic pain medications or controlled anxiety medications.

4) All other maintenance medications (i.e. asthma, allergies, and bedwetting, etc.) are refilled only if the child has been seen within 3 months. If not, an appointment is needed before refills can be prescribed.

5) No antibiotics are prescribed or refilled without a patient evaluation in our office.

Prior authorizations:

We submit all prior authorization requests to the insurance companies in a timely manner. Approval or denial by the insurance companies solely depends on them and we are not able to give you any timeframe as to how long it will take.

I have read and understand this office policy and agree to comply with these guidelines, and I accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____ **DOB:**_____

Parent/Legal Guardian Name: _____ **Relationship**_____

Signature: _____ **Date**_____

PREMIER PEDIATRICS NEW PATIENT HISTORY FORM

Name: _____ Date: _____

Form filled out by: Mom Dad Legal Guardian

Past Medical History:

Birth History: Vaginal delivery C-section Weight: _____ Premature: ____ Wks. NICU stay: ____Wks.

Any delivery complications? No Yes: _____

Abnormal Health History? No Yes: _____

Overnight Hospital stays? No Yes: _____

Any surgery? No Yes: _____

Any Developmental delay? No Yes: _____

Any known allergies? No Yes: _____

On any medications now? No Yes: _____

Psycho-Social Stressors? No Yes: _____

Family History: Any significant health problems in the family (Mom, Dad, Grandparents)?

No Yes: _____

Social History: Biological child Adopted Foster care Group home: _____

Daycare School: ____ Grade Homeschool: ____ Grade Smoking inside the house/car

Lives with: Mom Dad Grandparents Foster Parents Other: _____

Has this child ever been removed from home (been in foster care)? No Yes: _____

Anything else we should know?

_____

_____

_____

Parent/Guardian Name: _____ Signature: _____

PREMIER PEDIATRICS
CONSENT FORM

Please list all physicians (s) names and fax numbers the records to be released from:

Physician name:	Address:	Phone #:	Fax#:

Please mail records if more than 10 pages

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information to: **Premier Pediatrics LLC**
7960 SW 60th Ave, Ocala, FL 34476
Phone: 352-671-6741 Fax: 352-671-6742

Reason(s) for this authorization (check all that apply):

☐ at my request to provide continuity of care

☐ other (specify) _____

☐ This authorization ends on (date) _____

☐ Indefinitely

II. My Rights

I understand that the release or transfer of the information specified to any person or entity not specified above is prohibited. An additional written consent must be completed for any proposed new use of the information or for its transfer to another person. I release and hold harmless Premier Pediatrics LLC and the physicians of the medical practice from all liability that may arise from complying with this authorization.

☐ I understand that the medial records may contain medical and administrative information from other health care providers.

☐ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization.

☐ I understand that the medical records may contain medical and administrative information from other health care providers.

☐ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

☐ I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

X_____ _____
Patient or legally authorized individual signature Date

X_____ _____
Printed Name if signed on behalf of the patient Relationship

Last revised: June 2014

Authorization for non-biological parents/guardians/caregivers

If you are a non-biological parent/guardian/caregiver, you are required to bring the following signed authorization from the biological parents/legal guardians to your patient's first visit. If parents are divorced or separated and have shared custody, each parent must fill out a separate form. If one parent is not involved in the child's care, the involved parent needs to provide proof of full custody.

Person giving the authorization:_____ DOB _____

Relationship to the patient: _____

I am authorizing (name of person being authorized_____, DOB _____, to bring my child(ren) named below to Premier Pediatrics for medical care. This person is also authorized to take decisions on behalf of the child(ren) regarding his/her/their medical care, as well as access medical records if needed.

_____

_____

_____

_____

Is this person also financially responsible for this child's care at our facility? Please check one.

Yes☐ No, I am responsible for any financial obligations or insurance issues ☐

Signature of the person giving the authorization: _____Date

Signature of the authorized person: _____Date