Ocoee Pediatrics

Patient Registration Form

- Patient Information:

Name_____ Date of Birth _____ M F Doctor _____Address: Same as primary guardian? Y N If No, who does this child live with?

_____

Race: White Black/African American Asian American Indian/Alaskan Native Not Provided

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Not Provided Preferred Language:

- Primary Parent/Guardian: Please list parents/guardians separately regardless of marital or custodial status

Name _____SSN#_____ Date of Birth_____

Address_____City_____ State _____Zip_____

Please check box of preferred phone method for reaching you

Home Phone_____ Cell Phone_____Email_____

Marital Status: please choose all that apply

Married to_____ Divorced/Sep. from_____ I have full custody Shared custodyN/A

Relationship to Patient(s) _____ I am the individual filling out this form Financially Responsible

- Secondary Parent/Guardian:

Name _____SSN#_____ Date of Birth_____

Address_____City_____State_____Zip_____

Please check box of preferred phone method for reaching you

Home Phone_____ Cell Phone_____Email_____

Marital Status: please choose all that apply

Married to_____ Divorced/Sep, from_____ I have full custody Shared custody N/A

Relationship to Patient(s) _____ I am the individual filling out this form Financially Responsible

- Other Parent/Guardians/Emergency Contacts:

Name_____Cell Phone_____

Relationship to patient(s) Step Parent, Married to_____ DCF Caseworker Other_____

Name _____Cell Phone_____

Relationship to patient(s) Step Parent, Married to_____ DCF Caseworker Other_____

Siblings:

Name_____DOB_____ Lives with patient

Name_____DOB_____ Lives with patient

Name_____DOB_____ Lives with patient

Name_____DOB_____ Lives with patient

- Pharmacy Information

Name_____

Address/Crossroads_____

Phone_____

- Insurance Information____

Primary Insurance Company_____

Member ID#/Group # _____

Subscriber Name_____ DOB_____

Note: If secondary insurance applies, please provide that information below. Both insurance parties must be made aware that the other exists. If they do not, please contact necessary parties. Medicaid is always secondary to commercial insurance.

Secondary Insurance Company_____

Member ID#/Group #_____

Subscriber Name_____ DOB_____

Pharmacy Authorization:

I hereby authorize Ocoee Pediatrics to electronically send prescriptions to a participating pharmacy of my choice. Ocoee Pediatrics may electronically receive information regarding my child's prescription history, drug interactions, prior authorization requirements, or requested substitutions. _____ Initial

Authorization and Consent for Treatment, Assigning of Benefits, Financial Responsibility, HIPAA Acknowledgment:

I hereby authorize Ocoee Pediatrics to provide medical services to the above named patient and to use and release medical information as required for treatment and health care operations. I hereby authorize Ocoee Pediatrics to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Ocoee Pediatrics all benefits for service rendered. I understand that failure to make insurance co-payments at the time of service will result in additional charges. I have received or reviewed a copy of the current Notice of Privacy Practices.

_____ Initial

Signature_____

Printed Name_____

Date_____

Ocoee Pediatrics

PLEASE READ CAREFULLY PATIENT-DOCTOR AGREEMENT

Missed/Changing Appointments

We schedule appointments according to urgency and availability.
In order to receive the maximum benefit from care; it is important to adhere to this schedule. Please arrive at, or just before, your appointment time.
If you find that you are running late, please call our office to determine if we can hold your appointment.
If for any reason you are unable to keep your scheduled appointment, you must give our office 24 hour notice or you will be charged a $50.00 service fee.
Patients that miss 3 appointments without cancellation will be discharged from this practice.

_____ Initial

Office Policy

No food or drink (excluding water) in the office.
No cell phone use allowed while interacting with the staff or physicians.

_____ Initial

Insurance Authorization and Assignment of Benefits

I authorize and request that insurance payments be made directly to this office and any medical payment from the patient's insurance for services rendered.
Patient understands that if she/he suspends or terminates care, any fees for services rendered to patient will be immediately due and payable.

_____ Initial

Payment Policy

I acknowledge full financial responsibility for services rendered and I understand payment for services are due on the day of service.
This includes co-payments and payment for medical forms.
Any balance that is left unpaid for over two billing cycles is subject to a $10.00 late fee.
This late fee will be applied to any unpaid amount.
If a check has been written for payment and the check is returned for insufficient funds, there will be a $35.00 fee added to your current balance.

_____ Initial

Communication

We are here to serve you. Please speak to us about any concerns that may arise at any time. By communicating how you are experience care in our office, you enable us to provide you with the best care possible. Thank you!

By signing below, I indicated that I have read the above policies and agree to the applicable conditions. I consent treatment, financial responsibility and insurance authorization.

Patient portal is available to access your information, limited medical records and forms.

_____
Parent Printed Name

_____ _____
Parent Signature Date

Ocoee Pediatrics **Delegation of Consent**

Name of Patient _____

Patient's Date of Birth _____

I hearby authorize (when I am unavailable to give consent) to the following individual(s):

_____ Name of person	_____ Relationship to child
_____ Name of person	_____ Relationship to child
_____ Name of person	_____ Relationship to child
_____ Name of person	_____ Relationship to child

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Florida. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (if 18 years or older) _____

Relationship to Patient _____

Date _____

Witness _____

Translator/Reader (if applicable) _____

Authorization to Obtain Medical Records

Records to be Released To

Ocoee Pediatrics
1551 Boren Drive, Suite A
Ocoee, FL. 34761
P: 407-395-2037 F: 407-395-2038

Records to be Released From

Office/Doctor _____

Address _____

Phone/Fax_____

Patient Information

Patient Name_____

Address_____

Date of Birth_____ Phone Number_____

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
6. This authorization shall expire upon my written request to revoke or according to state law;
7. A copy of this Authorization is valid as the original

_____

Signature of Patient or Patient Representative Date

_____

Description of Representative's Authority to Act for Patient