Celebration Pediatrics

PATIENT REGISTRATION

DATE: _____ **CHART # / OFFICE:** _____

1. PATIENT'S NAME: _____
LAST FIRST MI DATE OF BIRTH SEX

2. PATIENT'S NAME: _____
LAST FIRST MI DATE OF BIRTH SEX

3. PATIENT'S NAME: _____
LAST FIRST MI DATE OF BIRTH SEX

4. PATIENT'S NAME: _____
LAST FIRST MI DATE OF BIRTH SEX

CHILD LIVES WITH: _____ BOTH PARENTS _____ MOTHER _____ FATHER OTHER, PLEASE SPECIFY _____

PRESENT INSURANCE CARD

POLICY HOLDER NAME: _____ RELATIONSHIP TO PT: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

HOME #_____ WORK#_____ CELL# _____ DOB: _____SS#_____

EMPLOYER: _____ OCCUPATION: _____

FATHER'S NAME: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

HOME #_____ WORK#_____ CELL# _____ DOB: _____ SS#_____

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

MOTHER'S NAME: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

HOME #_____ WORK#_____ CELL# _____ DOB: _____ SS#_____

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF PERSON BRINGING CHILD IN

NAME: _____ **RELATIONSHIP:** _____

ANY CHANGES TO HIPAA FORM? YES _____ NO _____ IF YES, A NEW HIPAA FORM MUST BE COMPLETED.

ANY CHANGES TO FAMILY MEDICAL HISTORY? YES _____ NO _____ IF YES, A NEW HISTORY FORM MUST BE COMPLETED.

I AM AWARE OF THE NO SHOW, AFTER HOURS/WEEKEND AND TELE-CARE FEES. YES _____ NO _____ IF NO, A NEW FORM MUST BE COMPLETED.

I here by assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance and other health plans to: Celebration Pediatrics, P.A. This assignment will stay 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 whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____
Parent/Legal Guardian Signature **DATE**

Celebration Pediatrics Billing and Financial Policy

If you have insurance, we will file the claim and bill your provider. However, patients are responsible for any required deductibles, co-payments or outstanding balances. Payments are expected at the time of visit. If you are self pay, total payment is due at time of service.

Billing Information:

We will provide insurance claim filing for the insurance plans with which we participate. If there is a balance due after payment is rendered by the insurance company, we will expect payment within 30 days. Claims denied by insurance become patient responsibility.

It is the patient's responsibility to provide us with current insurance plan information prior to services rendered in order for accurate billing of services to be filed. You are also responsible for contacting your insurance company to make sure we are in network with your particular plan.

It is important for the patient to be familiar with the guidelines of their insurance plan requirements regarding authorizations, deductibles, co-payments and other vital requirements.

It is the patient's responsibility to obtain any referrals your insurance may require that may pertain to your office visit **PRIOR** to your scheduled visit. Failure to do so will result in the need to reschedule your appointment and a potential $25.00 late notice rescheduling fee.

A $25.00 returned check fee will be assessed to your account for any returned checks.

No Show Policy:

The Office policy is to charge a $25.00 fee for any "NO-SHOW" or same day CANCELLATION on same day SICK appointments. All future appointments require a 24 hour cancellation notice PRIOR to the appointment or the $25.00 fee will apply.

Tele-Care Call Policy:

All calls after normal business hours requesting medical advice will be referred to the Arnold Palmer's Tele-care Nurse Program. There is a **$20.00 fee per** call for this service. ***This fee becomes patient responsibility as it is a service that is NOT covered by any insurance plan.***

I have read the Financial Policy and agree to be bound by its terms.

X_____ Date_____

Print name_____ Date of birth_____

Celebration Pediatrics Associates, P.A.
Authorization To Release Or Use Information For Treatment, Payment or Health Care Operations

I _____(Guardian's Full Name) , hereby authorize the release or use of my dependents individually identifiable health information (PHI-"Protected Health Information") and medical record information by Celebration Pediatrics Associates, PA, in order to carry out treatment, payment, or health care operations on behalf of the patient: _____(Patient's Full Name) _____(Date of Birth). You should review the Celebration Pediatrics Associates, PA Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your dependent's PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my dependent's PHI and medical record information, confirm or change appointment times and speak to the office on my dependent's behalf with the following individuals who are my family members, legal representatives, guardians, healthcare surrogates, or have power of attorney:

_____	_____	_____
Name	Date of Birth	Relationship
_____	_____	_____
Name	Date of Birth	Relationship

Any additional individuals should be listed on the back of this form if needed.

I agree and have been given notice that the Practice may also disclose the following types of information contained in my dependent's medical record to the appropriate authorities as we are required by Florida State Law §384.25. (Please initial all categories below):

_____ HIV/Aids Information _____Mental Health Information _____Substance Abuse Information

_____ Sexually Transmitted Disease Information _____ If Patient is under the age of eighteen (18), Pregnancy Information

I understand that if the practice needs to contact me, it will be via the primary phone number listed in my guarantor file. I agree to keep this number updated at all times and understand that my dependent's demographics are my responsibility. I acknowledge that I can update demographics through several sources. I can update them in the office directly, through a call to the phone center, or through my dependent's patient portal. Should the Practice need to communicate with me and my phone is unavailable, after 3 attempts a certified letter will be sent through the mail. I elect for correspondence to be directed to me in the optional form of: email or fax (Please Circle one) fax number or email to be used: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat your dependent if you (or an authorized representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the authorized party to act on the behalf of the Patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM/PM

X_____

Signature of Guardian or Authorized Representative

Please describe your relationship to the Patient and include a description of the Representative's authority to act on their behalf:

_____

Celebration Pediatrics Associates, P.A.

Patient Questionnaire – Please fill out one Questionnaire per child

Patient Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

PAST MEDICAL HISTORY (For Patient being seen today)

1. Any allergies to medications? Yes No
   If yes, then what are the symptoms and what happens? _____
2. Any Medications taken, if so, dosage? Yes No
   Medication: _____ Dosage: _____
3. Any Ear Infection? Yes No
4. Any pneumonia? Yes No
5. Has your child required any breathing treatments in the past? Yes No
   If yes, what kind? Saline Albuterol Pulmicor T Other: _____
6. Any urinary tract infections? Yes No
7. Any serious Accidents? Yes No
   If yes, details of accident and date (please use back of page if necessary): _____
8. Any operations?
   If yes, type and date: _____

FAMILY HISTORY (Please check and give relationship to your child)

Allergies/Hay Fever	_____	Diabetic Mellitus	_____
Asthma	_____	Kidney Disease	_____
Bleeding Disorder/Hemophilia	_____	Lung Disease	_____
Cancer-Children	_____	Mental Retardation	_____
Cancer– Adults	_____	Seizures	_____
Cardiac Death < 50 years	_____	Thyroid Disease	_____
Cystic Fibrosis	_____	Tuberculosis	_____

SOCIAL HISTORY (Please check and give details)

Siblings Name and Ages:

_____ _____

_____ _____

_____ _____

_____ _____

Parents are (circle one): Married Divorced Separated Single

Parents Occupation:

Mother: _____

Father: _____

BIRTH AND DEVELOPMENT

Birth Weight _____ Delivery: Vaginal or Caesarean If Caesarean, please give the reason: _____

At delivery, how many weeks gestation was the child: _____ Was oxygen needed at birth? _____

Were there any problems during the birth? If so, please describe: _____

Did the mother use any cigarettes, alcohol, recreational drugs or medications during the pregnancy? If so, what: _____

Was the child jaundice? _____ Age the child first walked? _____ School or Daycare attended: _____

THANK YOU FOR YOUR HELP