Celebration Pediatrics

1530 Celebration Boulevard, Suite 301, Celebration, Florida 34747
Phone (407) 566-9700 Fax (877) 534-5105

Patient Information/Información del paciente

Last Name/Apellido:	First Name/Primer Nombre:	Middle Name/Segundo Nombre:	Sex/Sexo:	DOB/Fecha de Nacimiento:

Race: ☐ African American ☐ Asian ☐ Native American/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
Ethnicity: ☐ Latino/Hispanic ☐ Not Latino/Hispanic
Primary Language Spoken in Home/Idioma primario hablado en la casa: ______________________________

Patient's Preferred Provider/Preferido Proveedor:

Parent /Guardian's Information (Información de los padres o el Guardián del paciente)

Last Name/Apellido:	First Name/Primer Nombre:	MI:	Sex/Sexo	DOB/ Fecha de Nacimiento:
Address/Dirección:	City/Ciudad:	State/Estado		ZIP/Zona Postal:
Home Phone/Número de teléfono de la casa:	Cell Phone/Celular:			
E-Mail Address/Correo Electrónico:				
Employer/Empleador:	Occupation/Ocupación:			

Parent /Guardian's Information (Información de los padres o el Guardián del paciente)

Last Name/Apellido:	First Name/Primer Nombre:	MI:	Sex/Sexo	DOB/ Fecha de Nacimiento:
Address/Dirección:	City/Ciudad:	State/Estado		ZIP/Zona Postal:
Home Phone/Número de teléfono de la casa:	Cell Phone/Celular:			
E-Mail Address/Correo Electrónico:				
Employer/Empleador:	Occupation/Ocupación:			

Medical Insurance/Seguro Médico

Name of Insurance/Nombre del Seguro:	Effective Date/Fecha Efectiva:	Telephone Number/Numero de teléfono:
Policyholder's Name/Nombre del Asegurado:		DOB/Fecha de Nacimiento:
Member ID Number/Numero de Identificación:	Group Number/Numero de Grupo:	

Signature of Person Completing This Form/Firma de persona llenado esta forma:	Date/Fecha:
➡	

How did you hear about Celebration Pediatrics?

☐ Currently Established ☐ Friend/Family ☐ Hospital ☐ Insurance Company ☐ IP Website ☐ OB/GYN ☐ Other

Name of Friend, Doctor, Hospital or Other Source of Referral: ______________________________

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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE 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) __________________ DOB.

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 from.

We reserve the right to change the terms of the Notice to 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 operation. 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 family members, legal representatives, guardians, healthcare surgeons, or have power of attorney:

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 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 always agree to keep this number updated 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 office, 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 # ________________________________

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 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 provider further treatment to you as of the time of the 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.

Signature of Guardian or Authorized Representative	Date	____________AM/PM Time

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

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