KidzCare Pediatrics

PATIENT REGISTRATION

Child: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy *Holder's SSN:* _____

Insurance Carrier: _____ID # _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy *Holder's SSN:* _____

Insurance Carrier: _____ID #_____

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____ *Email Address:* _____

Who lives in this household? _____

Parent/Contact 1: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ Cell *Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

Parent/Contact 2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If parents are divorced or separated, please fill out this section:

Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____/_____ *Phone*: (_____) _____ - _____

2: _____/_____ *Phone*: (_____) _____ - _____

Pharmacy Information: What pharmacy do you routinely use so we may process prescription and prescription refills?

_____

_____ _____

Signature of Parent/Legal Representative **Date**

_____ _____

State relationship if other than parent **Signature of Witness**

INSURANCE POLICY

1. All insurance recipients must present their current insurance card at the time of service. If you do not have your insurance card you will be considered a self-pay patient.
2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.
3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes in your insurance coverage or change of insurance of carriers.

This is to certify that I (we) the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.
I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates. If for any reason I fail to meet my financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates, to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by **KIDZCARE PEDIATRICS, PC** to carry out treatment, payment, or health care operations. I understand that I should review **KIDZCARE PEDIATRICS, PC** Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.
KIDZCARE PEDIATRICS, PC reserves for itself the right to change the term of its Notice of Privacy Practices for Protected Health information at any time. If **KIDZCARE PEDIATRICS, PC** does change the terms of Notice of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.
I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. **KIDZCARE PEDIATRICS, PC** is not required to agree to such requested restriction(s); however, if **KIDZCARE PEDIATRICS, PC** does agree to my requested restriction(s), such restriction(s) are then binding on **KIDZCARE PEDIATRICS, PC.** At all times, I retain the right to revoke this consent in writing, to **KIDZCARE PEDIATRICS, PC** except to the extent that action has already been taken.
KIDZCARE PEDIATRICS, PC may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, **KIDZCARE PEDIATRICS, PC** has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals).

I fully understand and have read the ***INSURANCE POLICY*** and the ***CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS*** and agree to abide by these policies.

_____ _____
Signature of parent/legal representative **Date:**

_____ _____
State relationship if other than parent **Signature of Witness**

KidzCare Pediatrics

Authorization to Treat Minor

I, _____hereby authorize the following person(s) to bring my child(ren) in for medical treatment.

I also allow them to make any medical decisions that are in the best interest of my child.

I understand that this person is required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that is due at the time of the visit. Without a picture ID the child will NOT be seen. Failure to present insurance card(s) and any co-payments due may result in the child not being seen as scheduled.

I can be reached at _____ for any questions and/or concerns.

Person authorized to bring the child to medical appointments:

1) _____relationship _____

2) _____relationship _____

3) _____relationship _____

_____ _____

Parent/Guardian (printed) ***Parent/Guardian (signature)***

This authorization will remain active unless a written statement is received by the parent/guardian to revoke an authorized person.

KidzCare Pediatrics

OFFICE POLICIES & PROCEDURES

Effective January 1, 2013, the following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and identification (DL, state ID, military ID, or any legal ID). All insurances will be verified upon arrival. All deductibles, co-pays, and/or coinsurance amounts will be due at the time of service.

2. If you are a new patient, please come to your appointment at least 15 minutes before the scheduled appointment time to complete the registration process.

3. Any routine call backs, prescriptions, or documents left for the physician will be completed within 48 hours.

4. At the time of service, if your account reflects an outstanding balance, you will be asked to pay the balance in FULL before you can check0in.

5. If you do not have your insurance card on every *office visit you will* be considered self-pay for that date of service.

6. There is a $25.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately (including but not limited to collection agency fees and legal fees).

7. To better serve all our patients, if you miss 3 appointments without calling 24 hrs. prior to the appointment you may be released from practice. This is not intended to cause any inconvenience to you, but to make these appointments available to patients who need appointments.

MEDICAL RECORDS RELEASE POLICY AND PROCEDURES

Effective as of January 01, 2011, our medical records release policy has made the following changes:

1. A medical records release must be filled out or requested on our patient portal by the parent or legal guardian of the patient **PRIOR** to the copying of any medical records. Please request or fill out one release per patient.

2. All medical records 12 pages or more will be copied for our personal use for a fee of $15.00 per patient. Medical records less than 12 pages will be copied for your personal use one (1) time free of charge. All additional requests will have a $15.00 charge. Please allow 10 business days for this to be completed.

3. If you are transferring to another physician, you may complete a medical records request for your child's records to be forwarded to your new provider at no charge to you. Please allow 30 business days for this transfer to be completed.

4. All shot records will be copied one-time as a courtesy for your personal use. All additional copies will have a charge of $5.00. Please allow 2 business days for this process to be completed.

5. All school, sports, daycare physicals or similar forms will be completed within 2 business days at no charge. Duplicate copies of these forms will be available within 5 business days and will have a charge of $10.00.

I have read and understand the ***OFFICE POLICIES & PROCEDURES*** and ***MEDICAL RECORDS RELEASE POLICY AND PROCEDURES.***

_____ _____

Signature of parent/legal representative ***Date***

_____ _____

State relationship if other than parent ***Signature of Witness***

KidzCare Pediatrics

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ DOB:_____/_____/_____

Treatment Dates/Information to be Released: _____

Specific Information is needed for:_____

Release To:

_____

_____

_____

Release From:

_____

_____

_____

Please state how you would like information released:
_____ Mail (provide address above) _____Fax Number (provide number above) _____ Pickup

I DO___ DO NOT ___ authorize the release of portions of the record relating to substance abuse, psychological/psychiatric. conditions and/or communicable disease, including AIDS, if present.

I understand that this consent is revocable except to the extent that action has already been taken. This consent will automatically expire 90 days from the date of signature unless another date is specified below. (*)

Note: Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent.

_____ _____
Signature of parent /legal representative Date:

_____
State relationship if other than parent

_____ _____
Signature of Witness Date:

***Authorization not valid beyond**_____
Date cannot exceed one year from Date of Signature