7645 Cita Ln, Suite 102
New Port Richey, FL 34653
Phone (727)853-2273 Fax (727) 853-2277
http://www.caringpediatrics.com

ACCEPTANCE OF POLICIES

Patient Name: ____ DOB: __________________________

Patient Privacy Practices

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

____ __________________

Legal Guardian Date

Patient Responsibilities

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patient Responsibilities. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

____ __________________

Legal Guardian Date

Consent to Treat

By signing here, I am consenting to treatment of myself, or dependent, by Caring Pediatrics. I understand that my/their medical information may be viewed or shared amongst the staff of Caring Pediatrics and its business associates. Every effort will be made to protect my privacy in accordance with the HIPAA regulations.

____ __________________

Legal Guardian Date

Permission to Release Medical Information

By signing here, I authorize Caring Pediatrics to release information from my (or my child's) medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. The authorization is valid for every visit to Caring Pediatrics until written notice revoking this authorization is provided.

____ __________________

Legal Guardian Date

"No Show" and Cancellations By singing this I understand and agree that I will be charged $40.00 after the 2nd **"NO SHOW"**. I understand that my child will not be seen for treatment until the outstanding balance is paid in full. Furthermore, I understand that if I **"NO SHOW"** 3 times in 1 year I will be requested to find another physician. I agree and understand that I am expected to call and cancel my child's appointment 24 hour in advance or I will be charged a fee of $25.00, which will need to be paid prior to rescheduling an appointment.

____ __________________

Legal Guardian Date

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FINANCIAL GUARANTEE

Patient Name: ____ DOB: _________________________

If Caring Pediatrics is contracted with my insurance company, Caring Pediatrics must follow their contract and my insurances' requirements. If I have a co-pay or deductible, I must pay that at the time of service. My insurance company makes the final determination of my eligibility. It is my responsibility to know what my insurance expects and requires. Failure to pay a co pay at the time of service results in an additional fee of $5.00 for collections. I agree to pay all co pay and deductible amounts at the time of service.

We will bill your insurance as a courtesy to you. This is not a requirement for Caring Pediatrics to do so. If your insurance fails to pay any balances, it is your responsibility to pay that said balance within 30 days of the statement being sent to you. I agree to pay all balances due within 30 days of receipt of statement. I also understand that it is my responsibility to keep my address current with Caring Pediatrics.

Failure to pay a balance within 30 days will result in a **FINANCE CHARGE** on the 31st day of delinquency in the amount of two percent (2%) per month or an **ANNUAL PERCENTAGE RATE** of twenty four (24%) percent. The minimum FINANCE CHARGE WILL BE $0.50. I understand the finance charge information listed above

A re-billing fee of $5.00 will be imposed on each account that is over 30 days past due. Also if more than 1 statement is mailed to me a $5.00 fee will be added to each account due. If Caring Pediatrics calls me to collect payment at $2.00 per phone call will be imposed. I understand the additional fees imposed if I fail to meet my obligations.

I understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if my past due status is reported to a credit agency, the fact that I or my child received treatment (and all details) from our office may become a matter of public record. I understand the above listed information regarding privacy.

If Caring Pediatrics is forced to take this measure of collections via a collection agency or credit bureau reporting I agree to pay all court costs, attorney's fees, docket fees and travel fees for the physician to and from the court/attorney's office.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. If needed it is the responsibility if the parents to collect monies from each other. Payment is expected at the time of service regardless of which parent is accompanying the minor child to the visit.

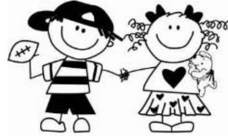
I understand that I will need to request, in writing, and pay a reasonable copying/printing fee if I want medical record transferred to another physician or organization. Furthermore I agree that the balance on all the accounts I am responsible for will be at (0) zero, prior to any and all medical records leaving Caring Pediatrics. I am aware that payment history is part of the medical record sent to other physicians unless otherwise requested not to.

I understand that Caring Pediatrics may request a credit on my account prior to my visits if I fail to keep up with my financial obligations to their facility. The amount of the request will depend on the payment history with Caring Pediatrics.

I, ____ the parent or legal guardian of ____________________________ date of birth____________________, have read and agree to the responsibilities and obligations that are set forth to the facility of Caring Pediatrics, PA. This is a legal document to be placed in my child's chart and will be used for collection purposes if needed.

____ __________________

Legal Guardian Date



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AUTHORIZATION WHEN PARENT/GUARDIAN IS NOT AVAILABLE:

Patient Name: ______________________ DOB:______________________________

There may be times when I will not be present with the above named patient and I give the following persons, over the age of 18, permission to bring him or her for medical examination, treatment and/or recommended vaccines. I give permission to Caring Pediatrics and its medical staff to provide care to the named patient as they believe necessary or advisable, in my absence. I will notify Caring Pediatrics of any change in the names listed below. This document will remain active until changed, in writing by the parent(s) or guardian(s).

Name____________________________ Relationship_____________________________

Name____________________________ Relationship_____________________________

Name____________________________ Relationship_____________________________

Name____________________________ Relationship_____________________________

______________________/___________ __________________________/_________

Signature/Relationship Printed Name Date

___________________________________ ___________________________/__________

Witness Signature Witness Name Date

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Caring Pediatrics – Patient Profile

PATIENT INFORMATION Today's Date: ________________

Name: ____ Sex: ☐ Male ☐ Female

Address: ____ Date of Birth _____/______/_______

____ Social Security #: _____-_____-_____

Parent/Guardian 1: _________________________Relationship: ________________ SS# _________________________

Parent/Guardian 2: _________________________Relationship: ________________ SS# _________________________

☐ Adopted ☐ Foster Care

Phone: (____) _____________________ ☐H ☐C ☐W ☐Other ______ Belongs to whom? ________________________

(____)_____________________ ☐H ☐C ☐W ☐Other ______ Belongs to whom? _________________________

(____)_____________________ ☐H ☐C ☐W ☐Other ______ Belongs to whom? _________________________

Email (required):________________________________ Spouse's Email: __________________________________

Financial Guarantor or Responsible Party: *(if adding someone other than you, that person **MUST** be present at the first visit and initial this portion in front of the staff.)**MUST BE COMPLETED IN FULL.***

Name: ____ Social Security #: _____-____-______
Address: ____ Date of Birth _____/______/_______
____ Phone: (_____) ___________________
____

INSURANCE INFORMATION

Primary Insurance: *(Please note under NO circumstances does Caring Pediatric bill secondary claims).*

☐ I do not have Health Insurance

Information is: ☐ Same as Patient ☐ Same as Guarantor

Subscriber's Name: ______________________________________ Relationship to Patient:______________________

Subscriber's Address: ______________________________________

____

______________________________________ Subscriber's Date of Birth: ____/_____/______

Subscriber's Social Security #: ____-____-_____ Spouse's Social Security #____-____-_____

Employer: ___________________________________ Spouse's Employer: ________________________

Employer's phone number: __________________ Spouse's Employer's phone number: ______________

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Patient Name: ____ **Date of Birth**: ______________________

PREGNANCY AND DELIVERY INFORMATION

How many pregnancies has the patient's mother had? ________ Live Births ______ Stillborn ______ Miscarriages ______

Please list any complications or infections during the pregnancy or at the time of delivery:

____

Smoking: ______cigarettes/day Alcoholic drinks: ______per week Drugs/Medicine ________________________

Where was the patient born?_____________________________________ ☐ Cesarean ☐ Natural ☐ Forceps/Vacuum
Medications to mother during labor: _______________________________ Group B Strep: positive negative
Birth weight: ____________ Length: _____________ APGARs ____/_____ Days in hospital: ______
Born at _____ weeks Hearing: Passed Failed- R/L

Newborn issues: ☐ Jaundice ☐ Feeding Problems ☐ vomiting ☐ Blueness ☐ needed oxygen ☐ Fever ☐ Seizures
☐ Breathing Problems ☐ Blood Transfusion ☐ Other: ____

PATIENT'S PAST MEDICAL HISTORY

Previous Physician's/Clinic Name: _________________________________ City, State ________________________________
Date of Last Physical: ______________________
Has the patient ever been hospitalized? ______ If yes, for what and when?

____

Previous surgeries: ____

Have you ever been or are currently being treated for the following illnesses?

☐ ADHD ☐ Hepatitis ☐ Measles ☐ Whooping Cough (Pertussis) ☐ Chicken Pox (date) _______ ☐ Broken Bones
☐ Ear Infections ☐ Pneumonia ☐ Head Injury ☐ Urine Infection ☐ Allergies ☐ Skin Problems ☐ Headaches ☐ Asthma
☐ Lead Poisoning ☐ Behavior Problems ☐ Learning Problems ☐ Developmental Problems ☐ Vision Problems
☐ Acid Reflux ☐ Seizures ☐ Heart Murmur ☐ Depression/ Anxiety ☐ Diabetes ☐ Speech Problems ☐ Cancer
☐ Hearing Problems ☐ Other ____

Medications (including Over-the-Counter, Natural (Herbal), Etc.): ____
Medication Allergies: ________________________________ Type of Reaction: ____________________________________
Food Allergies: ____________________________________
Are you followed by any specialists (if yes, please list) ____

SOCIAL HISTORY

Mother: Age: ______ Occupation: ____
Father: Age: ______ Occupation:____
Who lives in the home (Relation and Age)? ____

____

Pets: ____________________________________ Does anyone smoke? ____________________________________

Primary Language:____________________________ Daycare: Y/N Religious Preference ______________________

Race (circle one)

American Indian Asian Native Hawaiian

Alaskan Native African American White

Ethnicity (circle one)

Hispanic or Latino Not Hispanic or Latino

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Patient Name: ______________________________ **Date of Birth**: ____________________

FAMILY HISTORY (Please indicate the relationship to the child)

Diabetes ______________________________
Cancer ______________________________
Seizures ______________________________
Allergies ______________________________
Asthma ______________________________
Lung Disease ______________________________
Learning Problems ______________________________
Behavior Problems ______________________________
Kidney/Urinary Disease ______________________________
Mental Illness ______________________________
Developmental Delay ______________________________
Heart Disease/Stroke ______________________________
High Blood Pressure ______________________________
Lead Poisoning ______________________________
Sickle Cell Disease ______________________________
Immune/Autoimmune Disease ______________________________
Other ____

SAFETY INFORMATION

Seat Belt/Car Seat used? Yes/No
Firearms at home? Yes/No Locked up? Yes/No
Working Smoke Detectors? Yes/No
Where are the medicines kept? ____________________
Cigarette Smoking? Yes/No
Domestic Violence? Yes/No
Helmet? Yes/No
Cleaning solutions kept? ____________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship: ______________________________

Phone: (_____) ______________________________

May we leave test results on your home voicemail or answering machine/fax? ☐ Yes ☐No
May we leave test results on your cell phone voicemail? ☐Yes ☐No
Any restrictions to where we may leave results? ______________________________
Pharmacy Preference: ____________________ Phone: ____________________ Address____________________

How did you hear about Caring Pediatrics? ______________________________

Do you have any concerns or questions for the doctor today? ______________________________

____

____

____

By signing below, I hereby certify that the information furnished on this form is complete, true and accurate, to the best of my knowledge.

Signature: ______________________________ Relationship: ______________________________

Reviewed by: ______________________________ Date: ____________________