PATIENT REGISTRATION / DEMOGRAPHIC FORM

Date:________________ Previous PCP (if any):______________________________

Patient Information

Name:____ Date of Birth:_______________
First, Middle, Last, Suffix

Preferred Name:______________________ Gender:__________ Social Security Number:_______________

Race/Ethnicity: ❍ Asian ❍ Black ❍ Hispanic ❍ Pacific Islander ❍ White ❍ Other:_______________

Address:____ Phone #:___________________

City:____ State:_____ Zip Code:_______________

Grade:_____ School:____ Preferred Language:_______________

How did you hear about us?

❍ Our Website ❍ Insurance website or list ❍ Referred by Doctor___________________

❍ Newspaper ❍ Mailing (letter or postcard) Doctor Phone #___________________

❍ Radio ❍ Another patient (family or friend) ❍ Other_____________________________

Family/Contact Information

Patient resides primarlily with: ❍ Both Parents ❍ Mother ❍ Father

Legal Guardian:____ ❍ Other:________________________

Parents are: ❍ Married ❍ Divorced ❍ Separated/Other

Mother's Name:____ Daytime Phone:____________________

Occupation/Employer: __________________________________ Email:___________________________

Father's Name:____ Daytime Phone:____________________

Occupation/Employer: __________________________________ Email:___________________________

Insurance Information

Please provide your insurance card to the receptionist

Is this patient covered by Insurance? ❍ Yes ❍ No (Self-Pay)

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:__________________

Insurance Company: ____

Insured/Card Holder's Name:____ Birthdate:_______________

Relationship:____ Phone #:_________________________

Policy #:____________________________________ Group #:______________________________

Patient's relationship to subscriber: ❍ Self ❍ Child ❍ Other

PATIENT REGISTRATION / DEMOGRAPHIC FORM *cont.*

Emergency Contacts (Other Than Parents) / Consent To Bring Child

#1 Name:_______________ Relationship to Patient:_______________

Address:_______________ Cell Phone:_______________

#2 Name:_______________ Relationship to Patient:_______________

Address:_______________ Cell Phone:_______________

#3 Name:_______________ Relationship to Patient:_______________

Address:_______________ Cell Phone:_______________

Pharmacy

Pharmacy Name:_______________ Phone #:_______________

Pharmacy Address:_______________

Authorization to Release Information

The above information is true to the best of my knowledge. I hereby authorize All Kidz Pediatrics, to: (1) release any information necessary to insurance carriers regarding myself and/or my dependents illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photo copy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I hereby authorize payment directly to All Kids Pediatrics. I understand that I am financially responsible for charges, lab work, preventive assessments, and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract.

I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request.

_______________ _______________ _______________

Parent Name Signature Date

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for *All Kidz Pediatrics* to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to *All Kidz Pediatrics.*

I further understand that in order for *All Kidz Pediatrics* to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to *All Kidz Pediatrics*. I also understand that my healthcare information at *All Kidz Pediatrics* is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to *All Kidz Pediatrics* to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders.

No abnormal results will be communicated via our automated system.

I AUTHORIZE ALL KIDZ PEDIATRICS TO SEND AUTOMATIC ELECTRONIC COMMUNICATION VIA TEXT/EMAIL/VOICEMAIL MESSAGES.

Patient Name (Please Print):_____________________________ **Date:**_____________

Patient Signature:_____________________________ **Cell #:**_____________________________

(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

CONSENT TO TREAT MINOR

I hereby give consent to All Kidz Pediatrics to perform any radiology or lab testing examination, anesthetic, vaccines, medications, or medical treatment as deemed advisable by the doctor, as well as any medical assistant or midlevel provider, on staff of All Kidz Pediatrics to the below named minor.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnosis, treatments and hospital care which a licensed physician at All Kidz Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor Name: ___________________________________ Birthdate:_____________

Signed:____

Print Name:_____________________________________

Date:____

Please specify relationship to minor:

❍ Parent with legal custody ❍ Guardian with legal custody

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Telehealth Informed Consent Form

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "Telehealth Informed Consent" informs the patient ("patient," "you," or "your") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services provided:

Telehealth services offered by All Kidz Pediatrics, and the Practice's engaged providers may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate. Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- *Appointment scheduling*
- *Completion of medical intake forms*
- *Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications*
- *Two-way interactive audio in combination with store-and-forward communications between you and your Provider*
- *Two-way interactive audio-video interaction between you and your Provider*
- *Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files*
- *Delivery of a consultation report; and/or other electronic transmissions for the purpose of rendering clinical care to you*

Expected benefits:

- *Improved access to care by enabling you to remain in your preferred location while your Provider consults with you.*
- *Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider.*
- *More efficient care evaluation and management.*

Service limitations:

- *The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.*
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- *If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.*

Security measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible risks:

- *Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.*
- *In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at (954) 727-8010.*
- *The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.*
- *In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.*
- *In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.*
- *In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.*

Patient acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. *I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.*
2. *I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.*
3. *I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.*
4. *I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.*
5. *I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.*
6. *I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.*
7. *I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.*
8. *I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.*
9. *I understand I have the right to object to the videotaping of the telehealth consultation.*
10. *I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.*
11. *I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.*
12. *I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.*
13. *I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.*
14. *I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.*
15. *I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.*
16. *I understand that I may not be covered under my current health insurance plan for telehealth services.*

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Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ **ACCEPT.** *By checking the Box for this "***TELEHEALTH INFORMED CONSENT***" I hereby state that I have read, understood, and agree to the terms of this document. [Note – Box should not be pre-checked.]*

Patient's name	*Parent/Legal guardian's name*
Patient's signature	*Parent/Legal guardian's signature*
Date	*Date*

OFFICE POLICY

ALL KIDZ PEDIATRICS
TopLine MD Alliance

Appointment Policy

- Visits are by appointments only.
- Walk in patients without scheduled appointments will be offered the next available appointment.
- We strive to accommodate same day sick appointments, however, during peak seasons it may be difficult. We ask for your patience and will try to schedule for the following day.
- Please arrive 10 mins prior to appointment time. This allows the staff time to update any required information (forms, insurance, etc).
- Late arrivals
  - We encourage you to call the office If running late. Patients who arrive more than 10 minutes late for a well check appointment or 15 mins late for a sick appointment may be asked to reschedule for a later time if available. If late more than 20 minutes the appointment will be rescheduled for another day.
- Same day cancellations/No Shows
  - No show appointments will incur a $35 fee (after the first no show).

Prescription Refills

- Same day refills guaranteed if child meets criteria for the need of medication and you call office before 4 pm.
- ADHD medications require visits every 3 months . No medication will be refilled if a visit has not occurred within that time frame.
- Asthma/Allergy/Eczema medications will be refilled if patient has been seen for the condition within the past 6 months.
- Medications will not be refilled if called during after hours or on weekends.

Forms

- School forms/camp/sports/immunization forms will be completed at time of visit. Any extra school/immunization copies needed will carry a $10 fee per form.
- Forms dropped off in office may take up to 3 business days .
- FMLA paperwork, insurance letter or any letter on behalf of the patient or parents have a 7-10 day turnaround time. The office will call when they are complete.

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

Patient Information

Patient's Name:________________________________ Date of Birth:______________

Address:____

City:________________________________ State:______ Zip Code:______________

Day Phone #:________________________ Social Security #:______________________

Practice Information

Practice Name:________________________ Physician:__________________________

Address:____

City:________________________________ State:______ Zip Code:______________

Phone:__________________________ Fax:______________________________

Where do you want the records to be sent?

Name:____

Address:____

City:________________________________ State:______ Zip Code:______________

Phone:__________________________ Fax:______________________________

What records do you want sent or released?

(Please specify the years of records you wish to be sent or released)

Record Name	Years	Record Name	Years	Record Name	Years

How do you want the information delivered? *(Requests take 7-10 business days for processing)*

❍ Mail ❍ Patient will pick up *(fees apply)* ❍ Fax ❍ Pick up by:________ *(fees apply)*

Purpose of Release *(Why is it needed?)*

❍ Transfer of care to new physician ❍ Continuing care/Second opinion ❍ Other:________________

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release All Kidz Pediatrics from all liability arising from this disclosure of my health information. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. For patients and governmental entities: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. For other entities: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Name (Please Print):________________________________ Date:____________

Signature:____

(Patient, Parent, Guardian or Legal Representative)

FINANCIAL POLICY

Thank you for choosing *All Kidz Pediatrics* as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from us, your primary care physician if your insurance carrier requires it for your visits. Please allow 48- 72 hours for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $35.00 fee for missed appointments (no show). Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: All Kidz Pediatrics follows the American Academy of Pediatrics Bright Futures Guidelines for preventive care. Many insurance carriers limit what is covered under "preventive care". We strongly believe that these tools are necessary for the total well-being of children and it is not optional. You must pay for these services in full at the time of visit. Please let us know if you do not want screenings performed. Screenings may include Autism/Developmental/ Mental Health Screens, Vision, Hearing, and certain labs or tests.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

CONVENIENCE FEES: There is a flat fee of $10.00 for each set of School and Sports Clearance forms the office completes on your behalf which are not requested at the time of the well check-up.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name:____________________________________ **Date:**____________

Patient/Responsible Party Signature:____________________________________

English Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

VACCINATION POLICY

ALL KIDZ PEDIATRICS follows the immunization schedule recommended by the American Academy of Pediatrics.

Only patients who agree to take, at the minimum, the vaccines mandated by the Florida Department of Health will be accepted at ALL KIDZ PEDIATRICS.

Patient: ____

Parent/Guardian: _______________________________________

Signature: ____

Date: ____

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