

Patient Registration

Date _____

PATIENT INFORMATION

Legal Name: _____

Last / Apellidos

First/ Nombre

Middle Initial/ 2nd Nombre

Birth Date/ Fecha de Nac. _____ Sex/Sexo _____ Social Security #/Seguro Social _____

Street Address/ Dirección: _____ Apt/Unit # _____

City/Ciudad: _____ State/Estado: _____ Zip Code/Código Postal: _____

Phone/ Telefono: _____

Primary Email Address/ Correo Electronico: _____

Your Child's Race/Ethnicity/ Raza/ Etnia: **(select one)**

- American Indian/ Alaska Native Asian Native Hawaiian or other Pacific Islander
 Black or African American White Hispanic other Unreported/Refuse

Your Prefer Language: **(select one)**

- English Spanish French Other _____

PARENT INFORMATION/ INFORMACION DE LOS PADRES

Mother's Name/Nombre de Madre: _____

D.O. B/Fecha de Nac: _____ Phone/Tel: _____

Father's Name/Nombre del Padre: _____

D.O.B./Fecha de Nac: _____ Phone/Tel: _____

Preferred Pharmacy (select one)

- CVS Walgreens Publix Walmart Winn Dixie Address: _____

_____ City: _____ zip Code: _____

INSURANCE INFORMATION/ INFORMACION DEL SEGURO

Primary Insurance Name/ Nombre del Seguro Primario: _____

Type/ Tipo (Circle one): HMO/PPO

Insured's Name/ Nombre del Asegurado Principal: _____ D.O.B./Fecha de Nac: _____

Relationship/ Relación: _____ Phone/Tel: _____

ID #/ #de Identificación: _____ Group #/ Numero de Grupo: _____

Secondary Insurance Name/ Nombre del Seguro (2nd): _____

Type/Tipo: HMO/PPO

Insured's Name/ Nombre del Asegurado Principal: _____

Relationship/ Relación: _____ Phone/Tel: _____

ID #/ #de Identificación: _____ Group #/ Numero de Grupo: _____

ADDITIONAL INFORMATION

Emergency Contact/ Contacto de Emergencia: _____

Relationship to patient/ Relación con el paciente: _____

Work Phone/ Telefono del Trabajo: _____ Cell Phone/ Numero de Celular _____

Whom may we thank for referring you? _____

¿A quien Podemos agradecerle por recomendarnos? _____

Medical Information Authorization: I authorize release of my medical information necessary to process my/my child's claim. I further authorize payment directly to Happy Kids Pediatric Clinic. I understand that I am financially responsible for all charges whether paid by my insurance. I permit a copy of this authorization to be used in place the original.

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Autorizo la divulgación de mi información médica necesaria para procesar mi reclamo o el de mi hijo. Además autorizo el pago directamente a Happy Kids Pediatric Clinic. Entiendo que soy financieramente responsable de todo cargo ya sean pagados o no por mi Seguro. Permiso que se utilice una copia de esta autorización en lugar de la original.

Responsible Party/ Parent or Legal Guardian Name

Date

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Social History (Please circle below)	
Is child living with Mother/ Father/ Grand Parents/ Foster Parents	
Siblings Y / N	If its yes how many?
Passive smoke exposure Y / N	Pets at home Y/ N
Can child swim Y / N	Care giver Y / N
Smoke detector in home Y / N	Seat belt use Y / N
Daycare Y / N	School Grade _____
Birth History	
Prenatal History	
Birth History	
Birth Weight	
Type of Delivery (Circle One)	Vaginal Delivery / C-Section
Gestational Age	
Medical Problems after Delivery	
Past Medical History- Has your child ever had any of the following? (check as many apply)	
<ul style="list-style-type: none"> <input type="radio"/> ADHD <input type="radio"/> Asthma <input type="radio"/> Allergies <input type="radio"/> Autism <input type="radio"/> Eczema <input type="radio"/> Bronchiolitis <input type="radio"/> Pneumonia <input type="radio"/> Multiple ear infection 	<ul style="list-style-type: none"> <input type="radio"/> Developmental delay <input type="radio"/> Cerebral palsy <input type="radio"/> Seizure disorder <input type="radio"/> Thyroid disease <input type="radio"/> Learning disability <input type="radio"/> Reflux disease <input type="radio"/> Headaches/ Migraines <input type="radio"/> Other _____
Past Surgical History (check as many apply)	
<ul style="list-style-type: none"> <input type="radio"/> Tonsils Removed <input type="radio"/> Adenoids Removed <input type="radio"/> Inguinal Hernia Repair <input type="radio"/> Appendectomy 	<ul style="list-style-type: none"> <input type="radio"/> Ear Tube Placement <input type="radio"/> Heart Surgery <input type="radio"/> Broke Bone <input type="radio"/> Other _____

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Allergies Y / N							
Medications							
Food/ Environmental							
Current Medication Y / N							
Name	Dosage	Frequency			Started On		
Family History: First Degree relatives have no current problems or disability Y / N If Yes, then please mark X in the boxes below to all that apply							
Diagnosis	Siblings	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Thyroid Disease							
Heart Disease							
High BP							
Cancer (type)							
Diabetes							
Depression							
ADHD							
Learning Disability							
Asthma							
Eczema							
Other							

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PATIENT NAME: _____

Last

First

Middle Initial

DATE OF BIRTH: _____

ASSESSING THE RISK OF HIGH-DOSE EXPOSURE TO LEAD EVALUACIÓN DEL RIEGO DE ALTAS DOSIS A EXPOSICIÓN AL PLOMO

Does your child... Su niño....

1. **Live or regularly visit a house with peeling or chipping paint built before 1960? This could include a day-care center, preschool, the home of a babysitter or a relative, etc. Yes _____ No _____**
¿Vive en o visita regularmente una casa con pintura que se pelee y fue construida antes del 1960? Esto podría incluir un centro de infantil, Jardín de infancia, el hogar de una cuidadora o pariente. Si _____ No _____
2. **Live or regularly visit a house built before 1960 with recent ongoing or planned renovations or remodeling? Yes _____ No _____**
¿Vive en o visita regularmente una casa construida antes de 1960 con renovación o remodelación reciente, prevista o en curso? Si _____ No _____
3. **Have a sibling, housemate or playmate being followed up or treated for lead poisoning (that is blood lead greater than or equal to 15ug/dl) Yes _____ No _____**
¿Tiene hermanos o un pariente que recibe tratamiento para el envenenamiento por plomo (es decir, plomo en la sangre mayor o igual a 15ug/dl)? Si _____ No _____
4. **Live with an adult whose job or hobby involves exposure to lead? Yes _____ No _____**
¿Vive con un adulto cuyo trabajo o hobby consiste en exposición a plomo?
Si _____ No _____
5. **Live near an active lead smelter, battery recycling plant, or industry likely to release lead? Yes _____ No _____**
¿Vive cerca de una fundición de plomo activa, planta de reciclaje de baterías o alguna industria que libere plomo? Si _____ No _____

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CONSENT TO TREAT \AUTORIZACION PARA SER TRATADO

Date/Fecha: _____

I AUTHORIZE THE MEDICAL PROFESSIONAL OF THIS FACILITY TO TREAT
AUTORIZO AL PROFESIONAL MEDICO DE ESTA INSTALACION PARA TRATAR

NAME OF PATIENT/ NOMBRE DEL PACIENTE

AT THIS OFFICE FOR SICK CARE, ROUTINE EXAMS, IMMUNIZATIONS, EMERGENCY CARE,
AND REFER TO HOSPITAL AND/OR SPECIALISTS AS NEEDED. ALSO, I AUTHORIZE
PICTURES TO BE TAKEN FOR INDENTITY PURPOSE AND PATIENT CARE.

YO AUTORIZO A LOS MEDICOS PROFESIONALES DE ESTA OFICINA A QUE TRATEN AL
PACIENTE DE ARRIBA PARA PROPORCIONAR CUIDADO DE ENFERMEDADES Y EMERGENCIA.
EXAMENES DE RUTINA, VACUNAS Y PARA SER REFERIDO AL HOSPITAL Y/O
ESPECIALISTAS SEGUN SEA NECESARIO. TAMBIEN YO AUTORIZO A QUE TOMEN FOTOS
PARA PROPOSITOS DE IDENTIDAD Y DE ATENCION AL PACIENTE.

RELATIONSHIP/ RELACION
RELATIONSHIP/ RELACION
RELATIONSHIP/ RELACION
RELATIONSHIP/ RELACION

LIST ANY OTHER CHILDREN
NOMBRE DE OTROS HIJO(S)

FIRST NAME
NOMBRE

LAST NAME
APELLIDO

DOB
FECHA DE NAC

Blank lines for entering child information.

AUTHORIZED SIGNATURE OF PARENT OF LEGAL GUARDIAN/ FIRMA AUTORIZADA PADRE O
TUTOR LEGAL

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SIGNATURE ON FILE/ FIRMA GUARDADA EN ARCHIVO

I authorize use of this form on all my insurance submissions. /Yo autorizo el uso de esta forma en todas mis peticiones de seguros.

- ✓ I authorize release of information to all my Insurance Companies. / Yo autorizo a compartir información con todas mis compañías de seguros.
- ✓ I understand that I am responsible for my bill.
Yo entiendo que yo soy responsable de mi factura.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
Yo autorizo a mi doctora actuar como mi agente para ayudarme a obtener el pago de mi compañía de seguros.
- ✓ I authorize payment direct to my doctor.
Yo autorizo el pago directo a mi doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.
Yo permito que una copia de esta autorización sea utilizada en lugar de la original.

Name (please print) _____ Insurance number _____
Nombre (letra impresa) _____ Numero de Póliza _____

Signature(firma) _____ Date/Fecha _____

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Parent/ Legal Guardian Name:	
Child's Name:	Date of birth:
Child's Name:	Date of birth:
Child's Name:	Date of birth:

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a medical record claim. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete protected medical information including, but not limited to, psychological, psychiatric, alcohol and drug treatment records and laboratory reports including HIV testing data.

To:
 Happy Kids Pediatric Clinic
 5640 West Atlantic Blvd Suite 1
 Margate Fl, 33063
 Phone:954-657-8060
 Fax:866-525-2237

From:
 Facility/ Provider Name; _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Fax: _____

This authority to release includes, but not limited to: Medical Records, clinical and nurse's notes, history of Injury, subjective and objective complaints, X-rays, interpretation of diagnostics test (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records, or logs, physical examination reports, laboratory reports, tissue committee reports, operative reports and logs, progress notes, doctor's orders, physical therapy records, admission and discharge summary reports, all outpatient records, and any other document, records or information in your possession relative to past, present, or future physical and mental conditions.

In addition, it is specifically acknowledged by the releaser that such records may include and/or contain reference to any or all the following subjects. All medical records, reports, documents, or materials including: Drug, alcohol, or substance abuse history, Emotional, mental health, or psychiatric condition, HIV or AIDS infection or testing.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without written consent of the person to whom the information pertains or is otherwise permitted by state law.

A photocopy of this authorization, which contains my signature, shall be considered as effective and valid as the original shall be honored by those to whom it is provided.

 Signature of Parent or Legal Guardian

 Date

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**GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING
PELVIS/OR RECTUM**

I understand the planned office visit and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

- A rectal exam, if indicated due to gastrointestinal symptoms.
- Examination of external genitalia on well child visits and/or sick visits with symptoms including genitourinary area.

This examination will be performing by Dr. Carmen Mejía-Carvajal, from Happy Kids Pediatric Clinic of Broward, LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

Signature of Patient's Representative if under 18

Date _____

Revised 09/22

Notice of Privacy Practices

Happy Kids Pediatric Clinic of Broward, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

<p>Notice of Privacy Practices - ENGLISH.docxHOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:</p> <p>Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.</p> <p>Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.</p> <p>Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.</p> <p>Healthcare Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.</p> <p>Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.</p> <p>Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.</p> <p>Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received</p>	<p>To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.</p> <p>Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.</p> <p>Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.</p> <p>Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.</p> <p>Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.</p> <p>Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.</p> <p>Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.</p> <p>YOUR RIGHTS: You have the following rights regarding Health Information we have about you:</p>	<p>Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.</p> <p>Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.</p> <p>Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.</p> <p>We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.</p> <p>Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.</p> <p>Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.</p> <p>CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.</p> <p>COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.</p> <p>You will not be penalized for filing a complaint.</p> <p>6000 West Atlantic Blvd, Suite 1-2 Margate, FL 33063</p> <p>Office: 954-657-8060 Fax: 954-213-6507</p>
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<p>another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.</p> <p>Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.</p> <p>SPECIAL SITUATIONS: As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.</p>	<p>Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for <i>electronic</i> copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.</p> <p>Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.</p>	<p style="text-align: center;">Attn: Compliance Contact</p> <p style="text-align: center;">Please sign the accompanying "Acknowledgement" form</p>
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ARBITRATION AGREEMENT RELATED TO MEDICAL CARE, TREATMENT & ALL DISPUTES

The patient and undersigned Medical Care Provider (“MCP”) – which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration. This includes any non-U.S.A. dispute or any dispute brought by a patient against the MCP where the patient is not a U.S. citizen. It is the intent of the parties that all disputes under any circumstances of patient and/or physician nationality will go to binding arbitration as agreed herein under the aegis of the Federal Arbitration Act. The parties irrevocably agree that any clinician who has treated or will treat the patient may choose to execute and join in this Agreement at any time. Further, the parties agree that this agreement, in English, is sufficient for any patient or any provider whose native language is not English. By executing this agreement, the parties agree that they have been given sufficient opportunity to understand this agreement provided in English.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter “the Patient”) and the MCP agree that any complaint of any type which in any way relates to medical services shall without exception be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law or any nation’s law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement’s arbitrability to the arbitrators only and to no other person or entity. All issues regarding the validity, enforceability and scope of this Agreement or any part of it shall also be subject to arbitration. If either party challenges the validity of this Agreement in court, the prevailing party shall be entitled to attorneys’ fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound as the Patient is to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right or their rights under the laws of any nation to have any dispute decided in a court of law before a jury. All parties understand that they are giving up the right to have any dispute decided by a judge or jury through the court system. Resort to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration. The parties understand that care may be provided electronically by the MCP and its agents via tele-medicine, anywhere in the world.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term “patient” means both the mother and the mother’s expected child or children. The parties’ consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP. The parties agree that any treating medical provider may sign this agreement ex post facto and thereby participate in an arbitral process to resolve any and all claims against such an ex post facto signer. The parties agree that no claims against the MCP may be brought for medical services involving COVID-19 in any way whatsoever.

The signers agree that the maximum total amount of all non-economic and economic damages combined shall never exceed \$250,000, applied on a *per case* basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees, or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceeding. Non-economic means damages for pain and suffering, disfigurement, embarrassment, and anything else not representing loss of past or future earnings, medical or other costs. However, the arbitrators may choose to award damages in excess of \$250,000 only when extreme hardship is demonstrated. As consideration for the limitation on any awards, the MCP will pay up to and only the first \$2,500 of attorney fees for the Patient. The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Save as required by Medicare/Medicaid, the parties agree that any awards in excess of \$10,000 shall be paid in equal annual payments over 10 years without being reduced to present value. The arbitrators may reduce this time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to an injured patient or any other party) which shall diminish any awards for non-economic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP. The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Statute of Limitations: In no case shall the statute of limitations exceed 12 months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. **Severability:** If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to

be in full force and effect, and all other provisions will still apply. The parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury. **Timing:** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement/Merger Clause:** This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered, or modified in any way except by an instrument in writing, signed by all parties. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state or entity's law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to such procedures or any code of procedure as they may jointly decide. All arbitration hearings shall be conducted by Internet-based videoconference as arranged by the arbitrators. The MCP will provide pay any costs of videoconference bridging of the arbitration process. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay half the costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first \$2,500 as indicated above. The Patient shall pay half the costs of the arbitration as well. Reasonable but brief discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to rescission. You do not have to sign this agreement to receive care. **Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person or persons other than the Patient.) The Patient or representative agrees and states that he/she has consulted with any and all others who might be a party to any action (spouse, family member, etc.) and all such parties have agreed to be party to this Agreement without the need to sign this Agreement. **No Undue Influence:** The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non-economic damages, including loss of wages or other compensation, damage to reputation, full attorneys' fees, and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury to the Patient, the parties agree to promptly mediate in good faith with a qualified mediator prior to Arbitration. A qualified professional mediator with medico-legal background shall be mutually agreed upon. Mediation may occur by videoconference. **Provisions:** Any item of this Agreement may be discussed, negotiated, or changed by mutual agreement prior to signing it as presented here or during the 15-day rescission period. Please avail yourself of this opportunity.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP OR OTHER PARTIES WHO LATER JOIN IN THE ARBITRATION DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement as in full effect, and no item or provision may be crossed out, excised or removed save by mutual consent. I further agree and certify by signing this document that I have received my own separate copy of this Agreement in hard copy or electronically. I understand that this Agreement is valid, enforceable and legal anywhere, in any country, principality or geographical point on earth. I provide my consent to add any other parties at some later date who may participate in any arbitration process under this Agreement. For these parties added later as well, arbitration shall be the sole remedy for dispute resolution without any judge, jury or trial.

To Be Completed by the Patient, Parent, or other Authorized Representative

Name of Patient: _____ Signature (Patient, Parent, Authorized Rep.): _____ Date: _____

Signer's Relationship to Patient (pls. check one): Self Mother Father Other (Specify): _____

MEDICAL CARE PROVIDER'S (MCP'S) CONSENT TO ARBITRATION: In consideration of the execution of this Agreement, the undersigned as legal representative of the MCP hereby agrees to be bound by all the terms set forth above.

SIGNATURE of Medical Care Provider: _____ individually & on behalf of _____.

PARTIES ADDED After Date Above (Name, Company & Signature):

FINANCIAL POLICY/ AUTHORIZATION

Thank you for choosing **Happy Kids Pediatric Clinic** 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.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. COPAYMENTS ARE DUE PRIOR TO THE VISIT AND DEDUCTIBLES WILL BE COLLECTED THE SAME DAY AFTER THE VISIT. We accept Cash, Visa, MasterCard, Discover and American Express (credit card payments must be over \$5.00)

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

FINANCIAL RESPONSIBILITY: It is my responsibility to provide the office with all necessary information to file insurance claims, and to **notify the office of changes in coverage prior to any visits.** I understand it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/ hospitals where my child may receive care.

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

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

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a \$20.00 fee for missed appointment (no show). 1st missed will have reminder of policy, after 2nd no-show will be charge and have to be pay on next appointment.

NON-COVERED SERVICES: Please be aware that some, and/or perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by Medicaid or other insurers. You will be responsible for payment of these services, in full, at the time of visit.

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

There is a flat fee of \$10.00 for each of school and vaccine form, allow 72hrs to be ready.

- \$25.00 Sport Clearance
- \$20.00 letter done by doctor
- \$10.00 excuse done after office date
- \$40.00 IRS letter and FMLA

Patient's name: _____ Date: _____

Signature of Parent/Guardian or Patient if ≥ 18 y/o * _____ Revised 06/25