ADVANCED
PEDIATRICS OF BOCA

TopLine MD Alliance

New Patient Registration

Please list below all children's full name, date of birth and sex.

1. _____/_____/_____**M/F**
2. _____/_____/_____**M/F**
3. _____/_____/_____**M/F**
4. _____/_____/_____**M/F**

Parent/Guardian# 1:

Name _____ Date of birth _____

Relationship _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Parent/Guardian# 2:

Name _____ Date of birth _____

Relationship _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Best Contact # to confirm your child's appointment _____

Insurance Information :

Primary Insurance Company _____

Subscriber/Policyholder Name _____

Policy ID # _____

Group #_____

Insurance Phone Number _____

Insurance Address _____

Primary Language spoken in home _____

Referred to our office by _____

E-Mail Address _____

Preferred pharmacy:

Pharmacy Name _____

Pharmacy Address_____

Pharmacy Phone number_____

As Parent or Legal Guardian, I give permission to Advanced Pediatrics of Boca to treat the patient(s) listed above. I agree to pay for all services rendered in accordance with the financial policy of this practice. I am responsible for knowing the specifics of his/her insurance plan and its procedures. We strongly advise checking with your insurance carrier prior to visiting a specialty doctor, obtaining X-rays, lab work or other outside services.

Please sign below signifying that you have read and understand the above statement and that this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical, to the above carrier or its agent. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer or agent.

Signature : _____ **Date :** _____

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OFFICE FINANCIAL POLICY

At Advanced Pediatrics of Boca, LLC, our goal is to provide and maintain quality care for your child(ren). In order to ensure good flow of communication we want to let you know in advance our office financial policy. Please read this carefully and if you have any questions do not hesitate to ask a member of our staff. **Please initial each statement below**.

1. _____On arrival, please sign in at the front desk and present your current insurance card. Any changes in insurance, address or phone number should be provided at this time. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

2. _____Co-pays are due at time of visit. You are responsible for the balance on your account at this time as well.

3. _____If you have no insurance, payment for the office visit is to be paid at the front desk.

4. _____Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within *ten* business days of the receipt of your bill.

5. _____Returned checks will incur a $35 fee plus any bank fees incurred.

6. _____Balances over 90 days old will be forwarded to a collection agency.

7. _____If you participate with a high-deductible health plan, we require a copy of the health savings account debit card or a personal credit card remain on file.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the above information and understand it fully. I will notify this office of any changes in medical insurance or any other personal information that I have provided on the registration form. I certify that this information is true and correct.

I hereby authorize the physician to furnish information to the insurance carrier concerning medical services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances due in full within 10 days of receiving a statement unless arrangements have been made in advance. If you have any questions regarding the financial policy, please do not hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that a copy has been placed in your records.

Patient Name **Guarantor Signature** **Date**

ADVANCED PEDIATRICS OF BOCA

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OFFICE POLICY

Thank you for choosing our office to provide care for your child(ren). Please read our office policy information carefully. We are available to answer any questions you may have. **PLEASE INITIAL EACH STATEMENT** indicating your understanding and agreement of each policy.

_____ 1. Please read and initial our financial policy which is included in the packet.

_____ 2. We schedule visits by appointment only. Our office is open from 9am-7pm Monday and Tuesday, 9am- 5pm Wednesday-Friday and 9am-12pm on Saturdays. We will take calls for appointments starting at 8am. After hours we are available on call for urgent medical issues.

_____ 3. Missed appointments make it difficult to care for our patients. Please remember that there are other patients who would have liked the time set aside for your child. For well visits, please call 24 hours in advance if you need to cancel or reschedule your visit. For sick visits, please be courteous and call 2hrs or more in advance so that another sick child may have your appointment slot. **Failure to do so will incur a $50 fee.**

_____ 4. School forms may be filled out at the time of your child's well visit. Our staff will complete the school forms at other times as long as your child has had a well visit within the previous 12 months.

_____ 5. Depending on your insurance carrier, you may be responsible for obtaining a referral from us to prior to having an appointment with a specialist. We require 3-5 business days to process non-emergent referrals. Please do not call us from the specialist's office. Failure to obtain a referral will leave you at risk for payment of all charges associated with the appointment.

_____ 6. Please allow 3-5 business days to process prescription refills. Refill requests will not be processed after hours or on weekends.

_____ 7. In divorce situations, it is the policy of our office that the parent who brings in the child for the visit is responsible for co-payment and any deductible amounts due at the time of service. Our office staff will be happy to print receipts upon request.

_____ 8. For a copy of your child's medical records, a written request will provide you the immunization history, growth charts and the last well exam without charge. A request for additional records may be subject to a charge as allowed by Florida law.

Please sign below to indicate that you have read and understood the above office policies.

Signature_____

Date_____

ADVANCED
PEDIATRICS OF BOCA

TopLine MD Alliance

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Newborn Policy

1. The insurance for your newborn must be active by the 1 month well visit.

2. Until the insurance is verified "ACTIVE "You are responsible for the self-pay rate for each service provided, which is collected on the day of the visit.

3. Hospital charges are placed on Hold status until the insurance is active.

4. If there is no active insurance by the 2 months well visit, the hospital charges will be charged to the patients account at a self-pay rate.

5. If the insurance is not active at the 2-month visit, the patient is responsible for the cost of the visit as well as the vaccine charges, and procedures to be collected on the day of the visit. Any credit on the account will be used toward balance.

6. If no active insurance at 2 months, you may postpone your visit until active.

***Please call your insurance and pre-register your baby as soon as possible to avoid any billing delays.**

Parent Signature _____ Date _____

Parent Signature _____ Date _____

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NO SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice (2hr prior to Sick Appts & 24hr prior to all other Appts), another patient is prevented from receiving care. Therefore, Advanced Pediatrics of Boca reserves the right to charge a fee of $50.00 for all missed appointments ("no shows"). The "No Show" fee will be billed to the patient. This fee is not covered by insurance and must be paid before your next appointment.

Thank you for your understanding and cooperation as we strive to best serve our patients.

Patient Name (s)_____
Parent Signature_____
Date_____

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I authorize Advanced Pediatrics of Boca to discuss/share my children's medical information with all persons listed below. This list also includes who can bring my child(ren) to an appointment.

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

Print name_____

Signature_____

Date_____

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For New Patients!

Our office follows the CDC guidelines and Vaccine schedule. If you feel that you will not be able to follow the below schedule please advise as our office may not be the best fit for you and your family.

Well Visit/Vaccine Schedule

In Hospital: Hep B
Newborn:
2 weeks:
1 month:
2 months: Hep B, DTaP, Polio, Hib, Prevnar, Rota (oral)
combination shot
4 months: Hep B, DTaP,Polio, HiB, Prevnar, Rota (oral)
combination shot
6 months: Hep B, DTaP,Polio, HiB, Prevnar
combination shot
****yearly influenza vaccine during flu season starting at 6 months of age****
9 months
12 months: Hep A, MMR, varicella, CBC and lead
15 months: HiB and Prevnar
18 months: DTaP and Hep A
2 years: CBC, Lead (At doctors' discretion)
30 months
3 years
4 years: DTaP-Polio and MMRV
yearly visits 5-9
10 years:
11 years: Tdap, Meningitis (ACYW), HPV
12 years: HPV
yearly visits 13-15
16 years: Meningitis (ACYW), Men B
Men B booster at least one month later
17 years:
18 years: last pediatric well visit!

Please sign below that you acknowledge and agree to follow the above Vaccine schedule. Thanks

Parent/Guardian: _____ Date: _____

Childs Name: _____

Acknowledgement of Receipt of Privacy Practices

Our practice is dedicated to maintaining the privacy of health information that can be identified directly with you or your family. This is not meant to alarm you. We wan you to know that we are taking the Federal Privacy Laws (HIPAA-Health Insurance Portability and Accountability Act) seriously. These laws were written to protect the confidentiality of your health information.

In conducting the business of our practice we will create records regarding your child and the treatment and services we provide. We will maintain to the best of our ability the confidentiality of health information that specifically identifies your child. We will also provide you with this notice of our legal duties required by law and the privacy practices that we maintain concerning your families' *Protected Health Information (PHI).*

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal Law regarding the confidentiality of your health information and in keeping with these laws we want you to understand our procedures and your rights as our patient.

How your Health Information may be used:

To provide Treatment: We will use your PHI to treat your child, including but not limited to: obtaining lab test, or to write a prescription. Many of the people that work for our practice including doctors, nurses or staff may use your child's PHI to inform others that may assist in the care of your child such as: your spouse, other children, or grandparents. Finally, we may disclose your health information to other physicians that may need the information to properly care for your child.

To obtain payment: We may include your child's health information on invoices to collect payment from third parties for the care you may receive from us. We may contact your insurer and provide details regarding your child's treatment to determine if treatment is covered by said insurer, or to obtain prior approval. We may use your child's PHI to bill you directly for services and items.

To conduct Healthcare Operations: Our practice may use and disclose your child's PHI to operate our business. For example, our practice may use your child's PHI to evaluate the quality of care you received from us. We may disclose your child's PHI to other healthcare providers and entities in order to assist in their healthcare operations. We may use your child's PHI for review, auditing, compliance, medical review, legal services, and administrative uses.

Appointment reminders: Our practice may use and disclose your child's PHI to contact you and remind you of an appointment.

Treatment options: Our practice may use and disclose your child's PHI to inform you of potential treatment options and alternatives.

When legally required: We will disclose your health information when it is required to do so by any Federal, State, or local law including, but not limited to, public health, national security as well as when we are legally required to release information to a law enforcement official including under certain limited circumstances if your child is a victim of a crime, or in order to report a crime.

When there are risks to public health: We may disclose your child's PHI to public health authorities that are authorized by law to collect information for the purpose of (1) maintaining vital records such as births and deaths, (2) preventing or controlling disease, injury, or disability, (3) notification of certain communicable disease, (4) notifying a person regarding potential exposure to communicable disease, (5) reporting reactions to drugs or problems with products or devices, (6) recalls of products or devices, (7) to conduct health oversight activities, (8) in connection with judicial and administrative proceedings as

required by law i.e. in response to a court order, or if you are involved in a lawsuit or similar proceeding. We may also disclose your child's PHI in response to a discovery request or subpoena.

For Law Enforcement Purposes: As permitted or required by State law we may disclose your child's PHI to a law enforcement official, including, under certain circumstances, if your child is the victim of a crime or in order to report a crime.

Serious Threats to Health or Safety: We may, consistent with applicable law and ethical standards of conduct, disclose your child's health information if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Patient Rights

You have the following rights regarding your health information that we maintain about your child:

Confidential Communications: You have the right to request that we communicate with you in a certain way. For example, you have the right to request that we only contact you at home, rather than work, or privately without any other family member present. If you wish to receive confidential communications, you must make a written request detailing your wishes. You do not have to provide a reason for your request and every effort will be made to honor it.
Requesting Restrictions: You have the right to request restrictions on certain uses and disclosures of your child's health information. For example, you may restrict our disclosure of your child's PHI to only certain individuals involved in your requests. You must make your request in writing to our office.
Inspection and Copies of Health Information: You have the right to inspect, read, review, and copy the PHI including billing records. We request that you submit this information in writing in accordance with our office policies, including charging a reasonable fee for copying and assembling costs associated with your request in accordance with Florida Law.
Right to Amend Health Information: You have the right to amend your child's records if you believe the health information records are incorrect or incomplete. The request may be made as long as the information is maintained by us. A request for an amendment of records must be made in writing. You are required to provide us with a reason that supports your request for amendment. The request may be denied if you fail to submit your request in writing, if the record in question was not created by our office, is not part of our records or if the records in question are determined by us to be accurate and complete.
Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests must state a time period, which may not be longer than six years from the date of disclosure. The first accounting you request during any 12-month period is free of charge, but subsequent accounting requests may be subject to a reasonable cost-based fee.
Right to file a complaint: You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express ay concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

We are required by law to maintain the privacy of your health information and to provide you with this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice; we do reserve the right to change the terms of our Notice. If we change our Privacy Notice we will provide a copy of the revised Notice to you or your appointed representative. By signing below, I acknowledge receipt and accept the aforementioned Privacy Practices.

Signed: _____ **Date:** _____