ADVANCED PEDIATRICS OF BOCA

TopLine MD Alliance

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 _____

E-Mail Address_____

Parent/Guardian# 2:

Name _____ Date of birth _____

Relationship _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____Occupation_____

E-Mail Address_____

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 _____

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: _____

ADVANCED PEDIATRICS OF BOCA

TopLine MD Alliance

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 1hr 1/2 before appointment time 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

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**

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NO SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice (1 and a half hours 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(s)_____
Parent:_____
Signature_____
Date_____

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:**_____

ADVANCED PEDIATRICS OF BOCA

TopLine MD Alliance

For New Patients!

Our Office follows the AAP 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

Newborns will receive their first Hepatitis B vaccine in the hospital

RSV (Beyfortus): 1 dose depending on maternal RSV vaccination status. Can be given from birth through age 8 months for infants born October through March. Some babies qualify for a second dose

1st office visit: Usually a few days following discharge from hospital

2 Week Visit

1 Month visit

2 Month visit: Hepatitis B,DTap & Polio, Hib, Pneumococcal, & Rotavirus (oral)
Combo Vaccine

4 Month visit:Hepatitis B,DTap & Polio, Hib,Pneumococcal, & Rotavirus (oral)
Combo Vaccine

6 Month visit:Hepatitis B,DTap & Polio, Hib,Pneumococcal
Combo Vaccine

Annual influenza: Children 6 months and up (1st year receiving flu vaccine, return in 1 Month for booster)

9 Month visit:

12 Month visit: Hepatitis A,MMR, Varicella ¦ Hemoglobin & lead level also done at this visit

15 Month visit: Hib & Pneumococcal

18 Month visit: Dtap & Hepatitis A

2 Year visit: Hemoglobin and lead level depending on risk factors

2.5 Year visit:

ADVANCED PEDIATRICS OF BOCA

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3 Year visit:

4 Year visit: DTap & Polio,MMR&Varicella

5-8 Yearly visit well visit

9 Year visit: HPV #1
10 Year visit: HPV #2, Cholesterol screening test (done at lab)

11 Year visit: Tdap, Meningococcal (ACWY)

12-15 Yearly well visit

16 Year visit: Meningococcal (ACWY) Booster, Meningococcal B, Urine screen for female Patients. *Return in 6 month for Meningococcal B Booster

17 Year visit: Cholesterol screening test, HIV screen (done at lab)

18 Year visit: Last pediatric well visit before transitioning to an adult doctor

Please sign below that you acknowledge and agree to follow the above Vaccine Schedule. Thank you

_____ _____

Parent/Guardian Date

_____

Children's Name

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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_____

ADVANCED
PEDIATRICS OF BOCA

TopLine MD Alliance

Authorization for Release of Medical Records:

I authorize:

Advanced Pediatrics of Boca
9970 N Central Park Blvd., Suite 203
Boca Raton, FL. 33428
Phone: 561-487-1616/ Fax: 561-487-1619

To release my records to:

Facility _____
Address _____
_____
Main_____
Fax_____

For the Child(ren) named below:

1._____ Date of Birth_____
2._____ Date of Birth_____
3._____ Date of Birth_____
4._____ Date of Birth_____

By signing below, I am authorizing the release of the above named patients' records, growth charts and immunization history, to the facility mentioned above.

Parent Signature:_____ Date: _____

ADVANCED
PEDIATRICS OF BOCA

TopLine MD Alliance

Authorization for Acquisition of Medical Records:

I authorize:

Advanced Pediatrics of Boca
9970 N Central Park Blvd., Suite 203
Boca Raton, FL. 33428
Phone: 561-487-1616/ Fax: 561-487-1619

To acquire my records from:

Facility _____
Address _____
_____
Main #_____
Fax #_____

For the Child(ren) named below:

1._____ Date of Birth_____
2._____ Date of Birth_____
3._____ Date of Birth_____
4._____ Date of Birth_____

By signing below, I am authorizing the acquisition of the above-named patients' records, growth charts and immunization history, to Advanced Pediatrics of Boca.

Parent Signature_____ Date: _____

ADVANCED PEDIATRICS OF BOCA

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Credit Card Authorization Form:

By signing below, I understand the following:

In the event that my insurance company does not cover charges for services rendered at Advanced Pediatrics of Boca, or applies any financial responsibility to me as per my policy with them, I understand that I am responsible for payment of any and all charges incurred.

I hereby authorize Advanced Pediatrics of Boca, upon receipt of notification from my insurance company of my liability, to charge payment for services rendered at this facility to the credit card listed below.

Signature: _____ Date: _____

Circle one: Mastercard Discover Visa Amex

Credit Card #: _____ Exp Date: _____

CVV: _____ Zip Code: _____

Name, as it appears on card: _____

Patient Name(s): _____

Total Charge: _$_____

ADVANCED
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TopLine MD Alliance

Dear Parents,

I hope this letter finds you and your family in good health and high spirits. I am writing to inform you about an important aspect of your health insurance policy known as Coordination of Benefits (COB). Understanding and correctly managing your COB is essential to ensure that your child's healthcare expenses are covered appropriately by your insurance plans.

It is important to note that completing the COB process is the **responsibility** of the insured and must be done directly with your insurance company. Our medical office cannot complete this process on your behalf. Typically, insurance companies require you to verify or update your COB information once or twice a year. This can usually be done by filling out a form provided by your insurer or through their online portal.

Failing to provide the necessary COB information can result in denied claims, which may affect your child's access to healthcare services. Therefore, I encourage you to stay proactive in managing your COB information to ensure seamless coordination between your insurance policies.

If you have any questions about the COB process or need assistance in understanding your responsibilities, please do not hesitate to contact your insurance provider directly. Additionally, our office is here to assist you with any other questions or concerns you may have regarding your child's healthcare needs.

Thank you for your attention to this important matter. We are committed to providing the best possible care for your children and appreciate your cooperation in ensuring smooth insurance processes.

_____ _____

CHILDS NAME PARENTS SIGNATURE DATE

E-mail Consent & Acknowledgment Form

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

E-mail Consent & Acknowledgment Form

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name(s) (Print) : _____

Parent Signature : _____ Date : _____

Parent Email : _____