South Miami Pediatric Partners

TopLine MD Alliance

PEDIATRICS DEMOGRAPHIC FORM

Patient Information

Name:_______________________ _______________________ Date of Birth:____________
Last First

❍ Male ❍ Female **Child lives with:** ❍ Father ❍ Mother ❍ Both ❍ Other:____________

Address:____

City:_________________________________ State:_____ Zip Code:____________

Primary Phone: _______________________ Alternate Phone:_______________________

Email Address: ____

Parent's Marital Status: ❍Married ❍Separated ❍Divorced ❍Other: ____________

Languages spoken at home: ❍English ❍Spanish ❍Other: ____________

Siblings in the office: ____

Pharmacy Name:_______________________ Pharmacy Phone:_______________________

Pharmacy Address:____

Insurance Policy Holder Information *(Person)*

Name:____ Date of Birth:____________

Address *(If different from above)*:______________________________________

City:_________________________________ State:_____ Zip Code:____________

Phone Number:_______________________ SS#: XXX-XX-__________

Employer:____

Other Parent Information

Name:____ Date of Birth:____________

Address *(If different from above)*:______________________________________

City:_________________________________ State:_____ Zip Code:____________

Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance.

I hereby authorize payment, directly to South Miami Pediatric Partners of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work 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

SOUTH MIAMI PEDIATRIC PARTNERS, LLC

5901 SW 74th STREET, SUITE 312

SOUTH MIAMI, FL 33143

PH: (305)665-5808 FX: (305)665-6761

ATTENTION ALL NEWBORN PARENTS

Upon your first visit to our office our staff notifies you that there is a 30-days grace period in which you are responsible for adding the newborn to your insurance. It takes about a month for newborn to be processed.

If newborn is not added within the 30-days grace period, then newborn will be considered self-pay and it will be your responsibility to pay for your entire visit.

______________________ ______________________

Signature Today's Date

____

Print Name

FINANCIAL POLICY

Thank you for choosing South Miami Pediatric Partners 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. 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.

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.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

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. WIC forms are $5.00 each. We also charge a $25.00 convenience fee for having blood drawn in the office. We also charge a $15.00 walk-in fee.

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:______________________________

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 South Miami Pediatric Partners 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)

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 *South Miami Pediatric Partners LLC* to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to *South Miami Pediatric Partners LLC* .

I further understand that in order *South Miami Pediatric Partners LLC* to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to *South Miami Pediatric Partners LLC* I also understand that my healthcare information at *South Miami Pediatric Partners LLC* 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 *South Miami Pediatric Partners LLC* 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 SOUTH MIAMI PEDIATRIC PARTNERS LLC 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, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to *South Miami Pediatric Partners LLC* to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name)____ , age (if minor)________ . Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by *South Miami Pediatric Partners LLC* and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing. I acknowledge that *South Miami Pediatric Partners LLC* is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released. *South Miami Pediatric Partners LLC* has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold *South Miami Pediatric Partners LLC*, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production. I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name:____

Address:____

City:____ **State:**_____ **Zip Code:**____________

Telephone:____________________________ **Email:**____

Signature:____ **Date:**_____________

Name of Parent/Legal Custodian *(under age 18):*____

Signature of Parent/Legal Custodian *(under age 18):*____

Witness Name:____

Witness Signature:____ **Date:**_____________

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold *South Miami Pediatric Partners LLC* responsible for instances of these violations.

Signature:____ **Date:**_____________

E-mail Consent Form

Patient Name ____ Date ______________

Patient E-mail address ___________________ Patient phone number __________________

South Miami Pediatric Partners 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 patients 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 patients prior written consent, except as authorized or required by law.

E-mail Consent Form

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.

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.

E-mail Consent Form

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.

Patient Name (print) ________________________________

Patient Signature __________________________________ Date ____________________

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 (print) ________________________________

Patient Signature __________________________________ Date __________________