WEST VOLUSIA PEDIATRICS PATIENT REGISTRATION

PLEASE PRINT

MOTHER'S NAME:_____ MOTHER'S DATE OF BIRTH:_____
LAST NAME FIRST MIDDLE

MOTHER'S SOCIAL SECURITY NUMBER:_____ MOTHER'S OCCUPATION:_____

MOTHER'S EMPLOYER:_____ PHONE # OF EMPLOYER:_____

FATHER'S NAME:_____ FATHER'S DATE OF BIRTH:_____
LAST NAME FIRST MIDDLE

FATHER'S SOCIAL SECURITY NUMBER:_____ FATHER'S OCCUPATION:_____

FATHER'S EMPLOYER:_____ PHONE # OF EMPLOYER:_____

STREET ADDRESS OF PARENT/CUSTODIAN:_____
STREET ADDRESS city/state/zip

MAILING ADDRESS OF PARENT/CUSTODIAN:_____
city/state/zip

HOME PH:( )_____ PGR/CELL PH: ( )_____ EMAIL ADDRESS:_____

CUSTODIAN'S NAME:_____
(IF CHILDREN NOT LIVING WITH PARENT) LAST NAME FIRST MIDDLE

EMERGENCY CONTACT(other than parent):_____PH:_____
NAME RELATIONSHIP

LIST ALL CHILDREN:

Including any children *not* being seen today, and any children not being seen in this office.

_____					MALE OR FEMALE
LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	RACE	CIRCLE
_____					MALE OR FEMALE
LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	RACE	CIRCLE
_____					MALE OR FEMALE
LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	RACE	CIRCLE
_____					MALE OR FEMALE
LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	RACE	CIRCLE

NAME OF INSURANCE COMPANY:_____ WHO IS THE PRIMARY INSURANCE HOLDER? _____

ID #:_____GROUP #:_____ EFF. DATE: _____

I hereby authorize payment of insurance benefits directly to West Volusia Pediatrics. I understand I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted provider of services in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I understand I am directly responsible for payment of any billing fees, court costs and/or collection fees added to my account in the pursuit of collecting monies owed. I authorize the performance of whatever procedures necessary in executing the treatment of the above named patient(s).

_____ _____
Signature of Parent /Guardian Date

Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

West Volusia Pediatrics has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company. Any financial portion that is the "member's responsibility" such as a co-pay, deductible or a non-covered percentage will be collected ***at the time of service***._____(initial) If, for any reason, it is not collected at the time of service, a billing fee will be added to your outstanding balance for each statement that is mailed._____(initial) Remember, your insurance coverage is a contract between you and your insurance company. West Volusia Pediatrics is not responsible for services denied by your insurance company._____(initial) Further, should court or collection actions be necessary to secure payment, any & all fees will be charged to the Guarantor on the account. _____(init)

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

HMO INSURANCE PLANS: All co-pays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

NON-CONTRACTED INSURANCE PLANS: If we are not contracted with your insurance company you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources department) to send to your insurance company to request that payment be sent to you.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

MEDICAID: We accept Medicaid for newborn hospital follow up exams. If you do not have the baby's Medicaid information available at the time of the exam we will pend the charge for up to 30 days, to allow time for the Medicaid number to be assigned. If you do not provide us with the Medicaid billing information within 30 days, we will change the account to "Self Pay-No Insurance". At that point you are required to make payment within 30 days or you will be subject to rebilling fees and collection efforts.

MEDICAID MMAs: Effective 6/1/14**We are participating with the following Medicaid Managed Medical Assistance plans: Staywell, Healthease, and First Coast Advantage.

SECONDARY INSURERS: We do not file for secondary coverage. A billing copy will be presented to you as you check out of the office that can be used for that purpose.

DIVORCE DECREE: We are not a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, Mastercard, and personal checks (with photo id only). Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement will be assessed a $5 rebilling fee. If you experience circumstances beyond your control, please call our office immediately after receiving first statement and we will be happy to make payment arrangements. All balances reaching 90 days past due may be sent to a collection agency and/or submitted for legal action. Should your account be sent to a collection agency or submitted for legal action, you will be financially responsible for all collection fees, legal fees or court costs that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a returned check fee (the amount of which is based on the amount of the returned check), in addition to the original amount of the check. You will have 15 days to clear the outstanding check and future check writing privileges may be jeopardized. If you do not pay the check plus the return fee in the specified time, a complaint will be filed with the State's Attorney Office and we will be unable to continue a doctor/patient relationship.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hours notice in order for another child to be scheduled. If you do not cancel by the deadline, a $10 missed appointment fee will be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. *EXCEPTION: If you are a Medicaid recipient, please understand that we are unable to charge you for missed appointments. Therefore, in an effort to increase office efficiency, if you accrue more than 3 missed appointments with our office, we will be unable to continue caring for your child and you will be reassigned to a different doctor.*

I authorize medical care and accept the financial responsibility for my children, my step children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims. I authorize the download of my child's medication history and RX benefits into his/her account from an RX clearinghouse.

I have read and fully understand the financial policies of West Volusia Pediatrics, and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification.

_____ _____

Parent/Guardian/Personal Representative Date

Authorization For Medical Treatment of Minors

I, _____, parent or legal guardian of:

_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth
_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth
_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth

do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my children to medical appointments and sign for treatment to include immunizations. Please list anyone other than the child(ren)'s biological mother or biological father who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc… I understand that only my child(ren)'s biological mother and father *and* those listed below will have the authority to authorize treatment.

Authorized individuals include (please print name and relationship)*:

_____ _____

_____ _____

_____ _____

In the case of an emergency, unlisted individuals may obtain treatment for your child(ren). In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing.
*Please inform the above listed individuals to bring photo ID to appointments

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Authorizing your Teen/Young Adult to Come In Unaccompanied

_____My initials here indicate that I authorize treatment (except for immunizations) of my teen, 16 and above, in my absence. Please understand that your signature authorizes your teen to seek treatment that may ultimately become your responsibility for payment.

_____My initials here indicate that I authorize my child who is over the age of 18, to request and sign for their own immunizations/injections. Your initials here indicate that you understand that there are some services that might not be paid by your insurance and though you were not here to agree to these services, you have given your authorization to your child to act on your behalf. All services performed in this office are ultimately the financial responsibility of the parent.

Privacy Statement Acknowledgement

I acknowledge West Volusia Pediatrics, P.A. has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy. (See date on posted copies)

_____ _____

Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative

_____

Date

Authorization to Leave Messages on Voice Mail/Machines

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

_____Yes, please leave me a message Date:_____

_____No, don't leave any specific messages

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify West Volusia Pediatrics of any changes in my health status, my child(ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____

Signature Date

PATIENT MEDICAL HISTORY SHEET

PATIENT'S NAME:_____
(LAST, FIRST, MIDDLE)

DATE OF BIRTH:_____BIRTH WEIGHT:_____ BIRTH PLACE:_____

NAME OF PREVIOUS P HYSICIAN AND DATE LAST SEEN:_____

Circle One: VAGINAL BIRTH CAESAREAN SECTION (C-SECTION)

Circle response ↓

YES NO ANY PROBLEMS WITH THE PREGNANCY? DESCRIBE:_____

YES NO ANY PROBLEMS WITH THE DELIVERY? DESCRIBE:_____

YES NO WAS THE PATIENT PRE-TERM OR POST-TERM? HOW MANY WEEKS?_____

YES NO ANY PROBLEMS IN THE HOSPITAL NURSERY? DESCRIBE:_____

YES NO ANY HOSPITALIZATIONS SINCE BIRTH? WHERE AND FOR WHAT:_____

YES NO ANY SURGERIES? WHERE AND FOR WHAT:_____

YES NO ANY FRACTURES OR SIGNIFICANT TRAUMA? WHAT AND WHEN:_____

YES NO ANY SIGNIFICANT ILLNESSES? WHAT AND WHEN:_____

YES NO ANY DEVELOPMENTAL PROBLEMS, LEARNING DISORDERS, OR OTHER DELAYS?_____

YES NO DOES THE PATIENT REQUIRE EYE GLASSES? DATE OF LAST EYE EXAM:_____

YES NO DOES THE PATIENT REQUIRE ANY OTHER MEDICAL EQUIPMENT? WHAT KIND:_____

YES NO ANY ALLERGIES TO MEDICATIONS? LIST MEDICATIONS AND TYPE OF REACTION:_____

YES NO ANY OTHER ALLERGIES? WHAT KIND:_____

YES NO ARE THERE ANY MEDICAL PROBLEMS WITH THE PATIENT'S MOTHER, FATHER, BROTHERS, SISTERS, OR GRANDPARENTS SUCH AS DIABETES, CANCER, HEART DISEASE, HIGH BLOOD PRESSURE, KIDNEY DISEASE, ASTHMA, INTESTINAL DISEASE, LUNG DISEASE, BLEEDING DISORDERS, THYROID DISORDERS, SEIZURES, MENTAL RETARDATION, ETC.? LIST RELATIONSHIP AND TYPE OF PROBLEM._____

_____

YES NO ARE THERE ANY OTHER FAMILY MEMBERS WITH SIGNIFICANT MEDICAL PROBLEMS? LIST RELATIONSHIP AND TYPE OF PROBLEMS:_____

_____

YES NO DOES THE PATIENT OR ANYONE ELSE IN THE HOUSE SMOKE? WHO?_____

YES NO ANY REACTIONS TO PREVIOUS IMMUNIZATIONS? LIST:_____

YES NO ARE THE IMMUNIZATIONS CURRENT?

YES NO HAS THE PATIENT HAD CHICKEN POX? IF YES, DATE:_____

PRIMARY LANGUAGE OF CHILD:_____ ETHNICITY:_____

My signature below indicates that I acknowledge that West Volusia Pediatrics recommends that my child have routine health exams and immunizations following the guidelines and recommendations set by the American Academy of Pediatrics. These guidelines are posted in the reception area.

_____ _____
SIGNATURE OF PERSON COMPLETING THIS FORM RELATIONSHIP TO PATIENT

_____
DATE COMPLETED REV 0514 PATIENTINFOPACKET2014.DOC