Ocoee Pediatrics

Patient Name: _____ DOB: _____

Address: _____City_____State_____Zip_____

Phone: _____

Race: (check all that apply) _____ Black/African American ____White _____American Indian or Alaska Indian _____Asian _____Native Hawaiian or other Pacific Islander ____Other _____ ___Decline to Specify

Ethnicity: ____ Hispanic or Latino _ Not Hispanic or Latino __ Decline to specify

Preferred Language: ___ English ___Spanish ____ Haitian Creole ____Other: _____

Sexual Orientation and Gender identity:

Assigned sex at birth**:** _____

Gender identity: _____

Sexual orientation: _____

Communication:

To better manage your healthcare, we offer a patient portal that provides access to your medical information, limited records, and forms. Every patient **MUST** activate the patient portal to complete necessary forms related to your appointments. It also allows you to view visit notes, growth charts, immunization records, lab results, and send and receive secure messages to your provider. If you have had lab work done, we encourage you to check the portal for messages regarding your results.

We are here to support you every step of the way. If you have any concerns or questions, please do not hesitate to reach out to us at any time. Your feedback about your care helps us deliver the best service possible.

Patient Portal:

Please provide the following information (please print clearly). If both parents/guardians want access to the patient portal, you must provide different emails for each person.

Patient name: _____Email: _____

Ocoee Pediatrics

Consents for Treatment for Minor Child

Medication and Treatment Consent
This consent form is intended to confirm written consent for the patient named below (the "Patient") to receive medical treatment at Ocoee Pediatrics to include services rendered by its employed or contracted providers, and other medical professionals, (collectively "Ocoee Pediatrics"). My signature below hereby confirms my consent for Ocoee Pediatrics to provide health care services and prescribe medicinal drugs based on the judgement of Ocoee Pediatrics and includes, without limitation, consent for evaluation and treatment for medical conditions, including physical or mental health conditions and other sensitive matters, as deemed ordinary and necessary, and advisable, in the judgement of the provider.

Treatment Services
I understand that medical care and treatment will typically include, as determined by the health care practitioner, ordinary and necessary medical treatment, including a full physical examination including an external genital examination, diagnostic testing, vaccination and the prescribing of medicinal drugs as needed to treat health conditions ("Treatment Services"). By signing below, I acknowledge my consent to receive such services from Ocoee Pediatrics. I acknowledge that this consent specifically expresses my consent to receive an external genital exam from a Ocoee Pediatrics provider as a part of their medical care and treatment. I understand that I have a choice about the use of treatment services at Ocoee Pediatrics and other services that may be available or recommended during the course of their treatment.

Acknowledgement
By signing below, I represent that I am the patient named below, with the legal right to consent to medical treatment and medication prescribing and administration. I consent to Ocoee Pediatrics physicians, providers, and other employee medical professional to provide, solicit and arrange for health care services, and prescribe medicinal drugs when determined necessary in the professional opinion of the treating Ocoee Pediatrics provider.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Ocoee Pediatrics

Well Visit Policy

The purpose of your child's visit is what is called preventative care-looking for and discussing issues that may affect your child's growth, development and general well-being so that we can identify and prevent smaller issues from progressing into larger problems. This includes measurements, head-to-toe physical exam, discussion of growth, nutrition, development, safety issues and anticipatory guidance.

Immunizations are an important part of preventative care. Vaccines are billed to your insurance company. Most insurance companies cover childhood immunizations fully. We, however, have limited access to coverage and benefit information and you are ultimately responsible for knowing your plan limitations. If the immunizations are not covered by insurance, you will be responsible for any patient responsibility per insurance company.

Many of our visits included other screening or preventive care items that are billed to your insurance company which may or may not be covered under your insurance plan. These services are being done because they are part of the American Academy of Pediatrics Bright Futures Guidelines which are the gold standard of care in pediatrics designed to identify or prevent health conditions or illness. Each insurance policy has its own coverage limitations. Most, but not all, insurance companies pay for services recommended under these guidelines. The following is a list of screenings that are performed depending on the age of the child.

- Standardized developmental surveys (ASQ, MCHAT, etc.)
- Hemoglobin and lead blood test
- Vision screening
- Depression questionnaires
- Application of fluoride varnish (through age 5yrs)

Please also note that well visit does NOT include care of other chronic medical conditions (asthma, ADHD, allergies, mental health issues) or acute illnesses (pneumonia, strep throat, gastrointestinal illnesses, etc.) If we evaluate and treat chronic or acute conditions during a well visit, we will document and bill separately for those issues. As such, you may be required to pay a copay or co-insurance.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Ocoee Pediatrics

Payment Policy

Insurance Authorization and Assignment of Benefits
I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefit under Medicaid, and/or my insurance carriers to the provider. I authorize Ocoee Pediatrics to release to my health insurance plan any information needed to determine the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, this assignment of benefits may not apply, and I am responsible for payment.

Payment Responsibility and Insurance Information
You are responsible for all services rendered. Payment is due at the time of your visit and includes any co-payments, deductibles, and fees for medical forms. Any balance that remains unpaid for more than two billing cycles will incur a $10 late fee, which will be added to your outstanding balance. A $50 fee will be charged for returned checks.

Insurance Card
It is essential that you bring the most current insurance card to every appointment. We must have accurate and up-to-date information at the time of service. An insurance card is like a credit card—its information must be current and valid for it to be used. If incorrect insurance information is provided at time of service, you are responsible for the balance.

Saturday Appointments
We offer Saturday appointments. These visits are considered outside of normal business hours, and there is an additional charge that applies, which some insurance companies may categorize as patient responsibility.

Combined Visits: If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, these will be billed separately, and your co-pay and other charges apply.

Missed/Changing Appointments: We schedule appointments according to urgency and availability. **PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT.** Please make sure the text message/email registration is filled out **BEFORE** arriving at the office. A delay in filling this out can result in a canceled appointment. If for any reason you are unable to keep your appointment, you **MUST** give our office 24-hour notice, or you will be charged a $50 service fee. Patients that miss 3 appointments without 24-hour notice of cancellation will be discharged from practice.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Ocoee Pediatrics

HIPPA & Electronic Transmission of Private Health Information

Ocoee Pediatrics is committed to ensuring the privacy and security of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices on our website at https://ocoeekidsdocs.com/privacy-policy. You can also get a copy from the office. As part of our commitment to safeguarding your PHI, we have implemented secure methods for transmitting medical records. By employing these secure methods, Ocoee Pediatrics aims to protect the confidentiality, integrity, and availability of your medical records. If you have any questions or concerns regarding HIPPA and/or the transmission of your PHI, please contact our Privacy Officer at 407-395-2037.

Initials: _____

HIPAA Compliant Encrypted Email and Fax Transmission: Ocoee Pediatrics utilizes HIPAA-compliant encrypted email services to securely transmit medical records containing PHI. This ensures that your sensitive information remains confidential during electronic transmission. In addition to encrypted email, Ocoee Pediatrics may also transmit medical records via fax using secure E-fax. This method complies with HIPAA guidelines for safeguarding PHI during transmission

Use of Artificial Intelligence (AI) in Healthcare: This practice may utilize artificial intelligence (AI) tools to assist with tasks such as documenting patient encounters, analyzing medical images, and identifying potential health risks. These AI tools are designed to assist healthcare providers, not replace them. All AI-generated information will be reviewed and verified by a qualified healthcare provider. Your privacy and the security of your health information will be protected in accordance with HIPAA regulations. By signing this form, you acknowledge and authorize the use of AI tools in your healthcare. I grant permission for Ocoee Pediatrics to record my health information using AI generated dictation to the EMR system. I understand that all transcriptions will be handled in accordance with HIPAA regulations to ensure privacy and confidentiality.

Digital Updates and Communication: I acknowledge that Ocoee Pediatrics may contact me for various purposes through email or text messaging, including but not limited to updates, reminders, and other relevant communications.

Electronic Prescription Management: I understand that Ocoee Pediatrics utilizes electronic transmission of prescriptions to a participating pharmacy of my choice. I also acknowledge that Ocoee Pediatrics may electronically receive and send information regarding my prescription history, drug interactions, prior authorization requirements, or requested substitutions.

Security Measures/Potential Risks: I understand that Ocoee Pediatrics will take appropriate security measures to safeguard my health information during transmission. However, I acknowledge that no electronic transmission can be guaranteed to be 100% secure. I am aware of the potential risks associated with electronic transmission, including but not limited to interception by unauthorized parties, data breaches, and loss of confidentiality.

Revocation/Duration of Consent: I understand that I have the right to revoke this consent at any time by providing written notice to Ocoee Pediatrics, however I acknowledge that revocation will not apply to actions already taken in reliance on this consent. This consent shall remain valid until revoked by me in writing or until the completion of the purpose for which was provided, whichever comes first.

Signature: By signing this form, I affirm that I have read and understood the consent form and I voluntarily authorize the electronic transmission of my private health information as described herein. I acknowledge that I have received or reviewed a copy of the current Notice of Privacy Practices stated above.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Ocoee Pediatrics

Delegation Of Consent

Name of Patient _____ DOB: _____

I hereby authorize the following individual(s) make medical decisions if I am not available.

Name of Person	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above individuals may consent to any medical care and treatment that is deemed necessary and appropriate by a licensed healthcare provider at Ocoee Pediatrics. This consent includes, but is not limited to, medical and surgical procedures, as well an elective and emergency care. This delegation of consent will remain in effect until a new delegation of consent is complete.

Patient Signature: _____ Date: _____