Ocoee Pediatrics

Patient Name: _____ DOB: _____

Name of person completing form: _____ Relationship to patient: _____

Sex: _____ Male _____ Female

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: _____

Parent/Guardian 1 Information: Relationship to patient ☐ Mother ☐ Father ☐ Other: _____

First Name: _____ Last Name: _____

Email: _____ DOB: _____ Sex: ___M or ___F

Address: _____ City: _____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____ Work Number _____

What is your preferred method of contact? _____Cell _____Home _____Email

Parents are: _____Married _____Single _____Divorced

Parent/Guardian 2 Information: Relationship to patient ☐ Mother ☐ Father ☐ Other:

First Name: _____ Last Name: _____

Email: _____ DOB: _____ Sex: ___M or ___F

Address: _____ City: _____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____ Work Number _____

What is your preferred method of contact? _____Cell _____Home _____Email

At Ocoee Pediatrics, we believe that clear and timely communication is essential to providing the best possible care for your child. For this reason, if we are unable to reach you directly, our providers **may leave a voicemail** on your phone regarding lab results or other clinical information.

If you **do not wish** for us to leave voicemail messages, please indicate by checking the box below:

☐ I do **not** authorize Ocoee Pediatrics to leave voicemail messages regarding clinical information.

Additionally, we will send **text messages** for appointment reminders, lab reminders, lab results, and confirmations to the phone number you provide.

***If there is a custody case involving your child please be advised unless a court order is submitted to Ocoee Pediatrics, both parents will have rights to child's healthcare record.**

Name of Patient _____ **DOB:** _____

Primary Insurance Information:

Insurance Company Name: _____ Name of Insured: _____

Policy/ID Number: _____ Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ Name of Insured: _____

Policy/ID Number: _____ Group #: _____

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.

Parent/Guardian Name: _____ Email: _____

Parent/Guardian 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"). I understand that except as otherwise provided by law, Ocoee Pediatrics cannot provide health care services or prescribe medicinal drugs to a minor child without first obtaining written parental or legal guardian consent as applicable. My signature below hereby confirms my consent for Ocoee Pediatrics to provide health care services and prescribe medicinal drugs to the patient based on the judgement of Ocoee Pediatrics and includes, without limitation, consent for the patient to be evaluated and treated 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 of the patient that I am consenting to 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 for the patient to receive such services from Ocoee Pediatrics. I acknowledge that this consent specifically expresses my consent for the patient 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 to the patient during the course of their treatment.

Acknowledgement
By signing below, I represent that I am either a parent or the legal guardian of the minor child/children named below, with the legal right to consent to medical treatment and medication prescribing and administration on behalf of the patient. 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, to the patient named below.

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Parent/Guardian 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: _____

Parent/Guardian Name: (please print) _____

Parent/Guardian 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 child's 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 child's 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: _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature: _____ Date: _____

Ocoee Pediatrics

Shared Custody Statement

Ocoee Pediatrics is dedicated to the health and well-being of our patients. Because our patients are children, we rely on parents, legal guardians, and other supportive adults to assist us in their care. Given the sensitive nature of the unique challenges that can arise when children of divorced or separated parents need medical care, we want to share Ocoee Pediatrics philosophy with you to help navigate these sensitive areas and avoid misunderstandings during the treatment process. In general, we ask that parents NOT place our office in the middle of family disagreements. We do not believe this is in the best interest of patients and rely on parents to keep our practice atmosphere calm, professional and caring for the children we serve.

1. State and federal privacy laws provide that both parents, custodial or non-custodial, have a right to the child's medical record and information about their care unless a court has determined otherwise. If either parent requests information, we will honor that request. If a Court Order has been issued that restricts either parent's role, please provide a copy of the Court Order to our office.

2. Stepparents are not generally authorized under the law to consent to medical treatment for a child. If a stepparent brings the child in, they must be listed on the permission to treat form to be seen. Please assist us by keeping your paperwork current.

3. We may communicate about a patient's care with one parent, based on who is involved in the patient's encounter. We rely on parents to communicate with each other about the child's visit, dates of appointments, treatment recommendations, and other relevant issues, rather than calling both parents separately to discuss the visit due to lack of communication between parents.

4. The parent who brings the child in for an appointment is responsible for co-pays or insurance deductible payments at the time of service, even if the other parent is responsible for medical insurance. Please do not ask our office to collect payments from a parent who is not at or may be unaware of the visit.

5. When both parents are attending the appointment, in a non-urgent situation, if parents disagree about medical treatment, we will postpone recommended treatment until there is an agreement between both parents.

6. If there is an urgent situation and the child is extremely ill, we will do what we feel is in the best interests of the child in a manner provided by applicable law.

7. Other situations that are not in the best interest of your child and will not be tolerated and may lead to dismissal from Ocoee Pediatrics
    a. One parent makes appointments, and the other one cancels them.
    b. A parent who asks us to write or say negative things about the other parent.
    c. Parents who fight or create conflict in our offices.
    d. Any other behaviors which interfere with our ability to provide excellent medical care to all of our patients in a warm and peaceful environment.
    e. Changing demographics, email address or portal username/password without notifying the other parent.

We sincerely appreciate your trust in us, and ours in you, to work together in the best interest of children's health.

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 your 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 _____

Name of Person Signing_____

Parent/Guardian Signature _____Date: _____

Ocoee Pediatrics

Delegation Of Consent

Name of Patient _____ DOB: _____

I hereby authorize the following individual(s) to bring my child to the office visits and to make medical decisions if I am not available.

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

The above individuals may consent to any medical care and treatment for this child 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.

Name of person signing form	Relationship to Patient
Signature of Parent/Guardian	Date

Ocoee Pediatrics

HIPPA AUTHORIZATION TO OBTAIN RECORDS
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name_____ DOB_____

I hereby authorize Ocoee Pediatrics, P.A. to use or disclose the patient's protected health information as described in this authorization.

_____ Standard Electronic Medical Record includes Vaccine, Growth Chart, Problem List, Recent labs, All Office Notes.

_____ Specific record/information as follows: _____

_____ Other: _____

Purpose of Disclosure: Continuation of Care

Release Information From: (Previous Providers Information)

Medical Office/Doctor Name_____
Address: _____City_____State_____Zip_____
Phone:_____Fax: _____

Release information to:

Ocoee Pediatrics, PA
1551 Boren Dr. Suite A
Ocoee, Fl 34761
P: 407-395-2037 F: 407-395-2038

I understand that:

- There may be a charge for the release of these records pursuant to 45 CR 164.524 (c) (4) (HIPPA).
- I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information or that of my child that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Ocoee Pediatrics may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

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**A photocopy or scan of this authorization shall be considered as effective and valid as the original for 1 year from date signed*

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature Parent/Guardian Date

Ocoee Pediatrics

New Patient History Form

Patient Name _____ DOB: _____

Name of person completing this form: _____ Relationship to patient: _____

Allergies (medications, vaccines, food, other) _____

Current medications: _____

Delivery & Birth History:

Place of Birth: (Name of the hospital) _____ City_____ State _____

Type of delivery: ____ Vaginal _____ Caesarean

_____ Breech/feet first?

Any problems during newborn period? _____ Yes _____ No (if yes please explain) _____

_____

Was the child premature? _____ Yes _____ No (If yes) _____ weeks _____ days

Birth weight: _____ Passed hearing screening? _____ Yes _____ No

Passed newborn screen? _____ Yes _____ No

Child's Past Medical History: Please mark yes and no, with brief explanation if yes:

Any hospitalizations? _____ Yes _____ No _____

Any surgeries? _____ Yes _____ No _____

Any emergency room or urgent care visit? _____ Yes _____ No _____

Has your child been treated for any of the following:

ADHD/ADD		**Concussion**			**Pneumonia**		
Allergies		**Urinary Tract Infection**			**Liver Disease/Hepatitis**		
Asthma/Wheezing		**Injury/broken bones**			**Anemia**		
Eczema		**Vision Problems/ Wears Glasses**			**Eating Disorder/Anorexia**		
Seizures		**Development Problems**			**Mental or Behavior Challenges**		
Heart Condition		**Speech Problems**			**Constipation**		
Autism		**Kidney Disease**			**Diabetes**		
Ear Infections		**Hearing Problems**			**Thyroid/Endocrine Disorder**		
Headache/Migraine		**Chicken Pox**			**Other:**		

Ocoee Pediatrics

Patient Name _____ DOB: _____

Family History:

Do any family members have any of the following conditions?

Condition:	Mother	Father	Sibling	Grandparent	Aunt/Uncle
High Blood Pressure					
High Cholesterol					
Prolonged QT					
Early Heart Attack (under age 50)					
Sudden Unexplained Death					
Anemia					
Bleeding or Clotting Disorder					
Allergies					
Autoimmune Disorder					
Cancer					
Development/Genetic Disease					
Diabetes					
Thyroid Disease					
Deafness					
ADD/ADHD					
Migraines					
Seizures					
Mental Illness					
Drug/Alcohol Abuse					
Asthma					
Tuberculosis					
Kidney Problems					
Hip Dysplasia					
Other (list)					

Social History:

Who lives in your home? (include parents, siblings, and other family members)

_____

If parents are not living together or if the child does not live with parents, do both parents have custody?

____ Yes ____ NO

Does anyone in the house smoke? _____ Yes _____ No

Are there any pets in the home? _____ Yes _____ No

Are the parents/caregiver employed? _____ Yes _____ No If yes, Occupation: _____

_____