ALL My KidS PEDIATRICS

PATIENT INFORMATION					
Patient Last Name, First Name, MI		Birth Date	Male ☐ Female ☐	Social Security #	
Street Address			Race	Home Phone	
City	State	Zip Code		How did you hear about us?	

OTHER SIBLINGS AT THIS OFFICE			
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #

PARENT/GUARDIAN INFORMATION				
Primary Caregiver Name	Birth Date		Social Security#	Email
Cell Phone	Work Phone	Ext	Primary Language	
Other Caregiver Name	Birth Date		Social Security#	Email
Cell Phone	Work Phone	Ext	Primary Language	

EMERGENCY CONTACT INFORMATION (different from parent)				
Name	Home Phone		Cell Phone	
Address	City	State	Zip	Relationship to patient

INSURANCE INFORMATION		
Insurance Name	Insurance Phone	Payer ID # *(if available)*
PolicyHolder Name *(If Medicaid write Self)*	PolicyHolder Relationship to Patient (*Please Circle*) Parent / Self / Other:_____	Healthy Kids Program? *Yes* *No*
ID#/Policy #	Group#	Insurance Address

Who *if* anyone other than parents or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in to All My Kids Pediatrics without your presence and making medical decisions for his or her treatment.	**☐N/A**	**☐Yes the following individuals:**

Name	Relationship to Patient	Phone #
Name	Relationship to Patient	Phone #

PORTAL INFORMATION		
The patient portal is the best method of communication to our office. Lab results, daily encounters, immunization records, med refills and other important information may be accessed here.	**Initial here that I do NOT want:**	

I certify that the above information is correct to the best of my knowledge. I release All My Kids Pediatrics, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian Signature: _____ **Date:** _____

Signature of Person Responsible for Bill:_____

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REFERRALS	**Initial**
Your provider must review and approve all referrals. You must be seen for the complaint prior to the referral authorization. All My Kids Pediatrics participates with different plans and each plan has specific regulations on how a referral is issued. We ask that you understand that in many instances this is a time-consuming process, please allow adequate time for completion. Please do not schedule an appointment until your referral is complete. **MOST INSURANCE COMPANIES WILL NOT BACKDATE A REFERRAL.**	_____
LAB WORK	**Initial**
Labs may be accessed immediately through the patient portal without having to contact our office. Only abnormal labs will receive a call back. We ask that you allow sufficient time to receive your results via patient portal; if you have not received results within one week after your test was performed please call us and our staff will assist you. **Please mark your lab preference below**: Quest ☐ Lab Corp ☐ Any lab ☐ Other_____ ☐	_____
FINANCIAL POLICY	**Initial**
For insured patients, should your insurance company require a co-pay for your visit or a deductible, it will be due at the time of service. Please be aware that you are responsible for all co-payments, non-covered services, and deductible amounts. Your insurance company coverage is an agreement between you, the patient, and your insurance company, the insurer. It is **your** responsibility to know your insurance benefits when you are receiving services. **For uninsured patients**, payment is due at time of service. All past due amounts must be paid prior to receiving new service. **For newborn** mothers with Medicaid, please request a form to initiate the process. You may also directly call 866-762-2237 or email at http://www.dcf.state.fl.us/ess/ to activate your child. We will see your child on the first visit as a courtesy. Future visits will require you to have updated Medicaid or the visit will require payment. **Divorce/Custody**, **The parent and/or legal guardian who brings the child in for medical services will be required to pay the bill or any outstanding balance.** We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.	_____
No Show/Canceled Appointments	**Initial**
All appointments require at least a 24 hour prior notification or cancellation. No shows or appointments cancelled with less than 24 hours notice will be subject to a missed/cancellation appointment fee of $40.00.	_____
Insurance Lifetime Authorization	**Initial**
I hereby request payment of authorized insurance (Medicaid, Managed Care, Commercial) benefits to be made either to me or on my behalf to All My Kids Pediatrics for any services furnished to me by All My Kids Pediatrics. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid HMO carrier as the full charge, and the patient is responsible only for the coinsurance, and co-pay services. Coinsurance and the deductibles are based upon the charge determination of the Managed Care carrier. I hereby authorize payment of Insurance Benefits Directly to All My Kids Pediatrics for Services Rendered, and release of any Medical Information necessary to process claims. I am responsible for all Co-Payments, Non-covered Services and for Deductible Amounts.	_____
Prescription Refills Require a 24 Notice	**Initial**
Request for prescription refills should be called in between 10:00am and 3:00pm, Monday thru Friday. Refills can also be requested via patient portal. Calls and portal requests received after 4:00pm will be addressed the following day. Your provider must review and approve all prescription requests. Therefore, they will not be filled after office hours or on the weekends. Please do not call the after-hours line with medication refills. Providers are on-call for **Urgent Care Only**.	_____

_____ _____

Patient/Legal Guardian Signature **Date**

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Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical record information by **All My Kids Pediatrics** in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree that the Practice may also disclose the following types of information contained in my medical record:	**Please Initial**
HIV/AIDS Information	
Mental Health Information	
Substance Abuse Information	
Sexually Transmitted Disease Information	
If Patient is under the age of eighteen (18), Pregnancy Information	
I do not agree to any of the above types of information being disclosed by the Practice	

I agree and consent to All My Kids Pediatrics releasing information to me in the following manners:	**Please Initial**
Via **Mail**	
Via **Telephone**	
Via **Fax** to my designated fax number which is: _____	

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. By signing this consent form, you consent to our use and release of PHI about you or your child for the treatment, payment and health care operations as described in our notice. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____ _____

Patient/Legal Guardian Signature **Date**

Thank you for choosing All My Kids Pediatrics for your child's primary care needs.

Staff Initial:_____ Date:_____ Parent refused to sign ☐