New Patient Information

How did you hear about us? (Please check one) ☐ Friend ☐ Physician ☐ Yellow Pages ☐ Website ☐ Insurance Co. ☐ other_____

PATIENT INFORMATION				
Patient Name:	DOB	Sex assigned at Birth		
Parent Primary Email Address	Enable text messages about appointments and important messages to be sent to my email and text.	Yes	No	
Address:				
City	State	Zip code		
Cell phone number responsible for text appointment reminders:				

CONTACT INFORMATION					
Mother's Name:			**Father's Name**:		
Last 4 of Social Security #:			Last four of Social Security #:		
DOB			DOB		
Cell phone:			Cell phone:		
Alternative Phone:			Alternative Phone:		
Work Phone			Work Phone:		
Address (if different from above):			Address (if different from above):		
City	State	Zip code	City	State	Zip code
Name of Emergency Contact:	Relation to patient:		Phone:	Address:	

INSURANCE		
Primary Insurance Company name:	Subscriber #:	Group #:
Guarantor	Provider services #:	
Secondary Insurance Company Name	Subscriber #:	Group #:

I authorize the release of any medical or other information necessary to process my child(ren)'s insurance claim. This includes the release of medical information to other physicians or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to Colonial Medical Center, East Orlando for services rendered. All Payments are required on the date of service. We ask for 24 hour notice to cancel an appointment with our providers.

PLEASE NOTE: Insurance card(s) and co-pay amounts (if applicable) MUST be presented at EACH visit otherwise services may not be rendered.

Authorized by: _____(Parent/Legal Guardian) Date: _____

PHARMACY			
Name:	Address:	Phone:	Fax:

Authorization for Access to Protected Health Information and Medical Treatment of My Minor Child

For Divorced or Separated Parents: Each parent has equal access to health information about their unemancipated child and equal medical decision making for all treatments and services unless there is a court order to the contrary that is known us, where parental rights are restricted. A **copy of the court order is required** to be kept on file in your child's permanent medical record(s).

Please indicate below those individuals with who there is restricted access:
Name_____**Relationship**_____
Name_____**Relationship**_____

Signed_____Date_____Phone #_____

Section B: Authorization for a minor child, less than 18 years of age, to receive medical services with an alternative adult, other than a parent or guardian present.

I, _____, the parent/legal guardian of (Child) _____, born __/__/20__, do hereby consent to any medical care, laboratory services, and administration of medications or vaccinations, by a physician at Colonial Medical Center, East Orlando, which is deemed medically necessary for the welfare of my child, while in the care of the following individual(s) (See Below), while I am unavailable either in person or by phone. I also agree to be financially responsible for payment of all charges in connection with the care and treatment(s) rendered.

Name_____Relationship to Minor_____

Name_____Relationship to Minor_____

Name_____Relationship to Minor_____

This authorization is effective from today until ___/___/20___.

Signed_____Date_____Phone #_____

Require by Government Mandate (although you may Decline)

Language: _____

Race: _____

Ethnicity: _____

ALLERGIES

Medications? (please list)

Type of allergic reaction

_____Rash _____Hives _____Respiratory Problems _____Swelling of face, neck, tongue

Foods? (please list)

Type of allergic reaction

_____Rash _____Hives _____Respiratory Problems _____Swelling of face, neck, tongue

Child and Family Health History (please check any that apply)

Child	Family		Explain
_____	_____	ADD/ADHD	_____
_____	_____	Allergies	_____
_____	_____	Autism Spectrum	_____
_____	_____	Cancer	_____
_____	_____	Depression/Mental Illness	_____
_____	_____	Diabetes	_____
_____	_____	Drug/Alcohol Abuse	_____
_____	_____	Eczema	_____
_____	_____	Epilepsy/Seizures	_____
_____	_____	Frequent Headaches	_____
_____	_____	Frequent Ear Infection	_____
_____	_____	Heart Murmur	_____
_____	_____	UTI	_____
_____	_____	Exposure to Tuberculosis	_____
_____	_____	Symptoms of Tuberculosis	weight loss/night sweats/recurring fever/chronic cough

Surgical History

_____ PE Tubes _____ Adenoids & Tonsils _____ Appendix Other:_____

Does your child have asthma/wheezing/frequent cough _____Yes _____No

Has your child ever taken albuterol: Syrup/Inhaler/Nebulizer

Do you own a nebulizer? _____Yes _____No

Family history of asthma?_____

Immunizations up to date? (please check)

_____Complete _____Partial _____None _____Do not vaccinate

Do you have any concerns about your child's development? Physically/Mentally/Speech

Explain:_____

Does any in the household smoke? _____Yes _____No

Do you, friends or family have a pool? _____Yes _____No

Has your child been exposed to lead? _____Yes _____No

Do you have pets? _____Yes _____No

Do you & your children feel safe in your home? _____Yes _____No

Colonial Medical Center- East Orlando

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

CONSENT FOR TREATMENT The undersigned hereby consents to the provision of examination, treatments, medical & Laboratory procedures, drugs, and supplies to the patient, as ordered by the patient's physician, and acknowledges that no guarantee of assurance has been made as to results of such treatments, procedures or examinations.

RELEASE OF INFORMATRION The undersigned hereby authorizes Colonial Medical Center _East Orlando and any involved physician to disclose and release all of any part of the patient's record to any person or corporation which is or may be liable, under a contract to the patient, family member or employer of the patient for all or part of the charges.

PATIENT/GUARANTOR AGREEMENT The undersigned agrees that, in consideration of the services rendered to the patient, they are obliged to pay, and unconditionally guarantees payment, including but not limited to co-pays and deductibles on the patient's account(s). I understand that payment in full is required on a timely basis, regardless of whether any third party payment is pending.

In the event of payment default of any unpaid balance, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, the undersigned hereby agrees to pay any and all additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by Florida laws governing these transactions.

ASSIGNMENT OF INSURANCE BENEFITS The undersigned hereby assigns to Colonial Medical Center -East Orlando, for application to the patient's bill, any benefits or other recovery of any type, arising our of any insurance policy covering the patient or any other party liable to the patient, and authorizes direct payment to Colonial Medical Center-East Orlando for such benefit recovery. IT is agreed the Colonial Medical Center-East Orlando may accept any such payments. The undersigned is responsible for charges not covered by this assignment.

RELEASE OF CONFIENTIAL INFORMATION FOR BILLING PURPOSES Disclosure of substance abuse, psychiatric treatment and HIV information is protected under Federal or State law. Federal or State laws prohibit making any disclosure of confidential information without the consent of the person whom it pertains, or as otherwise permitted or required by Federal or State law. The undersigned hereby authorizes Colonial Medical Center – East Orlando and any involved physician(s) to disclose and release to the patient's insurance company or other third party, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding (please initial information to be released for billing)

_____ The patient's hospitalization and/or treatment for alcohol or drug abuse treatment
_____ The patient's hospitalization and/or treatment for mental illness.
_____ The fact that HIV testing was performed and the patients HIV test results.

This consent will remain in effect until the insurance claim has been settled: and may be revoked prior to that time, except to the extent that action has already been taken in regards to this claim.

- I give this practice my consent to use of disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
- I have been informed that I may review practice Notice of Privacy rights before signing this consent.
- I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
- I understand that I have the right to request a restriction of how my protected private health information is used. However, I understand that the practice is not required to agree to the request and I will be notified in writing
- I certify that I have read the above information and that I am the patient or duly authorized to execute the above and accept its terms

Signature_____Date_____

Witness_____(OFFICE STAFF ONLY)

Consent for Treatment

- I understand that healthcare services may include but are not limited to, medical examination, diagnostic tests, medication, and/or surgery and that such services may be deemed necessary by the healthcare provider.
- I acknowledge that the healthcare provider has explained the potential risks and benefits of the treatment options and has had the opportunity to ask questions and clarify any concerns.
- I understand that I have the right to ask for additional information about the proposed treatment, to refuse treatment, or to seek a second opinion.
- I authorize the healthcare provider and their staff to provide medical treatment to my child, and I assume full responsibility for payment for such treatment.
- I hereby authorize the release of any medical information necessary to process insurance claims or for any other legitimate purpose.

Parent Signature_____Date_____

Child's Name_____

Patient Eligibility Screening Record
Florida Vaccines for Children Program

1. Initial Screening Date: _____
   M M D D Y Y Y Y

2. Child's Name: _____ ____
   Last Name First MI

3. Child's Date of Birth: _____
   M M D D Y Y Y Y

4. Parent/Guardian/Individual of Record: _____ ____
   Last Name First MI

5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC):

   ☐ Yes **X** No

6. Primary Provider's Name: L i , X i a o F e n g M D ____
   Last Name First MI

7. This patient qualifies for immunization through the VFC Program because he/she (check only one box):

   ☐ a) Is enrolled in Medicaid
   ☐ b) Does not have health insurance
   ☐ c) Is an American Indian or Alaskan Native
   ☐ d) Is underinsured (has health insurance that does not pay for vaccinations)*
   ☐ e) This child does not qualify for immunizations through the VFC Program because he/she does not meet the eligibility criteria

Eligibility Criteria					
Date	**Is enrolled in Medicaid**	**Does not have health insurance**	**Is an American Indian or Alaskan Native**	**Underinsured (has health insurance that does not pay for vaccinations)***	**Does not meet eligibility criteria**

The health care provider must keep in the office a record of all children 18 years of age or younger who receive immunizations. The record may be completed by the parent, guardian, individual of record or by the health care provider. **VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed.** While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

***To be supported with VFC Program-purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC or under a deputized agreement with an approved provider.**

Colonial Medical Center, East Orlando

Office Policies

At CMCEO, we are committed to maintaining a strong physician-patient relationship. Informing you of our office policies in advance ensures smooth communication and helps us achieve our objectives. Please read each section carefully and initial. If you have any questions, feel free to ask any member of our staff.

Appointments

1) We have set aside to see and treat your child. If you are not able to keep an appointment, we require notice at least two hours before. **There is a $75 fee for missed appointments.**
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We try to keep wait times short. However, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit. Medicaid patients can have one physical appoint per year.
5) Parents **must** supervise children at **all** times.
6) Please keep our office clean by picking up after your child. Please do not allow your child to damage or deface our office and furnishings.
7) We are a "***by-appointment only*** "office. If available, we will make every attempt to get you an appointment later the same day

Initial:_____

Insurance Plans

Please understand

1) We must emphasize that as pediatric providers, our relationship is with **you,** not your insurance company.
2) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for the payment of the visit and to submit charges to the correct plan for reimbursement. If you have commercial insurance and Medicaid you MUST tell us both plans. If a claim is denied because you did not tell us about the commercial insurance and the claim is denied you will be responsible for the full amount of the bill regardless of Medicaid coverage**
3) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit. We will not see Medicaid patients (except newborns) unless they are assigned to Dr. Li.
4) We do our best to keep up with insurance plans. However, it is your responsibility to understand your benefit plan in regard to, for instance, covered services and participating laboratories. For example: Not all plans cover annual healthy (well) physicals, sports physicals and vaccinations. If these are not covered, you will be responsible for payment.

Initial:_____

Referrals

1) Marketplace patient: Advance notice is needed for all non-emergent referrals, typically 3-5 business days.
2) In general, we will not agree to a referral for a problem we have not been consulted about first. In most cases you will have to make an appointment to see the provider.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.
2) Co-payments are due at the time of service. A $15 service fee will be charged in addition to your co-payment, if the co-payment is not paid by the end of the business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 14 business days of receipt of your bill.
5) If previous arrangements have **not** been made with our office, any account balance outstanding longer than 28 days will be charged a $5 bill fee for **each** 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
6) For scheduled appointments, any account balance must be paid at check in. If your balance is 90+ days old, it must be paid in full prior to scheduling.
7) You may pay your bill by credit or debit card anytime on our website. The office will use text messages to assist in collecting balances. You may pay directly by responding to the text.
8) The accompanying parent or adult is responsible for full payment at the time of service. In the case of divorce/separation, please do not place our office in the middle of such disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for payment arrangements and assistance in the management of your account. It has been our policy since 2007 that all patients with plans that contain deductibles and/or coinsurance will be required to pay for their visits until their deductibles are met. **Please understand that if you send your child in with someone else you are still required to pay for your visit. We will not bill you because you do not accompany your child**. Please make sure the person bringing in your child has enough money to cover the visit or please call the office in advance to make a payment arrangement for your child's appointment.

   I understand that I will be required to pay for my child's office visit until my deductible is met. I also know that I must send payment with anyone accompanying my child to his/her appointments.

Initial: _____

Coordination of Benefits

Coordination of Benefits for People who have Private Health Insurance and Medicaid

- You must inform the office that you have both insurances.
- Failure to notify the office of both policies will result in claims not being paid.
- **If a claim is not paid you will be held financially responsible for the entire amount of the bill.**

Coordination of Benefits for People who have two Private Health Insurances

- You must inform the office that you have both insurances.
- Failure to notify the office of both policies will result in claims not being paid.
- **If a claim is not paid you will be held financially responsible for the entire amount of the bill**

Coordination of Benefits

- Each year you may receive a coordination of benefits letter to verify if you or your eligible dependents have obtained or will obtain other medical insurance coverage.
- It is important to keep your COB information current to avoid a delay in claims processing.
- If you receive a COB letter, fill it out and return it immediately, or you can update your COB information on the insurance companies web site.
- Failure to answer this letter can result in a denial of claims.
- **If a claim is denied due to you not answering the COB letter, you will be held responsible for the entire amount of the bill.**

Information Verification

- In addition, there are times that you will receive letters from your insurance company asking you to verify information.
- It is critical that you answer all information asked of you.
- This may include questions on whether your child is a full time student or if any injury was a result of an accident in the home or in the car.
- Failure to answer these letters can also lead to a denial of claims.
- **Again, if a claim is denied due to you not answering one of these letters you will be held responsible for payment of the entire amount of the bill.**

I understand that if a medical claim is denied by my health insurance company due to a lack of answering letters such as (but not limited to) COB, student verification and accident information I will be held financially responsible for my child's medical bill. I also understand that it is my responsibility to notify the office of secondary insurances. If a claim is not paid due to the lack of information, I will be financially responsible for my child's medical bill.

_____

Initial

After Hours Nurse Calls

1) After-hours calls should be reserved for true emergencies. Callers will reach a voice message which gives them the opportunity to reach the doctor. This will be considered a tele-med appointment, and all applicable co-pays will be billed to you the following business day.

Initial:_____

Forms

1) There is no charge for immunization and physical forms (including camp and pop warner forms) given at the time of your child's visit. This is considered part of the visit. *However*, should you lose any of your forms, there could be a $10 fee ($5 per form) to replace them. Payments must be made at the time you request them.

2) School sports physical forms are available in our office. We will fill this out at the time of the appointment. If you lose this form, there will be a $5 dollar fee to replace it. If we have one on file for the year we will email you a form at no charge.

3) FMLA forms cost $35 and IRS letters cost $15 Other Letters Cost $10 **Initial: _____**

Transfer of Records

1) If you transfer to another physician, we will provide you copy of your children's immunization record, free of charge.

2) You will need to fill out an authorization form either at our office or your new physician's. There is no fee if you have us fax your child's chart to the new provider. This is generally done within 2 business days

3) A copy of your child's records can be requested with a signed authorization form. If full chart is requested there will be a $25 fee per child. This will be put on a USB. A copy of your printed complete record is available for a fee of $1 per page for the first 25 pages and then .25 per page after that, per Florida State law. This will take 5 business days.

4) We provide records of your child's visits (including consultations and specialists) rendered here at CMCEO only. For any previous records, you must request them directly from your previous doctor(s).

Initial:_____

I have read and understand these office policies and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name: _____

Responsible Party Member's Name: _____

Relationship: _____

Responsible Party Member's Signature: _____