Seaside Pediatrics of Key West

PATIENT INFORMATION

Patient's Name: First:_____ Last:_____

Date of Birth: _____ /_____/_____ **Social Security No.**:_____-_____-_____ **Sex**: Male ❒ Female: ❒

Address:_____ _____City:_____ State:_____ Zip:_____

Phone:_____Email: _____

Other family members treated here:_____

INSURANCE INFORMATION1

Primary Insurance Carrier:_____ Policy #:_____

Policyholder's Name:_____ Group #:_____

Policyholder's Date of Birth: _____/_____/_____ Policyholder's Social Security No_____-_____-_____

Patient's Relationship to Policyholder: ❒ Self ❒ Spouse ❒ Child ❒ Other

PARENT(S)/LEGAL GUARDIAN INFORMATION

Who has legal custody of the patient?

Parents ❒ Mother only ❒ Father only ❒ Foster parent ❒ Grandparent ❒ Wesley House/Other ❒

IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT

Mother/Guardian's name:_____ **DOB**: _____/_____/_____ **SS#:**_____-_____-_____

Address: ❒ Check here if same as above

City/State/Zip: _____ Home #: _____ Cell/Work#: _____

Occupation:_____ Employer:_____ Phone:_____

Father/Guardian's name:_____ **DOB:** _____/_____/_____ **SS#:**_____-_____-_____

Address: ❒ Check here if same as above

City/State/Zip: _____ Home #: _____ Cell/Work#: _____

Occupation:_____ Employer:_____ Phone: _____

Preferred method of contact: ❒ Home Phone ❒ Cell Phone Email address: _____

Emergency Contact (Other than names Above)

Name:_____ Relationship:_____ Phone #:_____-_____-_____

Seaside Pediatrics of Key West

Pediatric Health History

Your child's health is important to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item, and we will be happy to discuss it with you. All information will be treated as confidential.

Child's Name:_____ Date of Birth: ____/ ____/ ____

S.S #:_____ Male _____ Female_____

Child's School/Day Care:_____ City/State: _____

Previous Primary Care Physician: _____ Phone No: _____

Pharmacy: _____ Phone No: _____

Allergies: Yes _____ No ____ **Any Current Medications: Yes _____ No ____**

Substance	Reaction	Medication Name	Dosage/Frequency

Any Surgical History? Yes _____ No ____ If yes, please explain: _____

_____

Date(s) of Surgery:_____

Any Hospitalization(s)? Yes _____ No ____ If yes, please explain:_____

_____

Date(s) of Hospitalization(s): _____

_____

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Seaside Pediatrics of Key West

Medical History

Please put an "**X**" in the column if your child has had any of the following;

General Symptoms	"X"	Gastrointestinal	"X"	Heart	"X"
Chills		Blood in stool		Chest Pain	
Dizziness		Constipation		Irregular Heartbeat	
Fainting		Vomiting		Shortness of Breath	
Headache		Reflux (infant vomiting)		Heart disease	
Weight Loss or Gain		Rectal Bleeding			
Cough more than 2 weeks		Diarrhea			
Wheezing		**Urinary**		**Skin**	
Stomach Pain		Bed-wetting		Eczema	
Vision Problems		Blood in Urine		Rash that won't go away	
Hearing / Speech		Long term diaper rash		Easy to bruise	
Difficulty breathing		Pain in vagina or penis		Hives	
Hearing Loss		Painful urination		Warts	
Frequent Ear Infections		Unusual urine color		Discoloration	
Speech Difficulty		Discharge from vagina or penis		Boils	
Ear infections - more than 2/year					
Respiratory		**Musculoskeletal**		**Behavior**	
Asthma		Broken Bones		ADD / ADHD	
Frequent Sinus		Muscle Sprains		Depression	
More than 8 colds/year		Coordination problem		Anxietv	
Nose bleeds		Swollen Joints		Past treatment for mental illness	
Frequent Runny Nose					
Seasonal Allergies					

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Seaside Pediatrics of Key West

Social History

Parents: Single / Married Stepmother / Stepfather

Daycare: Yes / No

Water: City / Well

Family Smoking: Yes / No

Home Type : House /Non House

Pets in home: Yes / No

Mold / Mildew: Yes / No

(**This information is pertaining to the child! If not applicable, leave it blank.)**

Alcohol / Drug Use: Yes / No

Sexually Active: Yes / No

Siblings

Name	Date of Birth	
_____	_____	Male / Female
_____	_____	Male / Female
_____	_____	Male / Female
_____	_____	Male / Female
_____	_____	Male / Female
_____	_____	Male / Female
_____	_____	Male / Female

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Seaside Pediatrics of Key West

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

To: Seaside Pediatrics of Key West
Jose M Texidor M.D
1075 Duval St. Unit C-14
Key West, FL 33040

I, the undersigned parent or legal guardian of _____, a minor child whose date of birth is _____, ("Child"), by this written authorization do hereby authorize and give my consent to Seaside Pediatrics of Key West / Jose M Texidor M.D its physician and their authorized personnel (referred to individually and collectively as "Physicians") to evaluate and administer medical treatment to my Child in those situations indicated by me below where I am not physically present with my child.

As initialed below to indicate my consent and/or the delegation of my authority to consent to the medical evaluation, diagnosis and treatment of my Child, I agree to and hereby authorize the following actions by Physicians, until such time as I revoke in writing the authorizations and consents listed below:

_____ I hereby authorize Physicians to see, examine, evaluate and treat (including lab work) my Child, in accordance with the personal requests of my Child's family member, _____, who is related to my Child as his or her _____, if I am not present, in accordance with the consent communicated by the above individual to Physicians pursuant to the delegation of my authority granted here, and consistent with the Physicians' professional judgment of my Child's medical needs.

FOR CHILDREN 16 YEARS OF AGE OR OLDER:

_____ I hereby authorize Physicians to see, examine, evaluate and treat my Child in accordance with my Child's personal requests if I am not present, consistent with the Physicians' professional judgment of my Child's medical needs.

Nothing herein shall be deemed as my request, direction, authorization or consent for Physicians to administer or deliver any examination, diagnostic testing, treatment or other medical services which Physicians, in their sole professional judgment, deem to be inappropriate in the absence of a parent or not medically necessary.

This document is intended to be a valid authorization and consent pursuant to Florida Medical Consent Law, Florida Statutes 766.103, and shall remain in force until revoked by me in writing.

_____ _____
Parent / Legal Guardians Name (Printed) Date

_____
Signature of Parent / Legal Guardian

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority. [5]

Seaside Pediatrics of Key West

JOSE M TEXIDOR M.D.

FINANCIAL POLICY

It is the policy of this office to help keep health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- ➢ Bring you child's current health insurance card to **every** office visit.
- ➢ Notify us of any changes in insurance, address, phone number, etc.
- ➢ Pay your co-pay or deductible at the time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- ➢ Double check with your plan as to the participation status of Jose M Texidor, MD. Please understand you are responsible for verifying this information with your carrier.
- ➢ Verify coverage limitations prior to appointment date.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us, the balance on your account is due and payable within 10 days of the statement date. If you are unable to pay the amount due or if you disagree with the billed amount, please contact our office immediately. There is a **$10 statement fee for any balance over 30 days.** (_____)

Co-Payments: We are required by our insurance contracts to collect all applicable co-pays at the time of service. **If a co-pay is not paid at the time of service, a $25 late fee will be assessed.** This is in addition to a statement fee if applicable. (_____)

Returned Checks: There is a fee, currently $30, for any checks returned by your bank.

Automobile Accidents: If your child is involved in an automobile accident, he/she must first be evaluated at a hospital ER. If your child requires follow-up care with his/her primary care doctor, we will provide this service, however, the visit is considered out of network as we do not have a contract with auto insurance companies. **These visits must be paid in full at the time of service.**

Missed Appointments: If a patient misses their scheduled appointment, without 24 hours notice given, **a fee of $20 will be charged**. (_____). Patients who continue to miss further appointments may be Discharged from the practice.

Transfer of Records: You will need to complete the Authorization for Release of Medical Records form, which can be obtained from our office. This form needs to be completed in its entirety in order for us to process the request. All balances should be paid in full before records are transferred.

Divorce: In case of divorce or separation, the parent or individual with whom the child resides, will be the parent responsible for all fees for services rendered, independent of insurance coverage and/or with a divorce decree may state. It is that parent's responsibility to collect from the other parent.

Newborns: Most insurance carriers require a newborn be added to the parent's policy within 30 days. You are fully responsible for any fees incurred if your newborn is not added within the allotted time. You may receive a statement within that time if we have not received verifiable insurance information. Please contact our office once you have received your newborn's active insurance information.[6]

Seaside Pediatrics of Key West

Secondary Insurance: Seaside Pediatrics of Key West / Jose M Texidor, MD, does not file secondary insurance. You will be responsible for all co-pays, deductibles, coinsurances, etc., that apply to your primary insurance, at the time of service.

Delinquent Accounts: If a balance remains on your account beyond **30 days** following the date of services rendered, it is considered delinquent and the account guarantor will become responsible for payment of the entire remaining balance prior to scheduling any appointments, unless arrangements have been made with our office.

If your account is delinquent beyond **60 days** following the date of services rendered, it will be turned over to a collection agency, you risk reporting of that information to national credit bureaus, **all future routine appointments will be canceled and no further routine appointments will be scheduled until the balance of your account is paid in full**. In addition, the account guarantor will be responsible for any collections and attorney's fees and any cost or expense associated therewith. You will be dismissed from the practice if your account is placed in collections. No further medical service of any kind will be given to anyone with an account placed into collections, including telephone advice.

Medicaid Policies and Information: If you are a Medicaid recipient, you must adhere to the policies of the Medicaid program. You must have a valid, active recipient ID number, which we will verify before any services are rendered. If the Medicaid recipient number is returned to us as Inactive, Unknown, Missing, Invalid, or Not Found for any reason, any and all charges will be collected before any services are rendered.

If your child is a newborn, and the Medicaid recipient ID number has not yet been processed, you can still see the physician; however, you must immediately contact Medicaid to inform them of the birth of your newborn. If the claim is denied by Medicaid, you will be responsible for any and all charges pertaining to the visit.

If your Medicaid recipient ID number is assigned to another physician/facility or is not assigned to anyone, then you, the parent/guardian, must call Medicaid and request that your primary care physician be changed to Jose Texidor for any future appointments. We cannot make this change for you – it is between you and your insurance carrier, which in this case is Medicaid. We are not allowed to see your child if another physician/facility is listed as the primary care physician.

The Medicaid Program does not cover any charges due to administrative fees. This includes the fees that are incurred due to print-outs of medical records as well as no show fees for missed appointments. If you have any problems or questions related to the Medicaid Program Policies and Guidelines, please contact them directly.

I have read this Financial Policy as outlined above and on page 1, and understand that I am ultimately responsible for the charges incurred and any additional charges or fees if applicable.

Patient's Name: _____ Date of Birth: _____/ _____/ _____

Guarantor Name: (please print) _____

Guarantor Signature: Date: _____

Relationship to Patient: _____

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Seaside Pediatrics of Key West

I request that payment of authorized insurance benefits be made on my behalf to Seaside Pediatrics of Key West / Jose M. Texidor M.D., for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form, I am accepting responsibility as explained above for payment for services rendered.

Parent / guardian Signature:_____ **Date:** _____/ _____/ _____

OFFICE POLICY FOR PAYMENT

Payment is expected **IN FULL** at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and/or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services **IN FULL.**

I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent / guardian Signature:_____ **Date:** _____/ _____/ _____

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Seaside Pediatrics of Key West

Receipt of Notice of Privacy Practices
Written Acknowledge Form

Patient Name:_____Date of Birth:_____

I,_____, have had the opportunity to review a copy

of Seaside Pediatrics of Key West / Dr. Jose M Texidor's Notice of Privacy Practices.

_____ _____. _____

Signature of Patient / Parent / Guardian Date

_____ _____

Relationship to Patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

I hereby grant permission to Dr. Jose Texidor's Office to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to contact any other relevant business that is deemed necessary.

Personal or detailed information will not be left on an answering machine or voice mail.

_____

Signature of Patient / Parent / Guardian[9]

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

Seaside Pediatrics of Key West
Jose M Texidor M.D.
Authorization for Release of Information

I hereby request the medical record for the following patient: First:_____

Last: _____ Date of Birth:_____ /_____/_____ Sex: Male ❒ Female: ❒

Social Security No.:_____ - _____ - _____ Phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Please release information from patient's medical record as indicated below to:

Seaside Pediatrics of Key West / Jose M. Texidor, MD / 1075 Duval St. Unit C-14, Key West, Fl. 33040

Information to be released:

❒ Immunization Record

❒ Well Visits

❒ Sick Visits

❒ Labs & Radiology Reports

❒ Entire Record

I specifically authorize the release of information relating to:

❒ Substance abuse (including alcohol/drug abuse)
❒ Mental Health (including psychotherapy notes)
❒ HIV related information (AIDS related testing)
❒ Genetic Testing

_____ _____
Signature of Parent/Guardian Date

Purpose of Disclosure: ❒ Changing physicians ❒ Consultation/second Opinion ❒ Continuing Care
❒ Legal ❒ School ❒ Insurance ❒ Other*

*If "Other," please specify: _____

I understand that this authorization will expire _____ days after I have signed the form.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

_____ _____
Parent/Legal Guardian **Date**

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FOR OFFICE USE ONLY
DATE REQUEST FILLED: BY:_____ By:_____

IDENTIFICATION PRESENTED:_____ FEE COLLECTED:_____