Kidscare Pediatrics of Plantation, PA
7442 Royal Palm Blvd.
Margate, FL 33063
P: 954-472-2128 F:954-971-0098

Registration *Pediatric*

Patient Information

Date _____ Chart No. _____

Patient _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Mother/Guardian _____ DoB__/__/__ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB__/__/__ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Sibling _____ Sex: ☑M ☐F DoB__/__/__ SS# _____

Sibling _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Sibling _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relation _____ Phone _____

Party Responsible for Payment: ☐ Father ☐ Mother ☐ Guardian ☐ Both _____

Who referred you to our office? _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ DoB__/__/__ Relation _____

Medicaid/Champus/Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize KidsCare Pediatrics to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to KidsCare Pediatrics for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

Kidscare Pediatrics of Plantation, PA
7442 Royal Palm Blvd.
Margate, FL 33063
P: 954-472-2128 F:954-971-0098

Initial History
Pediatric

Patient's Name_____ Sex: ☐ Male ☐ Female DoB ___ /___ /___ Chart #_____

Form completed by _____ Relation to patient_____ Date ___ /___ /___

Family

Are mother and father ☐ married ☐ separated / divorced?

If separated / divorced, what is the patient's custody status?_____

If one or both parents are not living in the home, how often does child see that parent(s)?_____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age and where they live:_____

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No

Do you consider your child to be in good health? ☐ Yes ☐ No

Current Medications:

Drug Allergies? ☐ Yes ☐ No

Review of Systems and Past Medical History

Does the patient now have or has ever had any of the following:	Yes	No	*Explain*
1. a serious medical problem?	☐	☐	
2. been hospitalized or had surgery?	☐	☐	
3. had a serious injury or accident?	☐	☐	
4. chickenpox? When?_____	☐	☐	
5. allergies, asthma, bronchitis, respiratory infections?	☐	☐	
6. repeated ear infections, tubes, difficulty with hearing?	☐	☐	
7. problems with eyes or vision?	☐	☐	
8. heart problems or a heart murmur?	☐	☐	
9. anemia, bleeding problems or blood transfusion?	☐	☐	
10. abdominal pain, constipation requiring doctor visits?	☐	☐	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	
13. recurrent skin problems (acne, eczema, etc)?	☐	☐	
14. headaches, convulsions, other neurologic problems?	☐	☐	
15. diabetes, thyroid or other endocrine problems?	☐	☐	
16 . If patient is female, has she started her menstrual periods?	☐	☐	
If yes, is she having any problems?	☐	☐	

History Update *(date / initial) Changes in history noted in chart on day of visit.*

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____

Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name_____
Phone_____
Name_____
Phone_____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name_____
Phone_____
Name_____
Phone_____

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

_____
_____
_____

- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

_____
_____
_____
_____

Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". ☐ Yes ☐ No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

_____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

_____ Date _____
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

Name of Patient_____ Date ___/___/___ Chart #_____

Development

Are you concerned about the patient's... Yes No

1. physical development? ☐ ☐
2. mental or emotional development? ☐ ☐
3. learning ability? ☐ ☐
4. attention span or activity level? ☐ ☐

If in school, has the patient had...

1. tutoring outside of the classroom? ☐ ☐
2. placement in a special or resource class? ☐ ☐
3. to repeat a grade? ☐ ☐
4. educational or psychological testing? ☐ ☐
5. behavioral problems? ☐ ☐

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ excessive wt. gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐ other ☐ none

Did the mother smoke, use recreational drugs or alcohol? ☐ Yes ☐ No

Birth

Birth Weight _____ Length _____ Apgar _____ Was baby born at: ☐ Term ☐ Early ☐ Late

If early, how many weeks gestation? _____ Was labor difficult or prolonged? ☐ Yes ☐ No

Was delivery difficult or complicated? ☐ Yes ☐ No

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast _____ ☐ Formula _____

☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea

☐ blood in stools ☐ other ☐ none

Family History

If a family member has or has had any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. ☐ _____ Deafness
2. ☐ _____ Allergies
3. ☐ _____ Drug allergies
4. ☐ _____ Asthma
5. ☐ _____ Eczema
6. ☐ _____ Respiratory infections
7. ☐ _____ Eye or visual problems
8. ☐ _____ Ear infections /tubes
9. ☐ _____ Tuberculosis
10. ☐ _____ Liver disease
11. ☐ _____ Immunity problems / HIV
12. ☐ _____ High cholesterol
13. ☐ _____ High blood pressure before 50 yrs
14. ☐ _____ Heart attack / stroke before 50 yrs
15. ☐ _____ Other heart problems
16. ☐ _____ Anemia / Blood disorders
17. ☐ _____ Diabetes before 50 yrs
18. ☐ _____ Thyroid or other endocrine prob.
19. ☐ _____ Obesity
20. ☐ _____ Bladder / Kidney
21. ☐ _____ Stomach / GI
22. ☐ _____ Cancer
23. ☐ _____ Epilepsy or convulsions
24. ☐ _____ Hereditary problems
25. ☐ _____ Learning prob. /Attent. span
26. ☐ _____ Emotional / Behavioral
27. ☐ _____ Mental illness
28. ☐ _____ Mental retardation
29. ☐ _____ Drug / Alcohol abuse
30. ☐ _____ Other

Provider Comments

History Reviewed by_____

KidsCare Pediatrics Of Plantation, P.A.

7442 Royal Palm Blvd.. Margate, FL 33063
Telephone: (954) 473-2128 - Facsimile: (954) 954-971-0098

Pediatric and Adolescent Medicine

Consent for Release of Information

Patient's Name: _____

Patient's Address: _____

Patient's Date of Birth: _____

I do hereby consent and authorize: _____
(Name of doctor, clinic, or hospital releasing information)

_____
(Address)

Phone #: _____ Fax: _____

To release copies of my medical information, including current and previous medical records for other practices and practitioners, hospitals, and any information relating to HIV testing , AIDS and any AIDS related syndromes to KidsCare Pediatrics . I agree that a copy of this release or a fax of this release shall be as valid as the original release.

Please send copies of all requested information as soon as possible.

☐ Send all records

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEEN TAKEN.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Kidscare Pediatrics of Plantation, PA

7442 Royal Palm Blvd., Margate, FL.33063

Phone : (954) 473 2128 fax : (954) 971 0098
email : lsp@kidscareped.com
www.kidscareped.com

PATIENT'S NAME_____

FINANCIAL POLICY- AJOKU, TOKI MD

FEE FOR SERVICE:

I understand that it is Dr. Ajoku policy to collect all NON-INSURANCE covered services at the time of visit. I also understand that since I do not have any insurance coverage I will agree to pay Dr. Ajoku by either cash or check at the time of the visit. Failure to leave without paying for services may result in placing my account for collection.

HMO/INDEMNITY

I understand that the services being provided to my child by Dr. Ajoku are covered in whole or part by my insurance coverage. However, I understand that I will be responsible for ant non-covered charges. As a service the office will file all insurance claims and hold my account sixty (60) days pending insurance payment. Should my insurance not pay within this time I will be responsible for these charges. **I FURTHER UNDERSTAND THAT MY INSURANCE COVERAGE IS A RELATIONSHIP BETWEEN ME AND THE INSURANCE COMPANY AND NOT BETWEEN THE DOCTOR AND THE INSURANCE COMPANY.**

MEDICAID/MEDIPASS

I understand that Medicaid covers the services provided to my child by Dr. Ajoku however, I understand that I am ultimately responsible for any non-covered charges. **I FURTHER UNDERSTAND THAT MY MEDICAID COVERAGE IS THE RELATIONSHIP BETWEEN ME AND MEDICAID AND NOT BETWEEN THE DOCTOR AND MEDICAID.**

PAYMENT OF BENEFITS

I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO DR. AJOKU. I UNDERSTAND THAT SHOULD MY BENEFITS LAPSE OR TERMINATE I AGREE TO PAY CHARGES IN FULL FOR ALL NON-COVERED AMOUNTS.

Responsible Party Relationship Date

KIDSCARE PEDIATRICS OF PLANTATION P.A.
Notice of Privacy Practice-Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result we are providing you with general information about the privacy rule. A federal regulation of the health insurance portability and accountability act of 1996. Our practice is complying with HIPPA's regulations.

What is HIPPA and how does the privacy rule affect you?
When the health insurance portability and accountability act (HIPPA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers and clearinghouses store and send a patients personal information as it relates to healthcare. The privacy rule was created to protect your rights as a patient of our practice and we are required by law to be complaint with the regulation as of April 13, 2003. Under the privacy rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following this practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable health information (IIHI)?
Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or identifies you as an individual.

What is the notice of privacy practice?
Our practice has an official notice of privacy practice in our waiting room informing our patients about their rights surrounding the protection of their IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our notice of private practice at ant time it will be posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe the different ways which we may use and disclose your IIHI:

Treatment appointment reminders release of information to family/friends.
Payment treatment options disclosures required by law.
Healthcare operations health related benefits and services.

The following categories describe unique situations in which we may disclose your identifiable health information:

Public health risk health oversight lawsuits and similar proceedings law enforcements.
Deceased patients, organ and tissue donation, serious threats to health and safety research.
Military, national security, workers compensation.

What are your rights concerning your individually identifiable health information(IIHI):

You have the rights regarding the IIHI that we maintain about you. In our notice of privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communications
2. Request restrictions
3. Inspection and copies
4. Amendment
5. Accounting disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide an authorization for other uses and disclosures

If you have any questions regarding this notice or our health information policies, please contact

7442 Royal Palm Blvd. Margate, FL 33062

I have read the Short notice provided by Kidscare Pediatrics of Plntation, P.A. and has been informed of how to obtain more information regarding our notice of privacy.

Signature_____

Print Name of Patient_____

ARBITRATION AGREEMENT RELATED TO MEDICAL CARE, TREATMENT & ALL DISPUTES

The patient and undersigned Medical Care Provider ("MCP") – which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way relates to medical services shall without exception be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. All issues regarding the validity, enforceability and scope of this Agreement or any part of it shall also be subject to arbitration. If either party challenges the validity of this Agreement in court, the prevailing party shall be entitled to attorneys' fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound as the Patient is to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right to have any dispute decided in a court of law before a jury. All parties understand that they are giving up the right to have any dispute decided by a judge or jury through the court system. Resort to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both the mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP.

The signers agree that the maximum total amount of all non-economic and economic damages combined shall never exceed $250,000, applied on ***a per case*** basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceeding. Non-economic means damages for pain and suffering, disfigurement, embarrassment and anything else not representing loss of past or future earnings, medical or other costs. The arbitrators may choose to award damages in excess of $250,000 only when extreme hardship is demonstrated. As consideration for the limitation on any awards, the MCP will pay up to and only the first $2,500 of attorney fees for the Patient. The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Save as required by Medicare/Medicaid, the parties agree that any awards in excess of $10,000 shall be paid in equal annual payments over 10 years without being reduced to present value. The arbitrators may reduce the time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to the injured patient or any other party) which shall diminish any awards for non-economic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP. The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Statute of Limitations: In no case shall the statute of limitations exceed 12 months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. **Severability:** If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury. **Timing:** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement/Merger Clause:** This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within

this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered, or modified in any way except by an instrument in writing, signed by all parties. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by videoconference; the MCP will provide equipment and pay all costs of videoconference bridging and of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500 as indicated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to rescission. **Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person or persons other than the Patient.) **No Undue Influence:** The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non-economic damages, including loss of wages or other compensation, damage to reputation, full attorneys' fees and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any Arbitration hearing. A qualified professional mediator with medico-legal background shall be mutually agreed upon.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence, paragraph or provision may be crossed out, excised or removed.

To be completed by the Patient, Parent, or Authorized Representative

Name of Patient: _____

Your relationship to Patient (check one): □ Mother
□ Father
□ Other (please specify) _____

_____ Date: _____
SIGNATURE of Patient, Parent, or Authorized Representative of Patient

MEDICAL CARE PROVIDER'S CONSENT TO ARBITRATION: In consideration of the execution of this Binding Arbitration Agreement, the undersigned, as the legal representative of the Medical Care Provider, hereby agrees to be bound by all the terms set forth above.

_____ Date: _____
SIGNATURE of Medical Care Provider – **Adetokunboh Ajoku, M.D., individually and on behalf of Life Spring Pediatrics, P.A.**

Kidscare Pediatrics of Plantation

Pharmacy

Patient's Name _____ Date _____

Kidscare Pediatrics of Plantation, PA is asking all Parents/ Guardian to please provide us with your Pharmacy information.

Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone:

_____

Email Info Request

Patient's Name

_____ Date _____

Kidscare Pediatrics Of Plantation, PA is asking all Parents/Guardians to please provide us with a valid email address. A patient web portal is available as a second option of your choice to stay in contact with your Physician's office regarding claim inquiries, referral status, and any other services you may be requesting from this office.

Email_____

If you do not have a valid email address you can provide us with the patient's email address if they have one available.

Child's
Email_____

Thank You,
MGMT