ADVANCED PEDIATRICS

3712 Winter Garden Vineland Rd.
Winter Garden, FL 34787
Tel.: (407) 656-2229
Fax: (407) 656-0998

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (____) _____ M/F _____ Social Security #: _____
MOTHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
FATHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
REFERRED BY: _____ PHONE: (____) _____

IN CASE OF EMERGENCY
CLOSEST RELATIVE NOT LIVING WITH YOU: _____ PHONE: (____) _____

PERSON RESPONSIBLE FOR BILL

LEGAL NAME: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
DRIVER LICENSE #: _____ STATE ISSUED: _____
ADDRESS: _____
MAILING ADDRESS (if different): _____
PHONE: HOME (____) _____ WORK (____) _____ CELL (____) _____
E-MAIL ADDRESS: _____ EMPLOYER: _____

INSURANCE COMPANY INFORMATION

Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

Secondary Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

PLEASE ANSWER THE FOLLOWING

Have you or anyone in your immediate family been a patient in our office before? ____ yes ____ no. If yes, please list:
Name: _____ Relationship: _____ When? _____
Has your child been seen in the hospital by our physicians? _____ yes _____ no.

ADVANCED PEDIATRICS
INITIAL PEDIATRIC HISTORY FORM

Child's Name: _____ **Birthday:** _____ **Today's date** _____

A. Birth History

1. Birthplace _____
2. Was pregnancy normal? _____
3. Was delivery normal? _____
4. Was baby full term? _____
5. Birth weight _____ length _____
6. Any nursery problems? _____

B. Growth and Development

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   Talked _____ Toilet trained _____
2. School history:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problems? _____
   _____
   Ever seen by a psychologist, speech therapist or special teachers? _____

C. Past Medical History

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail biting? _____
   Nightmares? _____
2. Diet:
   Nursed or bottle fed? _____
   Any colic problems? _____
   Used special diets? _____
3. Contagious diseases (what age?)
   Chicken pox _____
   Scarlet fever _____
   Any other? _____
4. Was your child ever diagnosed with any of the following? (what age?)
   Seizures _____ Asthma _____
   Bronchitis _____ Pneumonia _____
   Ear infections _____
   Any other? _____
5. Medications: Does your child take any medications now?
   _____
   _____

D. Hospitalizations

(When, where, why?) _____
_____
_____

E. Surgery

(When, where, why?) _____
_____

F. Serious Injuries

(When, where?) _____
_____
_____

G. Allergic Reactions

(Drugs, immunizations, asthma, hives, eczema, etc.) _____
_____

H. Family History

1. Father: Living _____ Age: _____ Health: _____
2. Mother: Living _____ Age: _____ Health: _____
3. Brother/Sisters: _____ How many? _____
   Ages _____ Healthy? _____
4. Any family history of:
   Diabetes _____ Allergies _____ Convulsions _____
   Heart disease _____ TB _____ Cancer _____
   Other? _____

I. General Information

Has your child had any unusual problems with the following?
Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones/Muscles/Joints _____
Skin _____
Blood _____

J. Immunizations

Did you bring a record of immunizations of your Child?
_____ Yes _____ No

K. Any special comments about your child?

_____
_____
_____
_____
_____

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AUTHORIZATION FOR MEDICAL CARE

I (WE) _____ authorize
PRINT NAME OF LEGAL GUARDIAN(S)

Advanced Pediatrics and it's personnel to deliver medical services to my

child _____
PRINT CHILD'S NAME AND DATE OF BIRTH

I (WE) authorize the following people to bring my child in for treatment: (This form must be filled out in order for anyone other than parents listed on patient information form to bring in your child.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____ _____
SIGNATURE OF LEGAL GUARDIAN DATE

Relationship to patient: _____

_____ _____
WITNESS (PRINT/SIGN) DATE

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FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. We are committed to providing your child comprehensive Pediatric care. Please understand that payment of your child's bill is considered part of their treatment. The following is a statement of our financial policy. We require you to read and sign prior to any treatment. **ALL PARENTS MUST COMPLETE ALL PAPERWORK BEFORE THEIR CHILD IS SEEN.**

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR CREDIT CARDS. If a check is returned to us for any reason, your child's account will be charged the amount of the check plus a $25.00 returned check fee.

USUAL & CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

There is a $25.00 fee for all after hours telephone calls and a $25.00 fee for appointments not cancelled 24 hours prior to your appointment time.

WE CANNOT BILL YOUR INSURANCE COMPANY UNLESS YOU GIVE US A COPY OF YOUR CHILD'S INSURANCE CARD. Without a copy of the card, you will be responsible for 100% of the charges on that date of service. We will file to your insurance company, however, if you must pay a percentage of the bill, it must be paid at the time of service. **All copays are due at the time of service.**

The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable by your insurance policy.

If you are unable to pay the balance in full, we can arrange a payment plan. If the balance is 90 days past due and/or you default on your payment plan, the account will be forwarded to a collection agency. You will be responsible for any fees incurred from the collection agency and/or legal services hired by Advanced Pediatrics. Furthermore, your child will be discharged from the practice.

In the event that your insurance changes, it is your responsibility to notify us as we may be non-participating providers. Failure to do so will result in you being responsible for all charges incurred. It is not the responsibility of Advanced Pediatrics to ensure we are providers. Our main concern is the health of our patients.

Regarding HMO, Managed Care and Medicaid plans, you are responsible for making sure that our practice and/or doctors are listed as your child's Primary Care Physician. Failure to do so will result in you being responsible for all charges incurred.

We provide lab work as a professional courtesy. You are responsible for providing us with the correct laboratory in which to send lab work. If your child's lab work is sent to an incorrect laboratory, you will be responsible for all charges incurred.

I have read and fully understand Advanced Pediatrics' Financial Policy.

Parent's name (print)	Child's name (print)
X Parent's signature	Date

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ASSIGNMENT OF BENEFITS FORM

Date: _____

Patient: _____ Parent/Guardian: _____

Claim Group: _____

SS #/ID #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Advanced Pediatrics
3712 Winter Garden Vineland Rd.
Winter Garden, FL 34787

Or

If my current policy prohibits direct payment to a doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

3712 Winter Garden Vineland Rd.
Winter Garden, FL 34787

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed: _____ Relationship to Patient: _____

Date: _____ Witness: _____

Advanced Pediatrics

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CONSENT FOR TREATMENT
PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Advanced Pediatrics for the purpose of diagnosing or providing treatment to me/my child, obtaining payment for my/my child's health care bills or to conduct health care operations of Advanced Pediatrics.

I have the right to revoke this consent, in writing, at any time, except to the extent that Advanced Pediatrics has taken action in reliance on this consent.

My/my child's "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my/my child's past, present or future physical or mental health or condition and identifies me/my child, or there is a reasonable basis to believe the information may identify me/my child.

ADVANCED PEDIATRICS has an established privacy policy which is displayed in this office and I can request a printed copy of this policy.

x _____ _____

Signature of Patient or Parent / Guardian | Name of Patient

_____ _____

Relationship to Patient | Date

ADVANCED PEDIATRICS

3712 WINTER GARDEN VINELAND RD.
WINTER GARDEN, FL 34787
PH: (407) 656-2229 FAX: (407) 656-0998

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Parent / Guardian Name: _____

I AUTHORIZE: _____
Name of designated individual, organization or Provider

_____
Address

To release / obtain my healthcare information to / from: _____

_____

for the purpose of continued care.

Information to be Released:

_____ All Medical Records _____ Labs
_____ X-Ray and imaging _____ Immunization records
_____ Other: _____

Dates: From: _____ To: _____

1. **I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.**

   I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

   I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.

   I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

   I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

   I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Attorney or witness