PATIENT REGISTRATION

LAST NAME	FIRST		MIDDLE INITIAL	
HOME ADDRESS		CITY	ST	ZIP
HOME PHONE	EMERGENCY C	CONTACT	EMERG PH_	
DATE OF BIRTH	SEX	SOCIAL SECURITY NUN	1BER	
ETHNICITY	/: HISPANIC/LATINO NOT HISP	ANIC/LATINO PATIEN	DECLINED NON	E
RACE: AMER	INDIAN/ALASKA ASIAN	BLACK/AFRICAN AMER	_ CAUCASIANO	[HER
	NATIVE HAWAIIAN/OTHER PACIFIC	ISLANDER UNKNOWN	DECLINED	-
	Guaran	tor/Responsible Party		
LAST NAME	FIRST	REI	ATIONSHIP TO PATIEN	Τ
HOME ADDRESS		CITY	ST	ZIP
DATE OF BIRTH	SEX SOCIAL SECURI	TY NUMBER	EMPLOYER_	
EMAIL	HOME PH#	CELL	wor	ак
		Other Parent		
LAST NAME	FIRST	REI	ATIONSHIP TO PATIEN	т
HOME ADDRESS		CITY	ST	ZIP
DATE OF BIRTH	SEX SOCIAL SECURI	TY NUMBER	EMPLOYER_	
EMAIL	HOME PH#	CELL	WOF	RK

AUTHROZATION: I hereby authorize All About Kids Pediatrics to furnish all information concerning illness, treatment and demographics of the above named patient to third party payors and anyone assisting our practice in obtaining payment, including billing, coding and collection agents, attorneys and consultants. I will hold AAK blameless from any claim of liability arising out of disclosure and/or release of such information. I hereby assign to AAK all payments for medical services rendered to the above patient. Although covered by insurance, I am aware I am personally responsible for all charges. I am aware that a copy of the Notice of Privacy Practice fir the office of AAK is available upon request. Any restrictions that I wish to place on the above patients protected health information must be made in writing to the privacy officer. A photocopy of this authorization will be as valid as the original. I also understand that the office charges a return check fee of \$50.00 for NSF presented and a \$25 NO SHOW FEE for appointments cancelled, no showed or missed without the proper notice. If three or more appointments are missed the patient can be discharged from the practice.

Authorized Signature: _____ Date: _____ Date: _____

		atient Biography		
• •	Non-Hispanic/Latino			
Race: American Indian	/Alaskan Asian	Black/African American	Caucasian	Other
Patient: Name:	DOB:	Referred By:		_
Mother: Name:	DOB:	Occupation:		_
Father: Name:	DOB:	Occupation:		_
Siblings: Name:	Age:Name:		Age:	-
Name:	Age:Name:		Age:	_
BIRTH HISTORY:				
Hospital:	Birth Weight:	Delivery	Type: Vaginal C-Se	ection
Pregnancy/Post-Delivery Co	omplications:			_
MEDICAL HISTORY:				
Food Allergies:	Med	lication Allergies:		_
		eries:		
Chickenpox:	Frac	tures:		-
-		plems with periods:		_
For Boys: Circumcision:				
Circle all that apply:				
Frequent ear infections	Heart problems or mu	irmur Seizures		
Bladder or kidney infections Asthma		Pneumor	nia	
Use of alcohol or drugs ADD, ADHD, Behavioral problems Developmental		nental Delays		
Other Medical Problems:				-
Other Medical Specialists:				
SOCIAL HISTORY:				-
Lives with:				_
If shared custody: % of time	e with mom:	% of the time with dad:		_
Smoking in the home: Insic	le Outside None	Exposure to someone with	TB or immunodeficiency:	Yes No
	itside of the US: Yes No		il/shelter: Yes No	
FAMILY HISTORY: Please	write affected family membe	er in box.		
None Pertinent	Adopted Paternal His	tory Unknown Materna	al History Unknown	_
Deafness	Anemia	Bed-wetting (age >10)	Sickle cell trait	
Nasal Allergies	Bleeding Disorders	Alcohol Abuse	Sickle cell disease	
Asthma	Liver Disease	Drug abuse	Cancer	
Tuberculosis	Kidney disease	Mental Illness	Thyroid disease	
Heart Disease (age < 50)	Diabetes (age <50)	Mental retardation	Other Endocrine proble	ms
High Cholesterol	Epilepsy	Immune Problems or HIV		
		I		

Other:_____

Many people have trouble reading and remembering health information because it is difficult. Is this a problem for you? YES NO Within the past 12 months, were you ever worried that your food would run out before you had money to buy more? YES NO

ALL ABOUT KIDS PEDIATRICS, INC.

CONSENT FOR TREATMENT AND HIPPA CONSENT

Consent to treat and to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I______, understand that as part of my child's healthcare, this practice originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A consent for treatment in the office
- A means of communication among the many health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and treatment to the bill
- A means by which a third-party vendor can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand if I wish to obtain a copy of *The Notices of Privacy Practices* that provides a more complete description of information uses and disclosures, one will be made available for me. I understand that I have the right to review the notice prior to signing the consent. I understand that the office reserves the right to change their notice and practices and prior to implementation will make a copy available. I understand that I have the right to object to the use of my child's health information for directory purposes. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand and authorize, that at times it will be necessary for All About Kids Pediatrics to call my home or place of business and leave messages on an answering machine, voice mail or e-mail regarding your child or children.

For purposes of proper medical treatment, All About Kids Pediatrics, Inc. will give personal health information (PHI), including medical history and all test and lab results to referring physicians, treatment centers and hospitals necessary for the continuity of care of the patient. The hospital, referring physician and any other subspecialist may make this information part of their medical record. Transfer of this information will help hospital personnel, physicians and other needed staff properly treat the patient.

By signing this statement I verify that I have been given a copy of the notices of privacy upon my request detailing how my health information may be used and disclosed as permitted under Federal and State Law and outlining my rights regarding my health information ._____(please initial)

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

Patient Name

Date of Birth

Signature of Parent/Responsible Party

ALL ABOUT KIDS PEDIATRICS, INC

FINANCIAL POLICY

We are committed to providing your child with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates with a variety of insurance plans. It is your responsibility to:

- Bring your insurance card to every visit
- Be prepared to pay your co-pay and deductible at each visit. Payment can be made by cash, check, or credit card.
- NSF fees are assessed in the amount of \$50
- Pay for medical care not covered at the time of visit
- Resolve unpaid balances within 30 days. Late fees of \$5 per month and interest of 18% will accrue on unpaid balances.

If you have insurance that we do not participate in, our office is happy to file a claim on your behalf, however, payment in full is expected at the time of service.

Our office utilizes Merchants Credit for collection services. Should your account be delinquent be aware that interest charges and late fees accrue on accounts sent to collections. Patients whose accounts are sent to collection are discharged from the practice. In order to be reinstated to the practice you will need to settle your account with the collection agency and reimburse the office for the percentage our office had to pay the collection agency for your account.

Most of our patients are minors (18 years and younger). Parents of minor children must sign below. The parent, guardian is responsible for any payment due at time of service. Ultimately the parent signing this statement is responsible for the patient's bill. Our office does not interfere or get involved with custody agreements for patient care or for payment for services rendered.

All parents are responsible for any charges for newborn patients that are not eligible for services on the date seen. Our office will allow you 30 days without asking for upfront payment in order for you to get your insurance active. Our office files your insurance as a courtesy and you are ultimately responsible for the payment. We will do everything to help resolve issues but please remember our office staff is limited in what we can do. At times we will ask you to contact your carrier or employer when issues arise. If you have questions about your insurance we are happy to assist you. Specific coverage issues should be directed to your insurance carrier's member services department. The number will be on your insurance card.

Questions about financial arrangements should be directed to the billing department. Our office provides a prompt pay discount for patients with no insurance of 40% when paid on the date of service. We will assist with payment plans when necessary but you will be required to provide an active credit card to keep on file for us to process your monthly payment.

Please sign that you have read and agree to this financial policy.

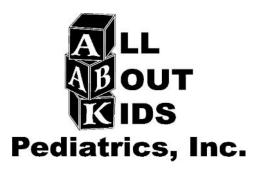
Patient Name

Signature of Parent/Responsible Party

Created: 9/09 Revised: 2/19/18

Date of Birth

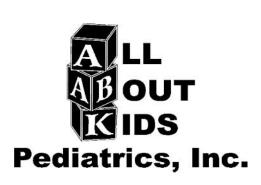
Date



Kristen V. Walker, MD, F.A.A.P. Amanda D. Peck, MD, F.A.A.P. Board Certified Pediatricians Merit Wallace, APRN Certified Nurse Practitioner

Date:	
AUTHORIZATION FOR R	ELEASE OF PATIENT RECORDS OR INFORMATION
Patient Name:	Date of Birth:
Social Security Number:	Dates of Service:
Requesting Records From:	Phone:Fax:
I,, (Patient/Parent or Legal Guardian)	hereby request and authorize the release of the following records:
Complete Medical Record _	Immunization Records Physician Office Records
Hospital/Surgicente	er Diagnostic Testing Emerg. Room Visit
Other:	
My Records may contain the following and, unle	ess crossed out and initialed, I specifically authorize their release
HIV Test Results (test for	AIDS) AIDS related Drug or Alcohol Records
Release of information is for continuity of care u	unless otherwise specified:
<u>3573 SW. Co</u>	o: <u>I About Kids Pediatrics, INC.</u> orporate Parkway Palm City, FL 34990 72-283-5431 or Fax: 772-283-5471
writing by sending written request to the above thereon. We may not condition treatment, pay	after you sign it. You have the right to revoke this authorization in address except to the extent that physicians listed above have relied ment, enrollment, or eligibility for benefits on your execution of this to this authorization may be redisclosed by the recipient(s) and no longer
Patient/Parent or Authorized Signature:	Date:

			-
Relationship to Patient:	Witness:	Date:	



Kristen V. Walker, MD, F.A.A.P. Amanda D. Peck, MD, F.A.A.P. Board Certified Pediatricians Merit Wallace, APRN Certified Nurse Practitioner

Authorization for Treatment in Absence of Parent or Guardian

Date:		
I,	hereby authorize to	
take my minor child,	for medical care and treatment in my absence. I	
authorize the above named person to sign a	nd authorize minor treatment and routine vaccinations in my absence.	
I can be reached at	should a medical emergency arise and decision-making regarding my	
child be necessary.		
This authorization is effective until		
Signature of Parent or Guardian	Date	
Witness	Date	
	prporate Parkway Palm City, Florida 34990	

Phone (772) 283-5431 Fax (772) 283-5471