PATIENT REGISTRATION

LAST NAME _____ FIRST _____MIDDLE INITIAL _____

HOME ADDRESS _____ CITY_____ST_____ZIP_____

HOME PHONE_____ EMERGENCY CONTACT_____ EMERG PH_____

DATE OF BIRTH_____SEX_____ SOCIAL SECURITY NUMBER_____

ETHNICITY: HISPANIC/LATINO _____ NOT HISPANIC/LATINO _____ PATIENT DECLINED _____ NONE _____

RACE: AMER INDIAN/ALASKA _____ ASIAN _____ BLACK/AFRICAN AMER _____ CAUCASIAN _____OTHER_____

NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER _____ UNKNOWN _____ DECLINED _____

Guarantor/Responsible Party

LAST NAME _____ FIRST _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____ CITY_____ST_____ZIP_____

DATE OF BIRTH_____ SEX_____ SOCIAL SECURITY NUMBER_____ EMPLOYER_____

EMAIL _____ HOME PH# _____ CELL _____ WORK _____

Other Parent

LAST NAME _____ FIRST _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____ CITY_____ST_____ZIP_____

DATE OF BIRTH_____ SEX_____ SOCIAL SECURITY NUMBER_____ EMPLOYER_____

EMAIL _____ HOME PH# _____ CELL _____ WORK _____

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: _____

Patient Biography

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline

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-Section

Pregnancy/Post-Delivery Complications: _____

MEDICAL HISTORY:

Food Allergies: _____ Medication Allergies: _____

Hospitalizations: _____ Surgeries: _____

Chickenpox: _____ Fractures: _____

For Girls: Age at Menarche: _____ Problems with periods: _____

For Boys: Circumcision: _____

Circle all that apply:

Frequent ear infections	Heart problems or murmur	Seizures
Bladder or kidney infections	Asthma	Pneumonia
Use of alcohol or drugs	ADD, ADHD, Behavioral problems	Developmental Delays

Other Medical Problems: _____

Other Medical Specialists: _____

SOCIAL HISTORY:

Lives with: _____

If shared custody: % of time with mom: _____ % of the time with dad: _____

Smoking in the home: Inside Outside None

Exposure to someone with TB or immunodeficiency: Yes No

Travel to or visitors from outside of the US: Yes No

Exposure to someone in jail/shelter: Yes No

FAMILY HISTORY: Please write affected family member in box.

None Pertinent Adopted Paternal History Unknown Maternal 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 problems
High Cholesterol	Epilepsy	Immune Problems or HIV	

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 Date

Revised 8/09

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 Date of Birth

Signature of Parent/Responsible Party Date

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

ALL ABOUT KIDS
Pediatrics, Inc.

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 RELEASE OF PATIENT RECORDS OR INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Dates of Service: _____

Requesting Records From: _____Phone:_____Fax:_____

I, _____, hereby request and authorize the release of the following records:
(Patient/Parent or Legal Guardian)

_____ Complete Medical Record _____ Immunization Records _____ Physician Office Records

_____ Hospital/Surgicenter _____ Diagnostic Testing _____ Emerg. Room Visit

____ Other: _____

My Records may contain the following and, **unless 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 unless otherwise specified: _____

Please release the above health information to:

All About Kids Pediatrics, INC.
3573 SW. Corporate Parkway Palm City, FL 34990
Phone: 772-283-5431 or Fax: 772-283-5471

You are entitled to a copy of this authorization after you sign it. You have the right to revoke this authorization in writing by sending written request to the above address except to the extent that physicians listed above have relied thereon. We may not condition treatment, payment, enrollment, or eligibility for benefits on your execution of this authorization. Information disclosed pursuant to this authorization may be redisclosed by the recipient(s) and no longer protected by the federal privacy law.

Patient/Parent or Authorized Signature: _____Date:_____

Relationship to Patient: _____ Witness: _____ Date: _____

ALL ABOUT KIDS Pediatrics, Inc.

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 and 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

3573 SW Corporate Parkway Palm City, Florida 34990

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