## Please fill out all information completely

## 2021 New Patient Registration

**All Patient(s) Names: (First Middle Last/ Date of Birth/ Gender)**

_____
_____
_____
_____

Home Address: _____ City: _____
State: _____ Zip: _____ Preferred Telephone: _____
E-Mail Address: _____
Race: _____ Ethnicity: _____ Preferred Language: _____

**Preferred Pharmacy**: _____ Location: _____

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Marital Status of Parents: □Married □Divorced □Single (Never married) □Spouse Deceased
**Mothers Name**: _____ DOB: _____ SSN: _____
E-Mail Address (You may receive appointment reminders):_____
Home Address (□Same as Child): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ (□Primary) Cell Phone: _____ (□Primary)
Employer: _____ Work Phone: _____

**Fathers Name**: _____ DOB:_____ SSN: _____
E-Mail Address (You may receive appointment reminders):_____
Home Address (□Same as Child) : _____
City: _____ State: _____ Zip: _____
Home Phone: _____ (□Primary) Cell Phone: _____ (□Primary)
Employer: _____ Work Phone: _____

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**Primary Insurance**: _____ Effective Date: _____
Name of Insured: _____ DOB_____ SSN: _____
ID Number: _____ Policy Type: PPO / HMO / PPC /Other:_____
Group Number: _____ Co-Pay Amount: _____
Guarantor Relationship to Patient: _____

**Emergency Contact: (*NOT* *Mom or Dad*)**
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

**Financial Policy, Assignment Information, and Release of Information**

I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize any insurance to be paid directly to Pediatric Wizards or its assignees. I am responsible for any non-covered services, supplies, co-payments, co-insurance, and deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This is acceptable and assignment will be in force for all future services by practitioners from this office.

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Patient / Parent / Guardian Signature Date Witness Signature Date

## Medical History Form

*Welcome to our practice! We look forward to providing the best care for your child from birth throughout college. Please complete this information for our records. Thank you!*

**Childs Name:** _____ **Date of Birth:** _____

**Birth History:**
Birth Weight: _____ Birth Hospital/State: _____

☐ Full-Term (>37 Weeks) ☐ Vaginal ☐ Forceps ☐ Vacuum

Premature (<37 Weeks) # weeks: _____ ☐ C/Section – Due to: _____

Pregnancy Concerns: ☐ None _____
Newborn Concerns: ☐ None ☐ Jaundice ☐ Other: _____

**Specialty Care:**
Has your child ever seen a medical specialist? ☐ Yes ☐ No
Please Describe: _____
_____
_____

**Past Medical History:**
Does your child have a history of any medical conditions? ☐ None
(Please check all that apply)

| | | | |
|---|---|---|---|
| **Genetic:** | ☐ chromosome abnormality | | |
| **Development:** | ☐ delay speech/language | ☐ delay motor skills | ☐ autism |
| **Learning:** | ☐ special education | ☐ dyslexia | |
| **Behavior/Mood:** | ☐ ADHD | ☐ anxiety | ☐ obsessive-compulsive |
| | ☐ depression | | |
| **Hearing:** | ☐ ear tubes | ☐ hearing loss | |
| **Vision:** | ☐ strabismus | ☐ amblyopia | ☐ myopia |
| | ☐ astigmatism | ☐ cataract | |
| **Speech:** | ☐ speech delay-expressive | ☐ articulation | ☐ stuttering |
| | ☐ speech therapy | | |
| **Neurologic:** | ☐ seizures | ☐ migraines | ☐ head trauma |
| | ☐ concussion | | |
| **Respiratory:** | ☐ seasonal allergies | ☐ asthma | ☐ croup |
| | ☐ RSV | ☐ pneumonia | ☐ BPD |
| **Cardiac:** | ☐ heart murmur | ☐ VSD/ASD | |
| **Gastrointestinal:** | ☐ constipation | ☐ acid reflux | ☐ liver disease |
| | ☐ pyloric stenosis | | |
| **Urology:** | ☐ bladder infection | ☐ urinary reflux | ☐ kidney disease |
| | ☐ enuresis | | |
| **Muscle/Bone:** | ☐ club foot | ☐ intoeing | ☐ hypotonia |
| | ☐ scoliosis | | |
| **Dermatology:** | ☐ eczema | ☐ acne | ☐ warts |
| | ☐ molluscum | ☐ hemangioma | |
| **Infectious:** | ☐ tuberculosis | ☐ HIV | ☐ meningitis |
| **Heme/Onc:** | ☐ anemia | ☐ leukemia | ☐ cancer/tumor |

Other medical conditions: _____
_____
_____

**Hospitalizations:** ☐None
Date:_____ Due to:_____
Date:_____ Due to:_____

**Surgery:** ☐None
Date: _____ Due to:_____
Date: _____ Due to: _____

**Current Medications:** ☐None ☐daily multivitamin
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

**Allergies:** ☐None
☐ Latex _____ ☐ Pets _____
☐ Food _____ ☐ Seasonal _____
☐ Medication_____ ☐ Indoor _____

**Care/Education:**
☐ Home ☐Day Care ☐Pre-school ☐School/Grade: _____ ☐Home School ☐ College

**Home Environment:**
Parents: ☐Married ☐Domestic partnership ☐Single parent ☐Divorced ☐Spouse deceased ☐Remarried
Occupation (Mom):_____ Occupation (Dad):_____
Guns: ☐ No ☐Yes – locked away?____
Smokers: ☐ No ☐ Yes - ☐ Inside ☐ Outside
Home: ☐ House ☐ Apartment
Pets: ☐ No ☐ Yes – type? _____

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**Family History:**
Other Children: Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Please list any family medical conditions:
Mother:_____
Father: _____
Sibling: _____
Grandmother/father(paternal): _____
Grandmother/father(maternal): _____
Blood Cousin: _____

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Please describe any other specific concerns you would like to discuss regarding your child:
_____
_____

How did you find out about us?
_____
_____

## Financial Policy *(These policies will be enforced and do apply to everyone)*

**Patient(s) Name(s):** _____

_____

1. **It is the policy of our office to collect co-payment/co-insurance/deductible at the time services are rendered**. Any amount due at the time of service that is not collected will be assessed at a $15.00 billing fee. We accept Cash/Visa/MasterCard/Discover. As a courtesy, we also accept personal checks. However, if a check is returned by the bank, the family account will be assessed a $25.00 check return fee and you will no longer be able to pay by check.

2. **For all services rendered to minor patients, we will look to the adult accompanying the patient** or the parent/guardian for payment. We will not get involved in arrangements made between divorced parents or custodial agreements.

3. **Pediatric Wizards has agreed to file primary insurance for patients who participate in insurance plans**. In order to do this as accurately as possible, we MUST see your child's insurance card at each visit and if you participate with a managed care program, our physician's name must appear on the card. If another physician's name is listed as the PCP, we will ask that you reschedule your appointment until the change has been made.

4. **Any services that are deemed to be the family's responsibility** (additional co-pay's, co-insurance, deductibles, etc.) or services considered non-covered by your insurance will be put to patient balance and will be due immediately.

5. **Any services that we file with your insurance that are not responded to after 90 days from the date** of service may be transferred to patient balance. This balance will remain the responsibility of the family until payment is received or written correspondence is received by the insurance company verifying that payment is forthcoming from them. Any balances not paid in full within 90 days will be forwarded to our collection agency, unless prior arrangements have been made. Any fees associated with collecting your debt will be your responsibility. Appointments will not be scheduled until the balance has been paid in full or an approved payment arrangement has been made.

6. **If we do not participate in your insurance plan, we ask that you pay in full** at the time services are rendered. We do provide those without health insurance a "private pay discount."

7. **We must have your child's insurance card or written verification from your insurance company** that your child is currently eligible for benefits by the 2 month check-up. If you do not have this available, then the visit will need to be paid in full and suitable payment arrangements must be made regarding the previous balance. Any applicable credit amounts will be refunded to you once contracted insurance information is received and dates of service are paid by the insurance company.

**Non-compliance with this financial policy may result in dismissal from the practice.**

*I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended at will by the practice.*

Patient / Parent / Guardian Signature Date

## Office Policy for Patients with Two Insurance Policies

**Patient(s) Name(s):** _____

_____

As of October 1st, 2005, Pediatric Wizards, P.A. will no longer bill secondary insurance for those patients listed on more than one insurance policy. We will continue to bill the patient's primary insurance as a service to you. However, all co-pays, co-insurance, and/or deductibles that must be paid per the patient's primary insurance will be required to be paid prior to any office visit.

If a patient has both commercial (Health First, Cigna, Aetna, BCBS, United, ect.) and government insurance (Medicaid, Medipass, HealthEase, Staywell, etc.) then ONLY the commercial policy will be billed and any co-pays or fees listed on the commercial service policy will be due at time of service.

We greatly appreciate your understanding in this matter. We will provide to you, at your request, pertinent forms and documents in order for you to bill your secondary insurance so that you may be reimbursed for any payment that would otherwise be covered by said secondary insurance. If you have any questions or concerns, please speak with our front desk.

Patient / Parent / Guardian Signature Date

## Office Policies *(These policies will be enforced and do apply to everyone)*

### Immunization Policy

**Pediatric Wizards, P.A. does not accept families who are unwilling to vaccinate their children.** This goes against our philosophy of high quality, preventative medicine. Please feel free to discuss immunization questions with your physician.

### Appointments

**As a courtesy, we allow 15 minutes for tardiness. After 15 minutes, we reserve the right to either fit you in as a walk-in or reschedule your appointment.** We run a tight schedule and cannot delay those that are on time.

We have a 'reminder' policy, whereby all scheduled patients are called 1-2 business days prior to their appointment to confirm that they will be attending**. Please remember that these calls are merely a courtesy. You are solely responsible for keeping your child's appointments**. We do not routinely 'double' or 'triple' book appointments. Therefore, if you do not call to cancel a scheduled appointment, you create a vacancy in our schedule which would have been otherwise filled by another sick patient. For this reason, it is our policy to charge a $50 no-show fee for each missed well check that has not been notified within 24 hour time frame and $25 for each sick appointment that has not been canceled. Also any appointment that is rescheduled more than 3x will be charged $25. Furthermore, our office may ask that you seek medical care elsewhere after 3 'no show' appointments.

Parent or legal guardian must accompany all patients to their appointments. In the event that a secondary caretaker brings the patient for an office visit, there must be written consent from the parent or legal guardian before the patient is examined. Verbal consent will not be accepted, and we may provide a designee form for the parent to fill out prior to the visit date. Vaccinations may not be given unless a parent or legal guardian is present to give authorization.

If you have a scheduled "Well Visit" appointment for your child and they are sick at the time of the visit, they will be seen as a sick appointment and the "Well Check" will be rescheduled.

### School/Health/Other Forms

Forms requested outside of a Well Check Appointment will be subject to a $25.00 charge. This includes (but is not limited to) physical forms, vaccine records, camp forms, etc.

### Prescription Refills

**Refills MUST be requested 2-3 days in advance**. Please make sure to provide us with all necessary information when calling, such as the patient's name, date of birth, exact name of medicine, strength, and dosage, along with pharmacy information. Also please be sure to provide us with a current phone number to contact you should we need to verify any information.

### Medical Records Policy

**All requests for medical records must be in writing and will take up to 14 business days to process.**

Medical records to and from another physician may be requested by completing the appropriate form provided by our office.

In accordance with Rule 64B8-10.003, Florida Administrative Code all Pediatric Wizards offices assess charges for reproducing patient medical records, as follows: $1 per page for paper records for the first 25 pages, and $0.25 cents per page for paper records thereafter. In addition, actual postage will be charged for all copies of records that are mailed. All fees must be paid prior to release of records.

### Waiting Room

Please be aware of the separation between the sick patient area and the well patient area. Keeping these areas separate as well as having separate toys in each area is an infectious control measure. We ask for the cooperation of the parents in keeping their children confined to the appropriate waiting area for their own protection. **We ask that other children who are brought in with the patient are not left unsupervised in the waiting room area.** A suitable supervisor is an adult or family member 15 years of age or older.

### Picture/Birth Announcement Policy

Pictures and birth announcements given to Pediatric Wizards become the property of Pediatric Wizards and may be proudly displayed in the office or on our website. We ask that if you do not wish to have these displayed, please indicate this on the announcement or photo.

### Use of Audio/Video recording at our Office

To ensure confidentiality and privacy any type of electronic recording is strictly prohibited at any location within this office. Thank you for your understanding and compliance.

**Visit Changes/Well Check to Sick Visit**

In the event that you are in for a well check and your child is showing signs of illness our staff reserves the right to change your appointment. At the time of appointment change we will collect any co pay, co-insurance, and deductible owed.

**Yearly Physical Exams**

It is the policy **of** Pediatric Wizards that in order to maintain an active status within our practice that you must keep with your wellness checks yearly. Failure to do so may result in our office asking you to seek medical care elsewhere.

Patient / Parent / Guardian Signature Date

## Health Information Privacy

**Patient(s) Name(s):** _____

_____

At Pediatric Wizards, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Pediatric Wizards, kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child.

- I have received a copy of the Notice of Privacy Practices from Pediatric Wizards.
- I understand that Pediatric Wizards may call my home and place of employment for health care reasons, appointment reminders, and to resolve billing issues.
- I understand that Pediatric Wizards may use letters or email to notify me of appointments or other pertinent information.
- I understand that Pediatric Wizards may fax immunization certificates, school excuses, physical reports/forms, or medication instructions to my personal work fax, or mail to my home. Pediatric Wizards cannot fax or send these documents to third parties (school, daycare, ect.) without a separate, signed authorization.
- I understand that Pediatric Wizards may leave messages on my answering machine or voicemail regarding appointments or limited lab information.
- I understand that Pediatric Wizards may discuss patient information with adults or minors present during the visit.

**I understand and agree to all the above unless I strike through one of the statements.**

Patient / Parent / Guardian Signature Date

## Medical Image Consent

Patient Name Date of Birth

I consent to have my child's, or individual to whom I provide guardianship's image to be taken by the staff at Pediatric Wizards as described below:

I understand that my child's, or individual to whom I provide guardianship's image will be recorded to document and assist with his/her care. I understand that Pediatric Wizards will own these images, but that I will be allowed to access them for viewing. Other than for treatment and identification purposes, images that identify my child, or individual to whom I provide guardianship, will **NOT** be released and or used outside the office without written authorization from me.

I may revoke or withdraw this consent at any time. Withdrawal of consent must be made in writing. Unless revoked earlier, this consent will be kept for the same period of time as any other part of the medical record. We will update the image from time to time. When this occurs, the outdated image will be erased.

By signing below, I am indicating that I have read and understand the information stated above. My questions regarding this issue have been answered.

Parent/Guardian Signature Date

## Social Media/Website (Please circle one)

**I GRANT** permission for above-names patient's photo/image and FIRST NAME ONLY to be published on Pediatric Wizard's Facebook page and/or website.

**I GRANT** permission for above-names patient's photo/image, without any personal identifiers, to be published on Pediatric Wizard's Facebook page and/or website.

**I DO NOT GRANT** permission for above-names patient's photo/image to be published on Pediatric Wizard's Facebook page and/or website.

**Designee Authorization Form**

I, the parent/legal guardian of the below named child(ren):

Child Name (Printed) Date of Birth

Child Name (Printed) Date of Birth

Child Name (Printed) Date of Birth

authorize the consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Wizards. In addition, I give permission for the following person(s) to bring my child to Pediatric Wizards in my absence and to act in my behalf in authorizing medical care and services. In the event of emergency or other illness, I understand that the physicians and staff of Pediatric Wizards will deliver and medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, Pediatric Wizard will assume that a child's biological and/or legal mother and father are both legal guardians who have access to treatment options and medical information for that child.

This authorization shall be in effect from _____ to _____ or until further notice.
Date Date

I designate the following people to bring my child on my behalf, to obtain treatment, and to discuss my child's health care with Pediatric Wizards.

Name Relationship Phone #

Name Relationship Phone #

Parent/Guardian Printed Name Signature Date

# RELEASE OF MEDICAL RECORDS AUTHORIZATION

**Today's Date:** _____

*Patient Name:* _____ *Date of Birth:* _____

1. I authorize, _____ (previous healthcare provider) Telephone:_____ Fax:_____ to disclose the protected health information described below to **Pediatric Wizards. (We are unable to accept records on disc.)**

2. This authorization for release of information covers the period of healthcare from:
   a. □ _____ to _____ **OR** b. □ all past, present, and future periods.

3. a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR**

b. □ I authorize the release of my complete health record with the exception of the following information:
   - □ Mental health records
   - □ Communicable diseases (including HIV and AIDS)
   - □ Alcohol/drug abuse treatment
   - □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect **until** _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

*Signature of patient or personal representative* *Printed name of patient or personal representative and his or her relationship to patient*

**Pediatric Wizards, PA**
**1310 W. Eau Gallie Blvd Suite C**
**Melbourne, FL 32935**
**O: (321) 255-3434 F: (321) 255-0963**

Office Use Only
Completed By:_____
Date Completed: _____