All items highlighted MUST be completed

2024 Established Patient Registration

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

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Home Address: ____ City: _________________
State: ___________________ Zip: ________________ Preferred Telephone: _________________
E-Mail Address: ____
Ethnicity(circle): Hispanic Non-Hispanic Race: ___________________ Preferred Language: ___________

Preferred Pharmacy: _____________________________________ Location: ________________

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: ________________________

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.

____
Patient / Parent / Guardian Signature Date Witness Signature Date

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

Patient(s) Name(s): ______________________________
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1. **It is the policy of our office to collect co-payment/co-insurance/deductible or any remaining balances 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/American Express. 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. 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): ____
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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, UHC,etc) and government insurance (Medicaid, 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 ALL patients of Pediatric Wizards)*

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**. **If your appointment is not confirmed, we reserve the right to cancel your appointment.** 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 appointment that has not been notified within the 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.

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. Please note it is the office policy that if you are on maintenance medication that you must keep with your 3 month checkup. Well Checks are separate appointments that must be maintained yearly in order to keep with your prescription refills as well.

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 could 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.

Health Information Privacy

Patient(s) Name(s): ____

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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:**______________