Patient Registration

(Please print)

Patient:

Last Name_____ Patient First Name_____ Middle Initial _____

Sex: M___ F___ Date of Birth_____ Social Security #_____

Mailing Address_____

City_____ State_____ Zip Code_____ Home phone_____

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Preferred Language_____ Referred By_____

Siblings: Name Sex DOB SS#

_____

_____

_____

Previous Physician_____ **Pharmacy Name and Number** _____

Mother:

Last Name_____ First Name_____ Date of Birth_____

Mailing Address (list if different) _____

City_____ State_____ Zip Code_____ Cell phone_____

Social Security #_____ Marital Status _____

Email Address_____

Father:

Last Name_____ First Name_____ Date of Birth_____

Mailing Address (list if different) _____

City_____ State_____ Zip Code_____ Cell phone_____

Social Security #_____ Marital Status _____

Who is financially responsible for the patient (Guarantor)? _____

Emergency Contact

Name_____ Relationship_____ Number _____

Insurance Information

Primary Insurance

Name of Insurance Company_____ Phone Number_____

Mailing Address_____ City_____ State____ Zip Code_____

Insured's ID/Policy #_____ Group_____

Main Policy Holder _____ Policy Type: ☐ HMO ☐ PPO ☐ PPC ☐ Other_____

(CONTINUE TO BACK OF THIS PAGE)

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Print Patient Name_____ Date_____

I hereby authorize the release or use of my/or the patient's individually identifiable health information ("protected health information") and medical record information by Sunshine Pediatrics of Central Florida (the "practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining the patient or discussing the patient's care, treatment or medical condition with you, by signing this consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction (s); however, if we do agree, in writing, to your/the patient's requested restriction(s), such restrictions are then binding on the Practice.

I have been provided the opportunity to review the Practice's Notice of Privacy Practices in the waiting room and I understand I may receive a copy if I request it.

_____ _____ _____

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

I acknowledge and agree that the Practice may disclose my/the patient's protected health information and medical record information to the following individuals (other than parent): **(please initial line and write in name of individual)**

___ Spouse(other than child's parent)_____ ___ Grandparent_____

___ Legal Guardian_____ ___Other_____

I agree that the Practice may also disclose the following types of information contained in the patient's medical record.

	General Medical Information		Drug/Alcohol Abuse
	Financial Information		Labs/Diagnostic Testing
	Psychiatric Information		Pregnancy Information if patient is under 18 years old

I agree and consent to the Practice releasing information to me in the following alternative manners **(please initial the appropriate spaces below):**

____Via regular mail ____Via telephone ____Via home answering machine ____Via email

The Practice may refuse to treat you if you the patient's authorized representative, do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patients authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

_____ _____ _____

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to any evaluation or treatment that the assigned healthcare provider may deem necessary.

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Sunshine Pediatrics of Central Florida. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.
We bill only primary insurance we are contracted with and the patient is expected to know what coverage they have. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, I am responsible for payment in full.
Currently, we do not bill secondary insurances. In the event you have two insurances, we can provide you with any documentation necessary for you to submit a claim to your secondary insurance.

FINANCIAL POLICIES

Payment for all medical care is due at time of service.

In the case of divorced parents, responsibility and payment shall be that of the guarantor bringing the child in for treatment. Payment for co-payments, deductibles, co-insurance or any other balance not paid by your insurance company is owed prior to treatment.

There is a $35 returned check fee for any checks returned unpaid through Sunshine Pediatrics' bank.
I understand that, in the case of default, I am responsible for any costs incurred in the collection of patient account, currently 35% of the balance, as well as reasonable attorney fees and court costs.

During the course of your treatment, separate charges for laboratory, hospital or other services not offered directly by this office may occur. Our office is not responsible for billing these services. You may receive separate bills from these facilities. If you have questions regarding their charges, please contact these facilities directly.

I understand and agree to comply with Sunshine Pediatrics of Central Florida financial policy.

_____ _____ _____

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

(CONTINUE TO THE BACK OF THIS PAGE)

OFFICE POLICIES

We provide an after-hours telephone service to our patients for cases of medical emergencies. **If you are needing to schedule or cancel an appointment, speak to our billing department or a nurse please do so during regular business hours of 8:30 am to 5 pm.** Abuse of the after-hours service for anything other than an emergency may result in a **non-negotiable fee**.

For prescription refills have your pharmacy fax a refill request to our office and allow 3 days for processing. Please do not call the after-hours telephone or office nurse for refills.

As a courtesy to both our providers and other patients, we ask that you contact our office immediately if you are going to be late to your scheduled appointment. If you arrive more than 15 minutes late to your scheduled appointment time, your appointment will be forfeited and rescheduled.

PATIENT INFORMATION

A standard charge for transferring medical records is required by law. Please be advised requesting the transfer of medical records can take up to 5 days to process. For a doctor to doctor transfer of records, there is no fee associated for the first time of transfer. After that, the transfer of medical records will cost $1 per page.

For school & daycare shot/medical forms, a flat fee of $5 is required for all school, daycare, shot and/or medical forms at the time of pick-up. These forms are often referred to as blue and/or yellow forms. As a courtesy, these forms will be filled out at no charge during the time of a well exam.

For patient referrals, please allow 5 days as a doctor referral can take up to 3 days to process the correct insurance authorization. If a referral is pending authorization it may be necessary to reschedule an appointment.

NO SHOW/CANCELLATION/WALK-INS POLICY

Our office reserves the right to charge the following fees to reschedule your appointments or procedure. **If you are not on time for your appointment, the appointment will be rescheduled and a fee will apply.** Excessive NO SHOW, LATE ARRIVALS or SAME DAY CANCELLATIONS of appointments can result in your DISCHARGE from the practice.

Appointment Type	Amount	Notice Needed
Office Visit (sick or well)	$35	24 hours
Procedure/Med-Checks	$50	48 hours

This charge is not covered by insurance and therefore will be the responsibility of the patient/parent.

_____ _____ _____

Signature (parent/guarantor) Print Name (parent/guarantor) Date