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_____

Race/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 _____

Email Address_____

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/SAME DAY 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 _____

Sunshine Pediatrics of Central Florida, PL

Richard Rodriguez, M.D.

210 Lookout Place

Maitland, FL 32751

Phone 407-215-0400 Fax 407-215-0402

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Sunshine Pediatrics. When you schedule an appointment with Sunshine Pediatrics we set as de enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

1. A 35.00 no show fee will be applied to any missed appointments not cancelled within 24 hours/ Med Check/Behavioral Appointments need a 48 hour cancellation notice or $50.00 no show/same day cancel fee will apply.

2. At the 2nd no show you will receive a call from the office manager to give reminder about 3rd no show dismissal.

3. 3rd no show patient will receive a dismissal letter with medical records form to find a new practice

4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager.

You may contact Sunshine Pediatrics Monday-Friday from 8:00am-5:00pm at the number above (If you are calling to cancel an appointment set for Monday you will need to leave a voicemail over the weekend for a no charge cancellation, if voicemail if left Monday morning you will be charged.)

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____

Signature (Parent/Legal Guardian)

_____ _____

Relationship to Patient Date

Date: _____ Patient: _____

The policy of this office is that your child needs to be current with all required well visits REGARDLESS of vaccination status as per the AAP schedule. Failure to keep any of the routine well visits will be cause for discharge from out practice. NO EXCEPTIONS.

The schedule will be given to you or you can access it on the AAP website.

Please see attached wellness visit schedule and CDC vaccination schedule. You can also access it on the CDC and AAP websites for further information.

We appreciate your cooperation with our policies as we strive to provide the best possible care for you child.

By signing below, I am stating that I have read and understand this notice.

Thank you,

Management/Sunshine Pediatrics

Signature_____ Print name_____

Sunshine Pediatrics of Central Florida, PL

Richard Rodrigues, M.D.

210 Lookout Place

Maitland, FL 32751

Phone: 407.215.0400 Fax 407.215.0402

Sunshine Pediatrics Vaccination Policy

The providers in this office recommend the immunization schedule of the Centers for Disease Control and Prevention which is also the schedule endorsed by the American Academy of Pediatrics. There is no evidence that this immunization schedule is not in the best interest of most infants. However, the providers do understand that parents are concerned with giving so many vaccinations. As providers, we stress the importance of parents being informed of evidence-based healthcare information and safety for their child. It's our job to inform parents about available protection for your child against preventable diseases. Once we've done our best to inform parents, it's the parent's job to make decisions about their child's preventative healthcare. Because of our understanding of parents' concerns, if a parent is more comfortable following an alternate vaccine schedule, we are willing to work with the parents. We believe in informed choice, personal responsibility and respecting the parent's decision.

THIS BEING SAID, be aware that we cannot falsify or violate FLORIDA LAW:

- If you choose not to vaccinate or to follow a delayed schedule, you must sign the American Academy of Pediatrics "Refusal to Vaccinate" form at each and every well child visit.
- We cannot give you a FL 680 form unless your child is completely up-to-date according to the CDC/AAP immunization schedule.
- We do not and cannot issue a medical exemption from vaccines unless we have clear scientific documentation of a medical exemption necessity.
- We do not and cannot issue religious exemptions. You must go to your county health department to be issued a religious exemption.
- PLEASE do not ask us to violate or falsify FLORIDA LAW. Pressuring us to violate or falsify FL law can result in your child(ren) being discharge from our care.

If you are doing a delayed or alternative schedule from the CDC/AAP's recommended schedule, we can provide you with a 687 form which basically is a record of the vaccinations your child has received. This form is only a record; it is not FL 680 that certifies that the child is up-to-date on their vaccinations per CDC/AAP recommendations and State of Florida Regulations.

To further clarify the difference between a FL 680 form and FL 687 form: the FL 680 is certified by the healthcare provider that the child is up-to-date with the State of Florida Regulations (recommended schedule of the CDC/AAP), and the FL 687 is just a record of the vaccinations your child has received. Most daycare, pre-schools, public and private schools under State of Florida Regulations require the FL 680 and will not accept the FL 687.

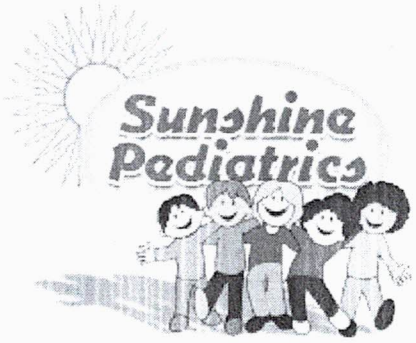
I understand that Sunshine Pediatrics' electronic medical record system automatically uploads your child's immunizations record to Florida SHOTS system.

If it is the choice of the parent to decline or delay vaccines of the CDC/AAP schedule a parent must sign the American Academy of Pediatrics Refusal to Vaccinate Form (can be found on our website) each time a scheduled vaccine is declined. I further understand that this policy is non-negotiable and non-compliance will result in immediate discharged of the patient from the practice.

I also understand a copy of this policy is on the Sunshine Pediatrics' website www.mysunshinepediatrics.com along with other information about Florida State Regulations, the CDC/AAP recommended immunization schedule and other helpful information regarding vaccinations.

I acknowledge I have read this policy and fully agree to abide by it.

Child's name (print):_____DOB_____
Parent/Guardian Signature:_____
Date:_____



Newborn Insurance Policies

Payment will be collected at **time of service** for all newborn visits until we are able to verify the patient's eligibility on your insurance plan.

- We accept all commercial plans, please select Dr. Richard G Rodriguez as your PCP.
- For marketplace and Medicaid: Please verify with your insurance that Dr. Richard Rodriguez is in network with your insurance, as we are not responsible for knowing every insurance plan available and our contract status with them. Also, please verify Dr. Richard G. Rodriguez is your selected PCP previous to ALL your appointments.
- The Medicaid HMO's we are in network with are Humana and Sunshine Health. Once coverage is verified, the billing department will then bill all claims to insurance and you will be reimbursed for payments made.

NOTE Refunds made will have deducted amounts related to co-pay, co-insurance, and deductible amounts. If insurance is not in network or we are unable to bill, then no refund will be issued.

Sunshine Pediatrics only **bills one insurance policy**. If you add your baby to two policies, we will only bill the primary insurance (which falls under the birthday rule: whoever's birthday is first in the year is considered the guarantor of the primary insurance.)

Circumcisions are an **elective procedure**. Therefore, we require payment for this procedure at the time of service. It will then be submitted to your insurance once baby is active. If we receive payment from the insurance company, you will promptly be reimbursed.

I hereby **grant permission** to Sunshine Pediatrics of Central Florida to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Sunshine Pediatrics of Central Florida. A photo static copy of this authorization shall be considered as effective and valid as the original.

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

Sunshine Pediatrics of Central Florida, PL
Richard Rodriguez, M.D.
210 Lookout Place
Maitland, FL 32751
Phone 407-215-0400 Fax 407-215-0402

INFORMED CONSENT PURSUANT TO FLORIDA STATUTES SECTION 456.51 CONSENT REQUIREMENTS/ EXPLANATION OF SCOPE OF CARE

The American Academy of Pediatrics recommends that all children and adolescents have an annual well exam visit where screenings and a complete physical exam are performed. One component of a complete physical exam is inspection and palpation of the external genitalia to ensure normal age-appropriate development and to document that there are no abnormalities. We will verbally inform you/the patient prior to doing this part of the exam, as we know there is sensitivity, but we need to ensure each patient has been evaluated appropriately. Additionally, if a child or adolescent presents with complaints that could be attributed to the genital area or rectum, we may need to examine the genitals and/or complete a rectal exam to ensure an accurate diagnosis.
Florida has passed a new law that requires any health care practitioner that is examining or treating a patient's pelvic region will need to obtain a written consent. **Though WE DO NOT PERFORM examination of the ovaries, uterus, and fallopian tubes in our offices, given the broad definition of "pelvic examination" [1] in the recently passed Florida legislation, in an abundance of caution, we are choosing to obtain the consent of each patient or their legally authorized representative for examination of external genitalia. This consent applies regardless of gender.** Our exam, procedures, and way of practice **has not and will not change** regardless of this new law. We will continue how we have always performed our physical exams but comply with the new requirement of consent.

CONSENT FOR EXAMINATION OF EXTERNAL GENITALIA

By signing below, the patient (or the patient's legal representative) acknowledges that he/she has been given the opportunity to ask questions about the external genitalia examination before signing this Informed Consent and that the patient (or the patient's legal representative) has voluntarily agreed to the external genitalia examination by a health care provider. If the patient lacks the capacity to sign this Informed Consent, this form will be signed by the person authorized to consent for the patient.

Under Florida Law, prior to performing a pelvic examination, consent must be obtained. While we do not perform internal pelvic exams in our office, the components below are included in the Florida law and may be performed at this examination or work-up:

- External genitalia examination, including of the penis, scrotum, vagina, and/or labia
- Examination of the perineal area or perianal area or rectum
- Taking of a rectal temperature in an infant
- Evaluation of labial adhesions or penile foreskin adhesions

The RISKS to the examination include (but are not limited to): discomfort.
The RISKS associated with failing or refusing to undergo the examination elements above include: the inability to obtain a diagnosis and/or delay in diagnosis of a medical condition; the inability for the health care provider to have accurate and complete information necessary to appropriately treat the patient; and, potential for infection for situations in which the provider is unable to take a rectal temperature.

The **RESONABLE ALTERNATIVES** include a refusal for the intervention assessment. In such case, shared decision making between the patient and his/her provider is vital to ensure health and wellbeing.
The **BENEFITS** include ability to obtain a diagnosis of a medical condition and the ability for the health care provider to have accurate and complete information necessary to appropriately treat the patient.

This consent is in legal good standing and has no expiration, until otherwise revoked and a refusal is signed and on file.
If you have any questions, please talk with your Sunshine Pediatrics health care provider.

I acknowledge that this consent was given freely and voluntarily. By signing below, I confirm that I have read, fully understand and consent to Sunshine Pediatrics of Central Florida conducting a pelvic examination. I also acknowledge that I understand the information in this form, including the purpose, risks, and benefits of the pelvic examination, and that I have had my questions answered. I acknowledge that this consent was given freely and voluntarily.

Patient Name:_____ _____ Date:_____

Signature of Parent, Guardian,
Legally Authorized Representative, Minor*,
Or Patient over the Age of 18

*Note
1. Minors that request examination and treatment for sexually transmissible diseases may provide consent to such treatment in accordance with Florida Law. (F.S. 384.30)
2. If you are a minor, and your physician believes that you would suffer probably health hazards if maternal health and contraceptive information and services of a nonsurgical nature are not provided to you, your physician may provide such services to you without parental consent in accordance with Florida Law (F.S. 381.0051 (4)).

[1] Florida Statutes 456.1 (Consent for Pelvic Examinations) broadly defines pelvic examination to include all of the following: examination of the vagina, rectum, OR external pelvic tissue OR organs using any combinations of modalities which many include the health care practitioner's gloved hand OR instrumentation.

Patient History

Patient Name:_____ Date Of Birth:_____

Birth History:

Adopted: Y / N
Multiple Birth: Y / N
Name of Hospital:_____
Term (in weeks):_____
Birth Weight: _____
Birth Length:_____
Condition at Birth (healthy?): Y / N
Please explain if No:_____
Delivery: C-Section / Vaginal
Breast Milk / Formula (type)_____

Assisted Conception: Y / N
Gestational Diabetes: Y / N
High Risk Pregnancy: Y / N
Induction of Labor: Y / N
Maternal Use of Alcohol: Y / N
Maternal Use of Tobacco: Y / N
Maternal Use of Drugs: Y / N
Surgeries (on baby): Y / N
Circumcision (Boys only): Y / N
Jaundice Y / N

Family History

Biological Mother:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Biological Father:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Extended Family History

Please list any family members with these health concerns

Kidney/Liver Disease:_____
Stroke:_____
Cancer:_____
Asthma:_____
Allergies:_____
Sudden Death:_____
Developmental Disability:_____
Seizures:_____

High Cholesterol:_____
High Blood Pressure:_____
Heart Problems:_____
Diabetes:_____
Hypo/Hyper Thyroid:_____
Mental Illness:_____
Reflux:_____
Anemia:_____

Social History

Who lives in home:_____
Smokers in home: Y / N

Pets in Home:_____