Pediatrics by the Sea Patient Registration

(Bold Items are required)

Patient Information

Patient Name:_____
Last **First** **MI**

□ **Male** □ **Female**

Social Security #:_____ **Birth Date:**_____

Phone (Primary): _____ Cell/Landline Carrier (if you would like texts): _____

Phone (Secondary):_____ Cell/Landline

Address: _____
Street Apartment #

_____
City State Zip Code

Email address: _____ Ok to receive emails: yes/no

The government requires us to collect information on our patients' ethnicity, race and preferred language. If you prefer not to share your child's ethnicity and race, simply check prefer not to answer.

Race: □ African-American □ Alaskan Native □ Asian or Pacific Islander □ Hispanic-African Descent
□ Native American/Eskimo/Aluet □ White □ White Hispanic □ Prefer Not to Answer

Ethnicity: □ Hispanic/Latino(a) □ Not Hispanic or Latino(a) □ Prefer Not to Answer

Preferred Language: □ English □ Spanish □ Creole □ Portuguese □ Russian □ French □ Italian

Parent/Guardian Information

Mother/Guardian

Name:_____ Birth Date:_____ SSN#:_____

Address (if different from pt's):_____
Street City State Zip Code

Primary Phone: _____ Cell/Landline Employer/Occupation: _____

Father/Guardian

Name:_____ Birth Date:_____ SSN#:_____

Address (if different from pt's):_____
Street City State Zip Code

Primary Phone: _____ Cell/Landline Employer/Occupation: _____

Insurance Information

Name of Subscriber:_____ Birth Date:_____ SSN#:_____

Patient's relationship to subscriber: □ Self □ Spouse □ Child □Other_____

In case of emergency.please provide the NAME and Phone of the nearest relative not living with you:

_____

Consent for Services

I hereby authorize Pediatrics by the Sea to release any medical information required in the course of examination and treatment and permit payment directly to them any benefit due for their services rendered. I recognize and accept responsibility rendered regardless of insurance coverage. This includes, but is not limited to co-insurance, deductible, and non-covered service.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent or guardian

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Pediatrics by the Sea** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatrics by the Sea's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatrics by the Sea reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatrics by the Sea's Privacy Officer at 285 SE 5th Ave., Delray Beach, FL 33483.

With my consent, Pediatrics by the Sea may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatrics by the Sea may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Pediatrics by the Sea may e-mail to my appointment reminder cards and patient statements. I have the right to request that Pediatrics by the Sea restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Pediatrics by the Sea's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatrics by the Sea may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Patient's Name Date

We are excited to welcome you and your family to our practice!

Our office participates in many insurance plans. Before your first visit, please check to make sure that we accept your insurance. If your insurance plan requires you to select a doctor as your primary care doctor, we suggest you contact your insurance company and choose one of our doctors before your child's first visit here. If you have any questions about what insurances we accept or whether you need to select a doctor, please contact our office and we will be happy to assist you.

As a courtesy to our patients, we submit all visit charges to your insurance company on your behalf. We are also happy to work with your insurance company to help get your procedures and visits covered, as well as obtain any necessary referrals or authorizations. If we discover there is a problem with your insurance, we make every effort to contact you before issuing you any direct bills.

You will be responsible for any co-insurance, deductibles or co-payments as determined by your insurance company. Co-payments are collected at the time of the visit, and deductibles and co-insurance charges are billed to you after your insurance company reviews our claim. We offer online bill pay to make paying your deductible and co-insurance charges easy.

If your child's insurance is inactive for a visit or your child is assigned to another doctor, you will be responsible for charges.

We understand that medical bills can sometimes feel overwhelming. Our office is happy to work with your family to set up payment plans or other solutions to assist you in meeting your obligations.

Sign below to indicate you have read and understand this policy.

_____ _____

Signature Date

_____

Printed name

Permission to Treat

I (We) _____ authorize Pediatrics by
Print name(s) of legal guardian(s)
the Sea and its personnel to deliver medical services to my child(ren):

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

I (We) authorize the following people (people other than mother/father of child) to bring my child in for treatment and to receive medical information about my child:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that if I would like to make changes to the above list, I will need to notify Pediatrics by the Sea in writing.

_____ _____
Signature of legal guardian *Date*

_____ _____
Printed name of legal guardian *Relationship to patient(s)*

Office Policies

1. How to Contact Us: When your child has a medical issue and you would like to contact us, please simply call us at the main office phone number (561) 272-8991 for the east office and (561) 303-3707 for the west office. During normal business hours, simply press '0' and you will be directed to the front office staff. They will give your information to the doctor or nurse in the office that day who can give you medical advice. Outside of normal business hours, call our main office phone number and then simply press '9', this will direct your phone call to the doctor's cell phone who is on call.

2. Apppointment Cancellations: Please call our office to cancel any appointment that you will not be able to attend, preferably at least 24 hours before the appointment time.

3. Medication Refills: If you would like a refill of a routine medication, please contact the pharmacy and request them to send us a refill request or you can contact our office directly to request the refill. For controlled medication refills, you will need to request them from us directly. Please allow us 48 hours to process routine medication refills.

4. Persons you would like to designate to bring in your child for treatment or receive medical information about your child must be listed on the 'Permission to Treat' page of this packet. Changes to that list must be made in writing.

5. Letters: There will be a $20 charge for any letters to be written on stationary. This includes but is not limited to letters for disability, letters for school (excluding scripts for IEPs, 504 plans), or letters for attorneys.

6. Medical Records: A medical records release form must be filled out to have medical records transferred from our office to yourself, another medical provider, an attorney or any other third party. Medical records can be transferred to another doctor or healthcare facility for no charge but there will be a charge of $1 per page for any other release of records (after 25 pages, the fee is 25 cents per page). Our standard turn around time for medical records is within two weeks but the turn around may be shorter or longer depending on the volume of requests.

7. Patient Portals: We have two patient portals that you may sign up to utilize. We have a patient portal through our EHR to access medical records and we have a patient portal in which you can pay bills or set up a payment plan. Please contact our office if you would like to sign up for these.

8. Referrals: Please notify us if your child has a specialist appointment for which you need a referral. Our standard turn-around time for submitting referrals to insurance companies for approval is 3 business days. Depending on the urgency of the matter, we will do our best to respond to all requests in a timely matter but please understand that we are bound by the insurance company regulations in how quickly they approve the referral.

Sign below to indicate you have read and understand this policy.

_____ _____

Signature Date

_____

Printed name