New Patient Registration Form

Patient Demographics

Today's date: ___/___/___ Last Name: _____ First Name: _____

Nickname: _____ Date of Birth: ____/____/____ Sex: Male/ Female

Home Address: _____

City: _____ St: _____ Zip code: _____

Cell: (_____) _____ Alternate phone# work_____ home _____

Primary email: _____

Race: Asian/African American/ Caucasian/ Native American/ Hispanic/other: _____

Ethnicity: _____ Language_____

Pharmacy Name: _____ Location: _____Phone Number: _____

Do you agree to receive periodic messages from the practice (appointments, lab results, Rx, flu shot reminder) Y/N?

FATHER

Last Name: _____ DOB: ____/____/____

First Name: _____

Address: _____

City: _____State: _____Zip: _____

Best Phone #: _____cell/work/home

Alternate Phone: _____

Email: _____

Occupation: _____

Employer: _____

MOTHER

Last Name: _____ DOB: ____/____/____

First Name: _____

Address: _____

City: _____State: _____Zip: _____

Best Phone # _____cell/work/home

Alternate Phone: _____

Email: _____

Occupation: _____

Employer: _____

Siblings: _____

Biological Parental Status: Married / Single/ Divorced / Widowed Other: _____

If divorced, who has custody of the child? _____Who does the child primarily reside with: _____

Any court documents documenting custody of the child? YES / NO If so, please provide copies to the office

Stepfather Name: _____ Stepmother Name: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Pediatric Patient History

Patient Name: _____ Date of Birth: _____ Sex: _____

Completed by: _____ Relationship to Patient: _____

Who referred you to Mahoney Pediatrics: _____

Date of Last Physical Exam: _____

Pregnancy & Birth:

Mother's Age at Pregnancy: _____
Hospital of Birth: _____
Birth Weight: _____

Who resides in home? _____
_____
_____

During pregnancy did mother use/have:
(please circle all that apply)

Tobacco	Hepatitis B
Alcohol	Group B Strep
Drugs	Syphilis
Hepatitis B	HIV

Family Medical History:
Has anyone in your immediate family been
Treated for (please circle all that apply):

Anemia	Cystic Fibrosis
Asthma/Lung disease	Heart disease/murmur
High blood pressure	High cholesterol
Tuberculosis	Diabetes
Thyroid Problems	Kidney disease
Seizures	Other: _____

Baby: (please circle all that apply)

Premature	C Section
Jaundice	Breathing problems
Breast feeding	Formula
Birth complications	

Has/does your child:

Y N Have allergy to Medicine? _____

Y N Have other allergies? _____

Y N Take medication? _____

Y N Had surgery? (age & procedure) _____

Y N Been hospitalized? (age & reason) _____

Y N Had serious injuries? (age & description) _____

Y N Do you have any concerns about your child's development or behavior? _____

Y N Does your child have any communication needs:
Vision impaired/ Hearing impaired/Cognitive Issues?

If so: Reason: _____ Provider: _____ Phone: _____

Y N Does your child receive therapy/ counseling/ services (speech, ENT, allergy) from other providers?

If so: Reason: _____ Provider: _____ Phone: _____

Authorized Consent to Seek Medical Care

I have the legal right to consent to medical and surgical treatment because I am the parent/legal guardian of the patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that the providers at Mahoney Pediatrics P.A. and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician /patient relationship exists, or until I withdraw my consent.

_____ _____

Patient Name Patient's date of birth

_____

Parent Signature

IF YOU ARE ALLOWING SOMEONE OTHER THAN THE PARENTS TO BRING IN THE CHILD
(grandparents, nanny, friend, step-parent, aunt/uncle, etc. in case parents are at work or out of town)
Please complete and sign below

I (Parent/legal guardian) _____, am hereby giving permission in advance for the following person(s) to bring my child/children to Mahoney Pediatrics and to receive medical treatment and advise during my absence.

Name: _____ DOB: ____/____/____ Relationship: _____

Name: _____ DOB: ____/____/____ Relationship: _____

Name: _____ DOB: ____/____/____ Relationship: _____

Please specify dates: From ____/____/____ to ____/____/____ (ex: the week you will be out of town and child with grandparents)

We will continue to rely on the information on this form unless you request changes. It is <u>YOUR RESPONSIBILTY</u> to immediately notify Mahoney Pediatrics, P.A. of a divorce, legal separation, change in custody agreement, or any other circumstance which may alter this authorization.

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

"Notice of Privacy Practices"

I hereby give consent to Mahoney Pediatrics, P.A. and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operations.

I further authorize Mahoney Pediatrics, P.A. to furnish information from my medical records as requested by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, o there is a reasonable basis to believe information may identify me.

I understand that I have a right to request Mahoney Pediatrics, P.A. to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations. Mahoney Pediatrics, P.A. is not required to grant my request, but if they do, the restriction will be binding on Mahoney Pediatrics, P.A.

I acknowledge that I have received the HIPAA Statement and Notice of Privacy Practices for Mahoney Pediatrics, P.A., which provides more detailed information about how Mahoney Pediatrics, P.A. may use or disclose my protected health information.

Parent/Legal Guardian Name: _____

Patient Name: _____

Signature: _____

Date: _____

Mahoney Pediatrics, P.A., Palms West Professional Center IV,
12983 Southern Boulevard, Suite 100
Loxahatchee, FL 33470

OFFICE POLICY AND FINANCIAL AGREEMENT

Authorization of Assignment of Insurance Benefits & Release of Medical Records

Please read carefully and sign stating that you understand and agree with our policies

I understand payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. 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. I understand that, in case of default, I am responsible for any costs incurred in the collection of patient account, as well as reasonable attorney fees and court costs.

Returned checks are subject to a service charge of **$40.00** and you will lose your privilege to write checks in our office.

Missed appointments: Mahoney Pediatrics requires 24-hour advance notice for all cancellations. Failure to notify our office will result in a **$35.00** fee. This fee will be billed directly to the Responsible Party and not to the insurance company. Emergencies will be considered on a case-by-case basis for waiver of this fee. After the third no show, the patient may be discharged from the practice.

Medical Records: There will be a charge of $1.00 per page for the first 25 pages and $.25 thereafter for copying of medical records.

Medical Forms: Physical and immunization forms, school forms, Wic forms, and medication forms should be requested at your child's yearly well visit. If needed after that visit, we require 3 business days to complete them. **Your child MUST have had a well visit in our office in the last year for any forms to be completed**
FMLA paperwork is $20 and takes 5 business days to complete.

Divorced/Separated Parents: A divorce decree is a legal document binding only on the two parties to it. Mahoney Pediatrics P.A. is not a party to or bound by the divorce decree, custody agreement or other related agreement. The parent or guardian accompanying the pediatric patient at the time of the service is responsible for payment in full at the time of service.

Newborns: ***If you are enrolling your baby to an insurance policy please be sure to do so within 30 days of birth.*** As a courtesy we will hold claims for 30 days prior to submitting to the insurance allowing you this time to add the baby. Please note: Our office visits are not billable under mother's coverage. Baby must be added as an individual policy holder.

Mahoney Pediatrics P.A. only bills ONE insurance policy. If your child/children are covered by two policies, we will only bill the primary insurance.

Delinquent Bills: On a case-by-case basis Management will work with Responsible Party to address delinquent accounts. If unresolved, the account will be assigned to an external collection agency or attorney for collection. I will be responsible for all collection costs, including attorney's fees and court costs.

Discharging Patients: I understand that I may be discharged as a patient at the discretion of Mahoney Pediatrics, P.A. I understand that I will be given 30 days to find a new pediatrician and that Mahoney Pediatrics, P.A. will continue to provide care for emergency care and treatment during the 30 day time period.

Consent to Communications: You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide to us. You also consent to us and any other owner or servicer of your account contacting you using any communication channel. This may include text messages, automatic telephone dialing systems, and/or an artificial or prerecorded voice. This consent applies even if you are charged for the call under your phone plan. You are responsible for any charges that may be billed to you by your communications carriers when we contact you.

Your signature on the line below forms a legally binding agreement between Mahoney Pediatrics, P.A. and the undersigned patient (the Patient) who is receiving medical services, or the Responsible Party for minor patients until the age of 21. The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Mahoney Pediatrics P.A. and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason.**

RESPONSIBLE PARTY NAME: _____

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____

Primary Insurance: _____

Full Name of Insured: _____

Subscriber ID: _____

Group # _____

Subscriber DOB: _____ Effective Date: _____

Relationship to patient: _____ Co-pay $_____

Medical Records Release Authorization

To Whom It May Concern:

I hereby authorize Mahoney Pediatrics, P.A. to Release or Obtain from any listed provider or facility a copy, summary, or narrative of my legal records as indicated by the check mark(s) below, or to otherwise release confidential information.

Below is my child's information for the records that I am requesting: ONLY ONE CHILD PER FORM

Name: _____ D.O.B. _____

FAX RECORDS TO MAHONEY PEDIATRICS, P.A. FAX: 561-793-2510

Office Name: _____

Address: _____ City: _____

State: _____ Telephone: _____ Fax: _____

Check the reports to be disclosed:

Complete Records _____ Immunizations _____ Lab Results _____ Growth Charts_____
Radiology Reports _____ Last Well Visit _____ Consultations _____ Summary of Visits _____

Reason for Requested Disclosure: Change in Healthcare Provider___ Legal __ Personal Use __ Second Opinion ___

Other: ___ This authorization expires in 6 months from the date signed or earlier if necessary: _____/_____/_____.

Daycare/ School Release: I authorize Mahoney Pediatrics, P.A. to fax my child's medical information to:

Name of School: _____ Fax Number: _____

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use and that I am voluntarily signing the release of medical records authorization.
- This authorization may include disclosure of information relating to alcohol and drug use, and confidential HIV related information only if I **initial here**: _____.
- If I am authorizing the release of HIV related, alcohol or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization.

Parent's Name: _____ **Relationship to child:** _____

Parent's Signature: _____ **Date:** _____

Additional Policies for Divorced or Separated Parents ONLY

In case of a divorce, please do not put our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent, as well as who will attend the medical appointments and provide consent for treatment. If a Stepparent bringing a child for care is not listed on the consent to treat form, we will be unable to see your child that day.

We expect cordial behavior and cooperation in our office at all times.

Automated appointment reminder calls, emails, Rx notifications can only be sent to the phone number and email listed in the demographic section of our EMR. The patient portal can have two separate login accounts.

**** Please note both parents have access to child's information, unless a court order is on file****

Appointments may be cancelled **only** by the person who made the appointment initially. If someone other than the person initially making the appointment cancels, they will be charged a "no show" fee directly.

If both parents do not attend the patient's visit the Provider will not be able to speak on the phone later to the parent that was not in attendance. If you have questions and feel you *must* speak to the doctor regarding your child's care, you may make a virtual appointment at the end of the day for a fee of $40 paid in advance. This is not an appointment that is covered by insurance. Alternatively, you may make an appointment to see the doctor in our office with or without your child. This may be covered by your insurance.

Any request for letters to be written by the provider for legal purposes will incur a fee of $40/letter.

In the event a Court Order affects the rights of parents and children that will impact an office visit, please provide a copy of the document to the Management. We will make every effort to comply with the Court Order. It is the responsibility of the parents to inform our office of any changes in marital status or legal custody or any other circumstance which may alter this authorization. In the event that Management determines that Mahoney Pediatrics P.A. is unable to continue to provide care to your child/children we will continue to see the pediatric patient for 30 days on an emergency basis only, to permit you time to find a new provider.