Peninsula Pediatrics

13163 66th Street North Largo, FL 33773

Phone (727) 228-7000 Fax (727) 223-3614

Welcome to Peninsula Pediatrics, for your first visit to the practice, please bring the following items:

1. A photo ID- Driver's License or Passport
2. Insurance Card
3. Credit Card
4. Copy of child's immunization records
5. Completed new patient paperwork- completely filled out
6. If your child is coming in for a 9,18, or 30-month-old wellness exam- please complete the ASQ Survey.

PENINSULA PEDIATRICS

Patient Registration Form

Today's Date: _____

PATIENT INFORMATION:

Name: _____

Date of Birth: _____ Primary Pone#: _____ Sex: ☐ M ☐ F

GUARANTOR/INSURANCE INFOFRMATION:

Policy Holder Name: _____ Patient Relation to Guarantor: _____

Policy Holder DOB: _____ SS# _____ Insurance Plan: _____

ID #: _____ Effective Date: _____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

Mother/Father/Legal Guardian Name: _____ Date of Birth: _____

Mobile Phone: (_____) _____ Employer: _____

Home Address (if different from child): _____

City: _____ State: _____ Zip: _____

Mother/Father/Legal Guardian Name: _____ Date of Birth: _____

Mobile Phone: (_____) _____ Employer: _____

Home Address (if different from child): _____

City: _____ State: _____ Zip: _____

FORM COMPLETED BY:

_____	_____	_____
Name (print)	Signature	Date

PENINSULA PEDIATRICS

Pediatric Health History Form – Initial Visit (over 12 months old)

Child's Name _____DOB _____ Age_____ Today's Date_____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Delivery: ☐vaginal ☐C-section

Was your child premature? ☐No ☐Yes

Born at ___weeks

Birth Weight _____

Problems in the newborn period

_____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with (explain)

☐Asthma / reactive airway disease / Wheezing_____

☐Pneumonia or bronchiolitis _____

☐Seasonal Allergies _____

☐Eczema / Skin problems_____

☐Food Allergy _____

☐Recurrent ear infections _____

☐Pneumonia _____

☐Urinary Tract Infections _____

☐Seizures _____

☐Anemia _____

☐Broken Bone / Serious Injury_____

☐Depression/Anxiety _____

☐Heart Murmur _____

☐Constipation _____

☐Attention Deficit Disorder _____

☐Other chronic medical conditions_____

_____

Has your child ever been hospitalized? ☐No ☐Yes (explain)

_____

_____

Past surgeries or procedures?_____

_____

_____

Please list any specialist your child has seen, dates, and reason:_____

_____

Medications

Preferred Pharmacy: _____

Please list ALLERGIES to medicine

_____

_____

Current Medications

_____

_____

Any concerns about your child's development/nutrition?

_____

_____

Name of School or Daycare ☐NONE _____

Social History

Who lives in the child's household? ☐Mom ☐Dad ☐Step_____

☐siblings (#_____) ☐Grandparents ☐Other _____

Childs Parents are ☐married ☐unmarried ☐divorced ☐other

Moms Occupation _____ Dads Occupation_____

Do any household members smoke? ☐Yes ☐No

Family History

Circle all diseases below that have occurred in this child's brothers, sisters, parent, grandparents, aunts, and uncles. Please specify who (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

Condition:

ADD / ADHD
Allergies
Anemia
Asthma
Autism
Birth Defects
Bleeding Disorder
Cancer (specify type)
Depression / Anxiety
Diabetes
Digestive / Liver Problems
Heart Attach/ Stroke
High Blood Pressure
High Cholesterol
Kidney Problems
Migraines
Thyroid Disease
Seizures
Other:

PENINSULA PEDIATRICS

Permission to Treat & Notice of Privacy Practices

I have reviewed Peninsula Pediatrics Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

I (We) _____ authorize Peninsula Pediatrics of West Florida, PLLC
print name(s) of parent or legal guardian(s)

and its personnel to deliver medical services to my child(ren), listed below.

(please print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact in case of an emergency:

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

_____ _____

Signature(s) of Parent or Legal Guardian Date

_____ _____

( ) Primary Phone Relationship to patient

PENINSULA PEDIATRICS

Financial Policy and Billing Agreement

Patient Name: _____ **D.O.B.**_____

Peninsula Pediatrics of West Florida's billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

I understand and agree with the following financial policy of Peninsula Pediatrics of West Florida (Peninsula Pediatrics):

1) If we accept your insurance, you are responsible for any deductibles, coinsurance or co-pays at the time of service. **WE DO NOT TAKE SECONDARY INSURANCE**. Insurance policies with required co-pays must be paid at the time of service or we may charge YOU for the full amount of the visit. If your insurance carrier changes, or your phone number or address, it is your responsibility to notify us when CHECKING IN. If you fail to do so, you may then become responsible for the full amount of the visit. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.
    - CO-PAYS – It is our policy to collect your insurance co-pay at check in. This simplifies the office process and ensures the financial obligation is met at the time of service.
    - CO-INSURANCE / DEDUCTIBLE – Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.
2) **The guardian who brings the child in is responsible for payment**. Divorce/settlement/financial responsibility for issues related to the child are to be worked out between the parents.
3) As the guarantor, I am financially responsible for my newborn's first visit to Peninsula Pediatrics unless I can show proof of the insurance.
4) I authorize submission of a claim and direct payment to Peninsula Pediatrics for all services provided to the above patient. When a claim is submitted as an unassigned claim, I also authorize payment to be issued directly to Peninsula Pediatrics for the amount due in my pending claim for services of medical treatment to the above patient.
5) If my child needs to be seen by a specialist, I must obtain proper authorization and understand that I am financially responsible to the specialists. I must call the specialist and make the appointment and notify Peninsula Pediatrics of the appointment to ensure that proper authorization is obtained with a 5-business day advanced notice.
6) If there is a balance on my account, I will pay the balance in full within 30 days. I understand that if the balance is 30 days past due my credit card on file will be charged.
7) In the event that my account is sent to an outside collection agency, a 30% collection fee will be charged to my account before it is turned over to a collection agency. If my account is sent to an outside collection agency, I will be dismissed from the practice.
8) In the event you do not show up for a scheduled appointment (No Show), a $25.00 fee will be assessed on the above patient's account. After 3 No Shows you may be dismissed from the practice.
9) Any check returned by your bank for any reason will be assessed a $25.00 return check fee which will be added to your account and must be paid in full by either cash or credit card at your next visit and we will no longer be able to accept checks from you.

Financial Policy and Billing Agreement

Patient Name: _____ **D.O.B.**_____

BILLING

As a courtesy, Peninsula Pediatrics bills your health insurance provider on your behalf, with the following guidelines/exceptions:

- Insurance Card: It is critical that the most current insurance card is brought to every appointment. We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
- Auto Insurance: We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and we will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.

COMBINED VISITS

If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.

EVENING/WEEKEND/HOLIDAY SURCHARGE

Some health insurance providers bill a surcharge if you see your pediatrician after normal business hours, on the weekend, or on a holiday.

ADMINISTRATIVE FEES

Peninsula Pediatrics charges various fees for the following items, which require personnel and resources to address:

- Copies of medical records
- Special request completion of camp or sports physical forms (free during visit)
- Special request physician letters
- Returned check (for insufficient funds)
- "No-show" Fee: Assessed if you do not show up for a scheduled appointment

Peninsula Pediatrics is committed to providing the best treatment for our patients and we charge what is considered "usual and customary fees" for our demographic area. By signing below, I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, which are not covered by insurance. I will notify you of any and all future changes.

I have read the Financial / Billing Policy of Peninsula Pediatrics and I understand and accept it.

Signature of Parent/Guardian/Legal Representative: _____ Date: _____

CREDIT CARD ON FILE POLICY

At Peninsula Pediatrics we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Patient Name: Please PRINT **all of your children that are patients at Peninsula Pediatrics**

1._____DOB____/____/____

2._____DOB____/____/____

3._____DOB____/____/____

4._____DOB____/____/____

5._____DOB____/____/____

6._____DOB____/____/____

Authorization for Credit Card on File Program

Your credit card information is kept confidential and secure within our Electronic Health Records system. The information is encrypted in a cloud secured site like those used by hospital emergency rooms and urgent care centers; your information is not kept on our computer. Once we enter your information through this gateway, we do not have access to view or edit the information. Payments to your card are processed only after the claim has been filed and processed by your insurer, and after the insurance portion of the claim has been paid and posted to the account.

AUTHORIZATION - I authorize Peninsula Pediatrics to charge the following credit card for all balances for the patients listed above which my health insurance plan deems as "patient responsibility" i.e. co-pay's, deductibles, coinsurance, non-covered service, etc.

CREDIT CARD/DEBIT CARD (Check One): ___Visa ___Mastercard ___Discover ___Amex ___Debit

___Health Savings ___ Health Reimbursement ___ Flexible Spending

Last 4 digits of Card: ____ ____ ____ ____ Expiration Date: ____/____ Name on Card: _____

I understand that once my health insurance has processed my child's claims, I will receive a statement and text message. The statement will show any balances due that are patient responsibility. Peninsula Pediatrics will charge my credit card on file for the balance due, if they have not received payment or heard from me to arrange a payment within 30 days. If the balance due exceeds $100.00, I will receive a courtesy call prior to my card being charged. I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further routine well appointments until the balance has been paid in full.

Responsible Party's Printed Name: _____Relationship: _____

Signature: _____ Date: ____/____/____

Peninsula
Pediatrics
13163 66th Street N, Largo FL 33773

PARENTAL SEPARATION AND DIVORCE POLICY

At Peninsula Pediatrics of West Florida, PLLC, we understand that a family unit can have many different forms. Our focus is to provide complete and through medical care to your child(ren). Separation and divorce can sometimes present communication barriers between caregivers. Below are our office policies and procedures in these situations:

- In the absence of any legal documentation provided to us, both biological parents will have equal access to a patient's medical record.
- Unless restricted by legal documentation provided to us, either parent may schedule or cancel appointments, bring the minor(s) to appointments, and assist in making decisions on a minor's behalf. We do recommend that in cases of joint custody, both parents attend appointments or communicate with each other before and after each visit.
- Our office **will not call** (or otherwise notify) a parent in the case of an appointment scheduled by a different parent. We will contact the parent who accompanied the child to the appointment in cases of follow-up phone calls for things such as test results, but may reach out to an alternative legal guardian if they cannot be reached.
- All office correspondence will be sent to the primary address of the insurance holder. This includes billing statements, among other things.
- Our patient portal provides access to portions of a child's medical record from birth until they turn 18 years old. Access may be obtained by requesting it from our Office Manager, Cassandra Lindsey. Our system does allow more than 1 person access per patient, but they must request individually.
- Should issues between the parents become disruptive to our practice and inhibit the best care for your child(ren), we reserve the right to discharge a family from our care.

Patient's name:_____ DOB:_____

Parent Signature:_____ Date:_____

REQUEST TO RELEASE MEDICAL RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I authorize and request that _____, release my
(Doctor, practice, or hospital name)
Child/children's complete medical records, for the Treatment Planning to include:

Please send us

1. Patient Encounter/ Well Visit Summary
2. Most Recent Well Visit- (If no well visit- please send Allergies, Family and Social History)
3. Most Recent Sick Visit- (Within the past 12 months)
4. Patient Problem List and Specialist Note(s) if Applicable
5. Medication List
6. Pregnancy/ Birth Records
7. Diagnostic Testing/ Labs (Within the past 2 years)
8. Psychiatric /Mental Health Notes if Applicable

To: **Peninsula Pediatrics of West Florida, PLLC.**
Steven Moore, MD
13163 66th St. North
Largo, FL 33773
Phone: 727-228-7000
Fax: 727-223-3614

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses, and any and all reports of any type of character.

2. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

This authorization will expire one year from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient