Premier Care Pediatrics

NEW PATIENT INFORMATION

PATIENT Today's Date _____

Name: Last _____ First _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____ Ext. _____

Permission to Leave Message Home ☐ Yes ☐ No Work ☐ Yes ☐ No

Current Pediatrician _____ School _____

Date of Birth ____/____/____ Sex ☐ F ☐ M Social Security # _____-_____-_____

Employer (if any) _____ Address _____

PARENT/GUARDIAN

Relationship to Patient _____ Email _____

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Social Security # _____-_____-_____ Date of Birth ____/____/____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone (_____) _____-_____ Ext. _____

EMERGENCY CONTACT

Relationship to Patient _____

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext. _____

AUTHORIZATION TO RELEASE INFORMATION TO:

Name _____ Relationship to Patient _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext. _____

Address _____ City _____ State _____ Zip _____

Name _____ Relationship to Patient _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext. _____

Address _____ City _____ State _____ Zip _____

Pharmacy _____ Address _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Primary Insurance _____ Policy Holder Name _____

Policy Holder Sex ☐ F ☐ M Policy Holder DOB ____/____/____

Policy Holder SSN # _____-_____-_____ Policy Holder Relationship to Patient _____

ID# _____ Group # _____

Secondary Insurance _____ Policy Holder Name _____

Policy Holder Sex ☐ F ☐ M Policy Holder DOB ____/____/____

Policy Holder SSN # _____-_____-_____ Policy Holder Relationship to Patient _____

ID# _____ Group # _____

_____ _____

Patient or Guardian Signature Relationship to Patient Date

Premier Care Pediatrics
16637 Fishhawk Blvd. Suite 101 • Lithia, FL 33547-3800
Phone (813) 657-7337 • Fax (813) 661-4702
http://www.premiercarepeds.com

PARENT'S ACCEPTANCE OF POLICIES

Patient Privacy Practices
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Patients' Bill of Rights
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Patient Responsibilities
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Financial Responsibilities
I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Premier Care Pediatrics will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Premier Care Pediatrics permission to bill my or my child's insurance company on my behalf, and understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

_____ _____
Parent or Patient Signature Date

Consent to Treat
By signing here, I am consenting to treatment of myself or my dependent by the physicians of Premier Care Pediatrics. I understand that my medical information may be viewed or shared amongst the staff of Premier Care Pediatrics and that every effort will be made by Premier Care Pediatrics to protect my health information as is required by HIPAA regulations.

_____ _____
Parent or Patient Signature Date

Permission to Release Medical Information
By signing here, I authorize Premier Care Pediatrics to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to Premier Care Pediatrics until written notice revoking this authorization is provided by the patient or patient's legal representative.**

_____ _____
Parent or Patient Signature Date

If you are signing for the patient, please indicate your relationship here: _____
Relationship to Patient

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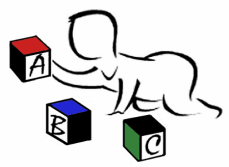
AUTHORIZATION TO PROVIDE MEDICAL CARE

I, _____, being the parent/guardian of _____, authorize the following list of individuals to consent for treatment of my above mentioned child. I understand that by providing the following information about the individuals, I am allowing Premier Care Pediatrics to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of my child, I may do so by requesting a new form, filling it out, and signing again. I also understand that if there is any necessary treatment that requires a major decision be made, Premier Care Pediatrics will make every effort to contact me first. However, if no contact can be made with a parent, and I have authorized the individual to consent for treatment, the individuals listed below have my permission to make decisions for my child's medical care. This authorization will be indefinite and will only expire if I fill out a new form. All individuals listed below will be required to provide at least one form of identification that must include a photograph as well as the information provided below for verification purposes. I understand that this is being done to protect my child's well-being.

The following individuals are authorized by me to consent for treatment:

Name of Individual	Relationship to Patient	Date of Birth

Signature of Parent **Name of Parent** **Date**



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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ DOB: _____ Phone #: _____

Street Address: _____ City, State, Zip: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone: Fax:

PLEASE **SEND** INFORMATION **TO**:

Premier Care Pediatrics
Name of Provider/Clinic/Organization

16637 Fishhawk Blvd. Suite 101
Street Address

Lithia, FL 33547
City, State, Zip Code

(813) 657-7337 **(813) 661-4702**
Phone: Fax:

I AUTHORIZE the following information to be disclosed: (Please mark all that apply)

- ☒ Complete Health Records
- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Well Child Visits
- ☐ Progress Notes
- ☐ Consult Notes
- ☐ Medication History
- ☐ Date(s)_____
- ☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ADDITIONAL PATIENT INFORMATION:
If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Guardian Date Signature of Witness Date

_____
Name of Patient or Guardian Relationship

☐ Pick-Up Records ☐ Mail Records ☒ FAX Records