Doctor Merchant PEDIATRICS

Patient Registration Form

(REV. 08/2021)

PLEASE PRINT

Patient Name_____DOB_____ Age_____
SS#_____ Race_____Ethnicity_____ Male ☐ Female ☐
In State Address_____City_____State___Zip_____
Out of State (If Applicable) Address_____City_____State___Zip_____
E-mail _____
Phone_____Alternate Number _____

Parent/ Guardian Information

Mother/Guardian_____D.O.B_____Home Phone_____
*REQUIRED Email_____
SSN:_____DL#_____DL State_____
Address_____ City_____ State_____
Zip Code_____ Occupation_____Employer_____
Work#_____Cell#_____
Father/Guardian_____D.O.B_____Home Phone_____
*REQUIRED Email_____
SSN:_____DL#_____DL State_____
Address_____ City_____ State_____
Zip Code_____ Occupation_____Employer_____
Work#_____Cell#_____

In Case of Emergency (Person Other than parent/guardian)

Name_____ Relationship to Patient_____
Address_____City_____State_____Zip_____
Home Phone_____ Work Phone_____
Is this person authorized to bring the child in? ☐ Yes ☐ No

Health Insurance

Primary Insurance_____Policy #_____ Group #_____
Policy Holder_____ Relationship_____ D.O.B_____
Claims Address_____ City_____ State_____ Zip Code_____

Secondary Insurance_____Policy #_____ Group #_____
Policy Holder_____ Relationship_____ D.O.B_____
Claims Address_____ City_____ State_____ Zip Code_____

PLEASE INITIAL BELOW AS AN INDICATION THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

_____ Assignment of Insurance Benefits
I hereby authorize direct payment of medical benefits to Merchant Pediatrics for services rendered by the physicians or organization; I understand that I am responsible for any balances not covered by insurance.

_____ Authorization to Release Information
I hereby authorize Merchant Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

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Name of Child_____ D.O.B_____

Consent of Treatment and Policies

PLEASE INITIAL BELOW AS AN INDICATION THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

_____ I understand each adult that wishes to be in the examination room must present ID and must be listed as an authorized adult. I also understand that all ID's will be scanned for the strict purpose of identifying within the practice and will not be released to an external source.

_____ I understand that a state ID or a valid drivers license and a Health Insurance Card will need to be presented at the beginning of every visit.

_____ I understand it is my responsibility to provide all the necessary documentation for my child. I also understand that if I fail to provide certain documentation, my appointment can be rescheduled.

Documentation includes: Birth Certificate, Discharge papers (newborns only), Previous Shot Records, Insurance information, and a valid state ID or Drivers License for parent or guardian.

Consent of Treatment

I have the legal right to give consent to the Physicians of Merchant Pediatrics to treat this child. I also give the physicians of Merchant Pediatrics consent to retrieve medication history from third party sources. I understand this consent will be valid during the entire term of care; furthermore, I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me for my child as a result of examinations. I also understand my child's photo will be taken for the strict purpose of identifying within the practice and will not be released to external sources.

Parent/Guardian Name (Print)_____

Parent/Guardian Signature_____

Relationship to child_____

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Office Policies and Procedures

PLEASE INITIAL BELOW AS AN INDICATION THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

Patient Name:_____D.O.B_____

Payment Policy

_____ Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment.

Cancellation Policy

Time has been specifically reserved for your appointment or treatment. Please call at least 24 hours prior to your appointment if you need to cancel your appointment, if not you will incur a $25 penalty fee.

Medical Record Fees

_____ + HRS 680 (Blue Immunization Form), HRS 3040 (Yellow Physical Form), and Forms for College or Military please note, fees may apply.

+Copies of Medical Records: $1 per page up to 25 pages, $0.25 each additional page thereafter.

Please Note: We have 30 days to process any medical release request. An additional fee will be charged if copies are required sooner.

+ Medical Disability/FMLA Form Completion: $25 per set of forms.

+ Notary available upon request, fees may vary.

Deductible

If your deductible has not been met for the calendar year, Merchant Pediatrics charges a fee of $50 for new and established patients.

Outstanding Balance

_____ If you have a previous outstanding balance, you are responsible for the balance. Full payment is expected in a timely fashion, but no later than 30 days from the receipt of your statement.

Insurance Signature Authorization Lifetime

_____ I certify that the information given by me in the applying for payment under title XVIII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or its intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies; I permit a copy of this authorization to be used in place of the original

Managed Care Patients

_____ I am aware that it is my responsibility to know and understand the terms and conditions of my insurance policy. I will not hold the staff of Merchant Pediatrics responsible if I do not follow through in obtaining appropriate authorization; in this event I will bear the full responsibility of the services rendered.

_____

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Authorization for healthcare decisions on appointments and treatments

I _____ the _____ of _____ _____
(Parent/Guardian Name) (Relationship to Child) (Patient Name) (D.O.B of child)

hereby give my permission for the following individual(s) to bring my child to Merchant Pediatrics for medical attention. I grant this/these individual(s) the ability to bring my child to any provider rendering services at Merchant Pediatrics for evaluation, immunizations, and any necessary medical treatment that my child may need.

Furthermore, this/these individual(s) will be acting on my behalf and I cannot hold any physician and/or staff member at Merchant Pediatrics liable, or pursue legal action for the healthcare decisions the named individual(s) made regarding my child's healthcare. This consent will be effective as long as I am the legal guardian and I can revoke this consent at any time. This consent is only valid for use in this practice.

I understand a different form is required and must be notarized in order to give this/these person(s) legal medical power of attorney.

Contact Name:_____ Relationship to Child:_____

Relationship to Me: _____

(Staff Only: ID Scanned? ☐Yes ☐No)

Contact Name:_____ Relationship to Child: _____

Relationship to Me:_____

(Staff Only: ID Scanned? ☐Yes ☐No)

Contact Name:_____ Relationship to Child: _____

Relationship to Me:_____

(Staff Only: ID Scanned? ☐Yes ☐No)

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN GUARDIAN
Government issued ID# OF PARENT/LEGAL

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

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AUTHORIZATION FOR THE COPY OR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Medical Release Form

Patient Name_____ D.O.B._____ Home Phone_____

Address_____

City_____State_____Zip Code_____

By signing this authorization, I authorize the party listed below:

Provider Name_____ Phone_____
Address_____ Fax_____
City_____State_____Zip Code_____

(Please select only one) Obtain from ☐ or
Disclose to ☐ Fees may apply according to FL. Statute 395.3025

MERCHANT PEDIATRICS AT THE FOLLOWING LOCATION:

Hunter's Creek 14015 Egret Tower Dr. Orlando, FL 32837 Tel: (407) 447-7100 Fax: (407) 447-6100 ☐	Kissimmee "The Loop" 1186 Cypress Glen Circle Kissimmee, FL 34741 Tel: (407) 846-7669 Fax: (407) 846-8091 ☐	Dr. Phillip's 6900 Turkey Lake Rd, Suite 1-5 Orlando, FL 32819 Tel:(407) 351-KIDS (5437) Fax: (407) 351-5449 ☐

The Following:
☐ Hospital records including Hx & Phys and Discharge Summaries from the dates: _____ to _____
☐ Emergency Room Notes from the period: _____ to _____
☐ Diagnostic Tests and Labs
☐ Immunization Records (Please fax immunization Records. All other requested records may be sent by mail)
☐ Office Notes from the period: _____ to _____
☐ Other_____

Purpose of Disclosure:
☐ Referral to Specialist ☐ Insurance
☐ Change of Physician ☐ Disability Determination/SSI
☐ Continuing Care ☐ Legal Investigation ☐ Other, please specify: _____

Information to be excluded/not released:
☐ Mental Health Records ☐ HIV Testing ☐ Drug/Alcohol Treatment ☐ Sexual Assault/Victimization Records
☐ Other, please specify: _____

I hereby authorize disclose of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

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Health History

Patient Information

Patient Name_____ D.O.B_____ Age_____ ☐Male ☐Female
Home Phone_____ Cell Phone_____ Emergency Phone_____
Child Lives with Mother/ Father/Both/ Other, Please Specify:_____
Who cares for the child during the day?:_____
Child's School_____ Child's Grade_____

Birth History

Place of Birth_____ Type of Delivery_____
Full Term? ☐Yes ☐No Birth Weight: LBS:_____ OZ: _____ Birth Length: IN: _____
Number of Pregnancies: _____ Number of Miscarriages: _____

Family History

Mothers/Guardian_____ D.O.B:_____ Occupation_____
Father/Guardian_____ D.O.B: _____ Occupation_____
Sibling 1:_____ Age_____ Sibling 2: _____ Age_____
Sibling 3:_____ Age_____ Sibling 4: _____ Age_____
Primary Language Spoken at Home?_____ Secondary Language? _____

Has there been a family history of?

☐Diabetes ☐Tuberculosis ☐Hay Fever ☐HIV/AIDS
☐Heart Disease ☐Cancer ☐Kidney Disease ☐Thyroid Disease
☐Convulsions ☐Asthma ☐Genetic Defects ☐Other_____

Nutrition History:

Is the child breast-feeding or on formula?_____ Please specify which formula_____
How many bottles a day (on average)?_____ Or total oz?_____
Any feeding problems?_____
Known allergies_____ Medications_____
Please address concerns with physicians.

Developmental History (If age appropriate)

Did your child complete the following? If no, at what age?
Roll over by 4 months: ☐Yes ☐No _____
Sit up by 6 months: ☐Yes ☐No _____
Say several words by 1 year: ☐Yes ☐No _____
Walk by 15 months: ☐Yes ☐No _____
Potty Trained by 2 years: ☐Yes ☐No _____

Medical History:

Has you child had any of the following? If yes, please specify
Specific allergies ☐Yes ☐No _____
Hospitalizations ☐Yes ☐No _____
Serious injuries ☐Yes ☐No _____
Major illnesses ☐Yes ☐No _____
Surgeries ☐Yes ☐No _____

Has your child experienced difficulty with any of the following?

☐Head ☐Eyes ☐Nose & Throat ☐Blood Disorders ☐Rubella ☐Bronchitis or Cough
☐Lungs ☐Ears ☐Heart ☐Nervous System ☐Chicken Pox ☐Digestive System
☐Skin ☐Mouth ☐Urination ☐Measles ☐Muscles & Bones ☐Pneumonia
☐Asthma ☐Anemia ☐Mumps ☐MRSA ☐Other

New Patient Registration Form (REV. 08/2021)

Safety & Accident Prevention: Please answer yes or no:

Are all medicines, cleaning products and other dangerous substances locked up and kept out of reach? ☐Yes ☐No
Is your home equipped with smoke alarms? ☐Yes ☐No
Do you have safety plugs in unused wall sockets? ☐Yes ☐No
Does your child known how to swim? ☐Yes ☐No
Does you child always use a car seat or safety belt? ☐Yes ☐No
Have you completed first aid training? ☐Yes ☐No

This is the number for Poison Control, if you do not have this number please take time to store this number.

1-800-222-1222

TB Risk

1. Has your child been in contact with a person with confirmed or suspected tuberculosis? ☐Yes ☐No
2. Has your child ever had a Tuberculosis test done in the past? ☐Yes ☐No
   If yes, was the test positive? ☐Yes ☐No
3. Have you or your child immigrated from Mexico, Haiti, Asia, Africa, South American or the Middle East? ☐Yes ☐No
4. Do you or your child live with a person who either immigrated or traveled from Mexico, Haiti, Asia, Africa, South American or the Middle East? ☐Yes ☐No
5. In the last 3 months have you, your child, or any one living in the home had any of the following: (If Yes, please circle)☐Yes ☐No
   (Chronic cough coughing blood night sweats weight loss excessive diarrhea)
6. Have you been exposed to a person that is HIV positive, or has a compromised immune system, homeless, resident of a nursing home, institutionalized, is or was incarcerated, drug user, or migrant farm worker? ☐Yes ☐No

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Notice of Privacy Practices

Our practice is committed to educating our patients about health care issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another health care provider that relates to treatment, payment and/or that identifies you as an individual.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Billing and Payment	Health Care Operations
Appointment Reminders	Patient Contact Information	Treatment Options
Health-Related Benefits and Services	Release of Information to Family/Friends	Disclosures Required by Law
Treatment Review by Specialist	Progress Report Requests by Insurance Carrier	

The following categories describe unique situations in which we may use or disclose your identifiable health information:
Public Health Risks Deceased Patients Military
Health Oversight Activities Organ and Tissue Donation National Security Inmates
Lawsuits and Similar Proceedings Serious Threats to Health or Safety Worker's Compensation
Law Enforcement Research Sale of Practice

What are your rights concerning your individually identifiable Health Information (IIHI)? You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential Communications	2. Requesting Restrictions	3. Inspection and Copies
4. Amendment	5. Accounting of Disclosures	6. Right to a Paper Copy of This Notice
7. Right to File a Complaint	8. Right to Provide an Authorization for Other Uses and Disclosures	
9. Right to Transfer Medical Records to another Provider(s).		

If you have any questions regarding this notice, please contact our privacy officer: Tonya Pryce, (407) 447-7100 ext 206

I have read the short notice provided by the Merchant Pediatrics practice and have been informed of how to obtain more information regarding our Notice of Privacy.

Signature of Parent/Guardian	Parent/Guardian Name (Print)	Date

Patient Name

Request a copy ☐Yes ☐No