PEDIATRIC ASSOCIATES OF LAKELAND

PATIENT NAME: _____DOB: #_____MR#_____

My staff and I would like to welcome you to our office. Here is some important information to make your visits to our office go smoothly. We have two office locations. The first is at 1920 Lakeland Hills Blvd. The second is at 2140 E. Edgewood Dr. The office hours are as follows:

	Lakeland Hills	Edgewood
Monday	8:30-5	8:30-5
Tuesday	8:30-5	8:30-5
Wednesday	8:30-7	8:30-5
Thursday	8:30-5	8:30-5
Friday	8:30-5	8:30-5
Saturday	8:30-12	closed
Sunday	closed	closed

The office phone numbers are: Lakeland Hills: 863-683-4661 Edgewood: 863-669-1212

For the safety and well-being of our patients, shoes must be worn by all children and parents at all times. We also stress cleanliness. **ABSOLUTELY NO FOOD OR DRINKS ARE ALLOWED IN THE WAITING AREAS OR THE EXAM ROOMS**. No strollers are allowed in the offices. If you have a stroller you must return it to your car. There is also absolutely **NO CELL PHONE USE IN OFFICE- YOUR CHILD WILL NOT BE SEEN.**

Both offices have three separate waiting rooms. They are for sick children, for well children and for well infants 0-6 months. No child over 6months is allowed in the well infant waiting room. Please ask the receptionist to direct you to the appropriate waiting room. If your child is sick with a rash such as chickenpox you must inform the receptionist immediately and you will be directed to a private area for the safety of your child and other children in the office.

If you are unable to keep an appointment you must call us 24 hours in advance so that we may schedule another sick child in the appointment time. If it is after hours you may leave a message on the voicemail to cancel or reschedule the appointment. An answering service is available after hours for **EMERGENCY** calls. We ask that you **do not abuse the after-hours calls for routine questions** that can be easily answered the next day when the office is open.

We do require payment at time of service. All insurance information will be verified by our insurance department at the initial visit so please have all of the information with you. We file insurance as a courtesy to our patients. If there has been a change in your insurance information between appointments then please supply us with the updated information. Due to new HIPPA regulations regarding patient confidentiality, **we require a photo ID confirmation for the adult that brings each patient to the office.**

In an attempt to provide the utmost care to all our patients, we ask that only 2 children be seen at one time in each room. More than 2 will require a second adult to supervise the children. We ask that you respect all other patients and staff and treat them as you would like to be treated. Any blatant disregard to this policy will cause termination of the patient and all siblings from this practice. We also ask that you clean up after your child if they make a mess.

Because we are concerned for the welfare and safety of our patients, we have found that if you miss more than 3 appointments without calling to cancel then you may be dismissed from the practice. If you miss more than 2 appointments for ADD/ADHD then we will no longer see your child for that condition or prescribe any medications for that condition. When appointments are missed you not only deny your child's medical care but also another child that could have been seen in that time period.

We stress preventative care by immunizing your child to the preventable childhood diseases, so please give the nurse your child's immunization record so that we may have the most accurate medical record for your child. If you choose not to protect your child with immunizations then you will be asked to find a new physician. Our goal is to care for children and help them grown into responsible, healthy adults. Please set a good example for them.

Respectfully,
Dr. Dorothy Ray, MD

Parent/Guardian Print Name: _____

Parent/Guardian Sign Name: _____ Date: _____

Name: _____**Birth Date:** _____ **Gender:** ☐ **Male** ☐ **Female**
Patient Social Security #: _____
Patient Home Address: _____
Street **City** **State** **Zip**
Race: ☐ Asian ☐ American Indian/Alaskan ☐ Black/African American ☐ Native Hawaiian/pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic ☐ non-Hispanic **DECLINE:** ☐

PREFERRED PHARMACY: _____**Location**_____ **Phone** _____

PARENT(S) OR GUARDIAN(S) INFORMATION: **Please list both Parents / Guardians** (do not write same in address line)

CHECK ONE: RELATIONSHIP TO PATIENT: ☐ **Mother** ☐ **Father** ☐ **Grandparent** ☐ **Foster Parent** ☐ **Other**_____
NAME: _____ **DOB**: _____
SOCIAL: _____ **PREFERRED CONTACT:** **Home:** ☐ **Cell:** ☐
HOME PHONE: _____ **CELL PHONE**: _____
HOME ADDRESS: _____
CITY, STATE, ZIP: _____
MAILING ADDRESS: _____
CITY, STATE, ZIP: _____
EMPLOYER: _____ **PHONE**: _____
EMPLOYER CITY & STATE: _____
EMAIL ADDRESS: _____

CHECK ONE: RELATIONSHIP TO PATIENT: ☐ **Mother** ☐ **Father** ☐ **Grandparent** ☐ **Foster Parent** ☐ **Other**_____
NAME: _____ DOB: _____
SOCIAL: _____ **PREFERRED CONTACT:** **Home:** ☐ **Cell:** ☐
HOME PHONE: _____ **CELL PHONE:** _____
HOME ADDRESS: _____
CITY, STATE, ZIP: _____
MAILING ADDRESS: _____
CITY, STATE, ZIP: _____
EMPLOYER: _____ **PHONE**: _____
EMPLOYER CITY & STATE: _____
EMAIL ADDRESS: _____

INSURANCE INFORMATION: **ALL INSURANCE INFORMATION MUST BE COMPLETE IN ORDER TO BILL**

PRIMARY INSURANCE COMPANY: _____ POLICY#:_____ GROUP: _____
ADDRESS: _____ PHONE: _____ EMPLOYER: _____
CHECK ONE: RELATIONSHIP TO PATIENT: ☐ **Mother** ☐ **Father** ☐ **Grandparent** ☐ **Foster Parent** ☐ **Other**_____
POLICY HOLDER: _____ DOB: _____ SOCIALSECURITY #: _____

INSURANCE ATTESTATION

I hereby acknowledge that I understand that **Medicaid** is to be used as **payer of last resort** and that **Commercial Insurance is always primary** and that all services must be billed to Commercial Insurance. I also understand that this office **does not file secondary insurance,** so Medicaid will not be billed. I also acknowledge that if I commit Medicaid fraud (failing to disclose that my child(ren) or the child(ren) under my care have commercial insurance and use Medicaid) that I will be personally responsible for the entire bill when the claim is denied by my insurance company for any reason whatsoever. I also acknowledge that if I commit Medicaid fraud then I will NEVER be able to use Medicaid for my child(ren)'s medical care at Pediatric Associates of Lakeland.

***INITIAL AKNOWLEDGMENT*_____**

ASSIGNMENT AND RELEASE/ FINANCIAL

I, the undersigned, certify that I or my dependent have insurance coverage and are assigned directly to Pediatric Associates of Lakeland. All insurance benefits, if any, are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Please be advised that you are required to show a copy of your current insurance card EVERY VISIT. As well as you are responsible for any and all copays, deductibles or visits deemed not covered by your insurance carrier. If your account goes to a collection agency for collections you hereby agree that you are responsible for all additional collection fees as well as any legal fees incurred as required by law. You hereby authorize treatment and assignment of your insurance benefits for the claims to be paid to Pediatric Associates of Lakeland for medical services rendered.

***INITIAL AKNOWLEDGMENT*_____**

HEALTH INFORMATION PRIVACY PROTECTION ACT

Acknowledgement of Notice of Privacy Practices: I hereby acknowledge that I have received and understand Pediatric Associates of Lakeland's Notice of Privacy Practices. ***INITIAL AKNOWLEDGMENT*_____**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of treatment necessary to process insurance claims. I authorize Physician/ARNP to obtain medication history from insurance company and pharmacy to insure proper treatment of your child.

****PARENT/ GUARDIAN SIGNATURE** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

****PARENT/ GUARDIAN SIGNATURE** _____

PEDIATRIC ASSOCIATES OF LAKELAND

PARENT/ GUARDIAN CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____

IN CASE OF INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD TO HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE OTHER PERSONS LISTED ON THIS FORM WILL BE ALLOWED TO SEEK TREATMENT FOR MY CHILD ONCE PARENT OR LEGAL GUARDIAN HAS ARRANGED AN APPOINTMENT FOR PATIENT unless Power of Attorney or Notarized letter is on file.

Persons listed MUST BE 18 YEARS OR OLDER

LIST FULL NAME & CONTACT PHONE NUMBER

Mother: _____ PHONE: _____

Father : _____ PHONE: _____

Guardian: _____ PHONE: _____

Court Order on file? YES: ☐ NO: ☐
(IF YES PLEASE PROVIDE US WITH A COPY OF ORDER)

**Patient lives with: _____ PHONE: _____

NAME: _____ Relationship: _____ PHONE: _____

NAME: _____ Relationship: _____ PHONE: _____

NAME: _____ Relationship: _____ PHONE: _____

NAME: _____ Relationship: _____ PHONE: _____

- I understand it is my responsibility to notify Pediatric Associates of Lakeland of any changes in the information recorded on this form and to provide the office with information if there are any custody restrictions involving my child.
- I certify that the information provided on this form is accurate, true and correct:

Print Name & Relationship: _____

Sign: _____

Date: _____

PEDIATRIC ASSOCIATES OF LAKELAND

- 1920 Lakeland Hills Blvd, Lakeland, FL 33805, Phone 863-683-4661 Fax 863-683-2579
- 2140 E. Edgewood Dr, Lakeland, FL 33803, Phone 863-669-1212 Fax 863-666-6089

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT NAME: _____
DOB: _____
SSN#:_____

Previous Physician/Office _____

Address _____

_____

Telephone/Fax # _____

Information authorized for use or disclosure, or to be obtained:

☐ All Medical information concerning this patient,

☐ Medical information of this patient compiled between _____ to _____
☐ Only: ☐ Hospital Records ☐ ER Records ☐ Dates of Treatment, if known _____

The information will be obtained, used, or disclosed for the following purpose(s) only,

☐ Insurance ☐ Continuity of Care ☐ Legal

☐ At the request of the patient/ Parent representative

☐ Other (specify) _____

I hereby authorize Pediatric Associates of Lakeland to release and obtain any medical and other pertinent information to and from all health care practioners, providers, agencies, schools, hospitals and institutions for the purpose of the client's diagnosis, care and treatment. I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to our office by certified mail.

The expiration date of this authorization CANNOT exceed one year from today _____.

THIS PERMISSION EXPIRES AUTOMATICALLY AT THE END OF ONE YEAR, BUT MAY BE REVOKED BY THE PARENT/GUARDIAN'S WRITTEN REQUEST AT ANY PRIOR TIME.

_____ Date: _____

Print Parent/Guardian/ Legal Representative Relationship to Patient

_____ _____

Signature Parent/Guardian/ Legal Representative Relationship to Patient Witness