Children's Cardiology Clinic

New Patient Registration

PATIENT INFORMATION

Last Name:		First Name:			
Birth Date:		Gender:		Email Address:	
Street Address:				Apt/Unit #:	
City:		State:		Zip Code:	
Phone Number:		Is this a mobile number? ☐ YES ☐ NO		Allow the office to send text messages? ☐ YES ☐ NO	
How did you hear about us?					

PARENT/GUARDIAN INFORMATION (If patient is under 18)

Mother Name (Last, First):		☐ Primary contact for patient			
Birth Date:		Email Address:			
Phone Number:		Is this a mobile number? ☐ YES ☐ NO		Allow the office to send text messages? ☐ YES ☐ NO	
Alternate Phone:		Is this a mobile number? ☐ YES ☐ NO		Allow the office to send text messages? ☐ YES ☐ NO	
Father Name (Last, First):		☐ Primary contact for patient			
Birth Date:		Email Address:			
Phone Number:		Is this a mobile number? ☐ YES ☐ NO		Allow the office to send text messages? ☐ YES ☐ NO	
Alternate Phone:		Is this a mobile number? ☐ YES ☐ NO		Allow the office to send text messages? ☐ YES ☐ NO	

EMERGENCY CONTACT INFORMATION

Emergency Contact Full Name:			
Phone Number:		Alternate Phone:	

INSURANCE INFORMATION

Insurance Name:		Insurance Phone:	
Policyholder Name:		Birth Date:	
Policyholder Relationship to Patient:	☐ Parent ☐ Self ☐ Other: _____		
ID# / Policy #:		Group #:	
Insurance Address:			
City:	State:	Zip Code:	

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

PCP Name:		Phone:	
PCP Address:			

PREFERRED PHARMACY INFORMATION

Pharmacy Name:		Phone:	
Pharmacy Address:			

CHILDREN'S CARDIOLOGY CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES &

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, the practice creates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means for communication among health professionals who contribute to my care, such as referrals
- Source of information for applying my diagnosis and treatment information to my bill
- Means by which a third-party payer can verify that services billed were actually rendered
- Tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
-

I acknowledge that I have been provided with a "*Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures and of my privacy rights. I understand that I have the right to:

- Review the "*Notice*' prior to acknowledging this consent
- Restrict or revoke the use or disclosure of my health information for other uses or purposes
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

I hereby permit and authorize the practice to discuss my/the patient's protected health information (PHI) with the individuals listed below including that may accompany me/the patient to this office for medical evaluation or treatment. Authorized individuals must present positive identification in person or state my passcode if communicating by phone. I understand that I may contact this office to edit or rescind this authorization at any time.

Passcode to be used by authorized indiviuals:_____

Name:_____Relation:_____ Phone:_____

Name:_____Relation:_____ Phone:_____

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

CHILDREN'S CARDIOLOGY CLINIC
A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

AUTHORIZATION AND CONSENT FOR TREATMENT

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING.
THEN, INITIAL APPLICABLE CONSENTS AND SIGN AT BOTTOM OF FORM

_____General Consent for Treatment

I consent for the medical care and treatment that includes a routine medical examination, diagnostic testing, immunizations (when indicated and provided by this office) and other medical services deemed necessary or advisable in the judgment of the physician or other practitioners providing care. I understand that certain aspects of care may be offered at a facility owned by the practice or treating physician, and if so, this information will be disclosed and alternative facilities identified. I understand that health care professional students may participate in my care under the supervision of an attending physician or other health care professional. I am aware that the practice of medicine (including surgery) is not an exact science and I acknowledge that neither the provider nor office staff has made any guarantee or assurance as to the results that may be obtained. I understand that the practice may refuse to provide care if I refuse to sign this consent or if, at any time, I choose to revoke this consent.

_____Consent for Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

_____Consent for Identification Photograph *(applicable only if this office is using an electronic medical record).*

I consent to a patient photograph that will only be used for identification purposes and will be securely stored. Medical care will not be affected if I refuse to provide consent or withdraw my consent in the future.

_____Consent to Call

I understand and agree that the practice may need to contact me regarding appointments, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from the medical group. These communications may include automated calls, emails, and text messaging sent to my landline and/or mobile device. I understand that I must voluntarily "opt-in" to receive automated text message communications from the practice and agreeing to additional Terms and Conditions as set forth by my mobile carrier.

_____Consent Testing in the Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to a patient's blood or bodily fluids, the patient will be required to undergo a blood test to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing and testing a small amount of the patient's blood. I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). If any test is positive, the practice will provide counseling about the meaning of these tests as it relates to patient healthcare. I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to provide consent for the initialed provisions as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

CHILDREN'S CARDIOLOGY CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account may be referred to a collection agent and/or attorney, and I agree to pay all collection related charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plans provisions. I understand that failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Florida Pediatric Associates for any medical services provided to me by that organization.

Release of Medical Information

I understand that Florida Pediatric Associates, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Florida Pediatric Associates and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review Florida Pediatric Associates Notice of Privacy Practices. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization. I acknowledge that I have received information regarding my rights to privacy of information under HIPAA regulations, as described in the Florida Pediatric Associates Notice of Privacy Practices.

Notice of Unauthorized, Non-Covered, or Out of Plan Services

I am aware that some services performed by Florida Pediatric Associates may be considered "non-covered" by my insurance carrier or Medicare. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that if my insurance plan does not consider any service rendered a covered service or if my insurance plan has not authorized this service, they will not pay for the service rendered during this outpatient visit. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge. I am responsible for the entire bill or balance of the bill as determined by the practice and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Waiver of "Usual, Customary and Reasonable" Clauses - *(For patients with "Out-of-Network" coverage).*

I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

For Medicare Recipients Only

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Practice for any services furnished to me by Practice physician or other provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

CHILDREN'S CARDIOLOGY CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

PAYMENT POLICY

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Thank you for choosing us for your healthcare needs. Our relationahsip is best served when expectations are clearly understood. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy to help you better understand your financial responsibilities in relation to the medical care we provide. We ask that you read the policy, ask any questions you may have and sign your name in the Acknowledgement section. A copy will be provided to you upon request.

All patients must provide us with valid identification (driver's license) and a current and valid copy of your primary (and secondary if applicable) insurance card(s) to provide proof of insurance. We do our best to confirm your insurance eligibility and determine what amounts you will owe prior to your visit, but sometimes that amount changes depending on the scope of services actually provided.

Our policy is to collect amounts due from patients, including co-payments, deductibles and co-insurance amounts on the same day that services are rendered unless other arrangements have been made in advance. The practice accepts cash, personal checks, debit and credit card payments although additional fees will apply if a persoanl check is denied for insufficient funds. The practice reserves the right to deny non-urgent care to patients that refuse to manage his or her responsibility.

Insurance
Our practice is contracted with most insurance companies including Medicaid and Medicare and we will submit claims to those companies on your behalf. Insurance plans may restruct the type and/or number of services covered and/or the number or type of eligible providers. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage and confirm that our doctors participate with your insurance plan, whether or not a primary care referral or insurance authorization is required, and that the services you require are actually covered by your health plan. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
If we are not contracted with your insurance company, payment for all services is expected at the time of service. As a courtesy, we will submit claims to your insurance company. If you do not have insurance coverage, payment for all services is expected at the time of service.

Co-payments and deductibles
All co-payments deductibles and co-insurance amounts required by your insurance company must be paid at the time of service without exception.

Non-covered services.
Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of visit.

Claims submission.
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes.
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment.
Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and may be discharged from this practice.

Missed appointments.
You may be charged a fee for missed appointments not canceled at least one day in advance. These charges will be your responsibility and billed directly to you. Please verify what this office charges for missed appointments fee with the Front Desk or office manager. Please help us to serve you better by keeping your regularly scheduled appointment. Excessive missed appointments will result in discharge from the practice.

Minor Patients
The adult accompanying a minor and/or the parent(s) (or guardian(s) of the minor) is responsible for payment at the time of service. Non-emergency treatment for unaccompanied minors will be denied unless payment arrangements have been made in advance.

Medical Records
We do not charge for sending medical records to another health care provider. If you request a hard copy of your medical record there will be $1.00 per page charge for the first 25 pages, and $.25 for each additional page.

Billing Questions
If you have a billing related question please contact Fountainhead Practice Management Solutions, LLC, 866-_____

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

Release of Medical Records

PATIENT NAME: _____ **DOB:** _____

RELEASE OF MEDICAL RECORDS TO CHILDREN'S CARDIOLOGY CLINIC by:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Please include any cardiology clinic notes, echocardiogram reports, ECG's, cardiac monitor results, genetic test results and EP or Cath lab reports for _____ to _____.

Please fax records to 888-494-2369. Call the office at 407-588-0550 if any questions.

RELEASE OF MEDICAL RECORDS FROM CHILDREN'S CARDIOLOGY CLINIC to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

I consent to allow my protected health information to be released as noted above. I understand that this authorization will expire one year from the date it is signed unless I specify otherwise.

Patient/Guardian Signature _____

Full Name of Guardian _____

Date _____

Children's Cardiology Clinic

Telehealth Consent Form

Telemedicine is the delivery of healthcare services when the healthcare provider and the patient (the "Patient") are not in the same physical location and communicate through technology. Electronically transmitted information may be used for diagnosis, treatment, follow-up, prescription, or education and may include medical records, medical images, interactive audio, video and/or data communications, and output data from medical devices, sound and video files. The Patient understands the following with respect to telemedicine offered by FLORIDA PEDIATRIC ASSOCIATES, LLC (the "Practice"):

1. The Patient has elected to have a telemedicine visit instead of an in-office visit at the Practice. The Patient agrees that the Practice will determine whether the Patient's condition is appropriate for telemedicine and acknowledges that the Practice may recommend an in-person visit.

2. There are potential risks associated with the use of telemedicine, including, but not limited to: the information transmitted may be less comprehensive than that available from an in-person visit and result in decreased accuracy of diagnosis or medical decision-making; delays in medical evaluation or treatment could occur due to deficiencies or failures of the telemedicine equipment; and security protocols could fail, causing a breach of privacy. The Patient understands that telemedicine often involves electronic transmission of the Patient's protected health information ("PHI"). The Patient's PHI includes, but is not limited to, the Patient's identifying information; medical history; diagnoses; communications to and from the Patient's other health care provider(s); etc. The Patient understands that PHI may be lost due to technical failures, cyber intrusion or other issues disrupting the Patient's telemedicine visit or causing delays in response from the Practice. The Patient assumes these risks and holds the Practice and its providers harmless from any claims arising out of the use of telemedicine to conduct the visit.

3. The Patient understands that telemedicine visits may be recorded and that the laws that protect privacy and confidentiality of medical information also apply to telemedicine. The Patient understands that PHI obtained during the telemedicine visit will not be disclosed to other entities without the Patient's consent unless otherwise permitted by applicable law or in accordance with the Practice's Notice of Privacy Practices. The Patient has the right to withhold or withdraw consent for telemedicine at any time without affecting the right to the Patient's future care, treatment, benefits, or programs for which he or she is otherwise entitled. Any such withhold or withdrawal of consent shall be given in writing, and shall be deemed to be properly delivered upon receipt if sent by: (a) certified U.S. mail, return receipt requested, (b) facsimile, or (c) personal delivery with receipt, to the principal address of the Practice. The Patient understands that if others are present at Patient's location during the Patient's telemedicine visit, the confidentiality of the Patient's telemedicine visit may be compromised.

4. The Patient understands the alternatives to telemedicine as they have been explained, and in choosing to participate in a telemedicine visit understands that some parts of the exam may require physical testing to be performed at another location at the direction of the Practice.

5. THE PATIENT UNDERSTANDS IT IS POSSIBLE THAT HEALTH INSURANCE WILL NOT COVER THE TELEMEDICINE VISIT(S). THE PATIENT MAY ELECT TO PAY OUT OF POCKET FOR THE TELEMEDICINE SERVICES IF THEY ARE NOT COVERED BY HEALTH INSURANCE. THE PATIENT AGREES THAT IF THE HEALTH INSURER DOES NOT PAY FOR THE TELEMEDICINE SERVICES, THE PATIENT WILL BE RESPONSIBLE FOR PAYMENT. THE PATIENT FURTHER UNDERSTANDS THAT HE OR SHE IS RESPONSIBLE FOR ALL COST SHARING OBLIGATIONS (E.G., COPAYMENT, DEDUCTIBLE) REQUIRED BY THE HEALTH INSURANCE PLAN ("COST SHARING OBLIGATIONS"). ALL OUT-OF-POCKET EXPENSES ASSOCIATED WITH THE TELEMEDICINE VISIT, INCLUDING COST SHARING OBLIGATIONS AND PAYMENT FOR NON-COVERED SERVICES, ARE DUE PRIOR TO THE TELEMEDICINE VISIT IF SUCH AMOUNTS ARE KNOWN AT THAT TIME.

6. The Patient understands that a patient must be physically located in the State of Florida during his or her telemedicine consultation(s) and represents that the Patient is located in the State of Florida during the entirety of each telemedicine visit. The Patient understands that if he or she is not physically located in the State of Florida, the Practice may decline to treat him or her via telemedicine.

7. The Patient understands that the Practice and its providers are located in the State of Florida and provide telemedicine services within the State of Florida. The Patient agrees that the venue of any action or proceeding relating to, involving, or resulting from the telemedicine services offered or provided or enforcement of this Telemedicine Consent shall be in Pinellas County, Florida, regardless of the location where telemedicine services are provided to the Patient. The laws of the State of Florida will govern any such disputes and the Patient consents to jurisdiction in the State of Florida.

8. The Patient has been advised of all the potential risks, consequences and benefits of telemedicine. The Practice has discussed with him or her the information provided above and the Patient has had the opportunity to ask questions about the information presented on this form. All the Patient's questions have been answered, and he or she understands the information.

By signing this form, I, _____, consent to telemedicine services to be rendered by the Practice. I represent and warrant that I am authorized to consent to services described herein.

_____	_____	_____
Print Patient Name	Signature of Patient/Guardian	Date

Appointment Policy

PATIENT NAME: _____ **DOB:** _____

_____ Please be advised that our clinic has a 24-hour cancellation policy. Please contact us at least 24 hours before your appointment if you need to change it, and we will be happy to reschedule you. (Appointments scheduled on Mondays must be cancelled on the Friday before.) This helps us ensure that others on the waiting list can be offered that appointment slot, and we can continue to offer the highest level of care to all our patients.

_____ We do understand that sometimes unexpected issues arise which prevent you from keeping your appointment with us. The first time you fail to provide a 24-hour notice to cancel or change your appointment, you will not be charged. However, subsequent cancellations or rescheduling without at least a 24-hour notice are subject to a **$50** fee. After three short-term cancellations and/or no-show appointments, the Children's Cardiology Clinic reserves the right to refuse to schedule any further appointments for you in our clinic. At that time, we will forward your records to the cardiologist of your choosing.

_____ Because our goal is to see patients at the time of their scheduled appointment and minimize wait times, please be advised that if you are more than 15 minutes late for your appointment, you may have an extended wait time, or it might be necessary for us to reschedule that appointment.

We appreciate your timeliness for your appointments because it helps the Clinic run smoothly for everyone.

Please initial the above paragraphs and sign below to acknowledge receipt of this policy.

I have read the Clinic Appointment Policy for the Children's Cardiology Clinic.

Patient/Guardian Signature _____

Full Name of Guardian _____

Date _____