RDV SPORTSPLEX

Pediatrics

Patient Information

Patient's Full Name: _____ DOB: _____Sex:_____

Patient's Full Name: _____ DOB: _____Sex:_____

Patient's Full Name: _____ DOB: _____Sex:_____

Patient's Full Name: _____ DOB: _____Sex:_____

Home Address: _____

_____

★

Mother's Full Name: _____ DOB: _____

Home Address: _____ Cell#: _____

_____ Home#: _____

Occupation: _____ Work #: _____ Ext: _____

E-mail Address: _____

★

Father's Full Name: _____ DOB: _____

Home Address: _____ Cell#: _____

_____ Home#: _____

Occupation: _____ Work #: _____ Ext: _____

E-mail Address: _____

★

Who carries the insurance for the child? MOTHER FATHER

Who is the primary contact for the child? MOTHER FATHER

Do you want to receive appointment reminders in text messages? Cell# _____ Phone Carrier: _____

Do you want to receive appointment reminders in e-mails? E-mail address: _____

★

Preferred Pharmacy: _____ Phone Number: _____

Address: _____

_____

*Please note if you do not provide full pharmacy information, we cannot electronically send prescriptions.

RDV SPORTSPLEX Pediatrics

Authorization for Medical Treatment

I hereby consent to examinations, treatments and procedures (including emergency treatments) which may be deemed necessary by our physicians, their associates or staff.

★

I authorize the staff of RDV Sportsplex Pediatrics to contact the following individuals by phone to deliver test results, gather additional information, or authorize care in the following order:

(Note: Both parents/guardians are usually listed first, followed by any other individuals, if any.)

1. Name:_____ Relationship:_____ Phone:_____
2. Name:_____ Relationship:_____ Phone:_____
3. Name:_____ Relationship:_____ Phone:_____
4. Name:_____ Relationship:_____ Phone:_____

★

In my absence, I authorize the following individuals to accompany my child to the office of RDV Sportsplex Pediatrics, and seek medical care and authorize treatment.

1. Name:_____ Relationship:_____ Phone:_____
2. Name:_____ Relationship:_____ Phone:_____
3. Name:_____ Relationship:_____ Phone:_____
4. Name:_____ Relationship:_____ Phone:_____

★

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Guarantor Name: _____ Relationship: _____

Guarantor Signature: _____ Date: _____

Authorization for Release of Confidential Health Information

I, _____ (Parent/Legal Guardian) authorize RDV SPORTSPLEX PEDIATRICS to obtain/release the entire medical record of my child(ren).

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Address _____ Phone _____

_____

Medical information is to be

☐ **obtained from** **or** ☐ **sent to**

RDV SPORTSPLEX Pediatrics

8701 Maitland Summit Blvd
Orlando FL 32810
Phone: 407-916-4520 Fax: 407-916-4525

and

☐ **obtained from** **or** ☐ **sent to**

the following facility/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

For the purposes of: ☐ Transferring out ☐ Personal Use ☐ Specialist

I understand that this consent is revocable upon written notice where the original authorization is retained, except to the extent that action has already been taken on this authorization, and that the office has been taken in reliance on this authorization, and that consent shall remain for one year unless otherwise specified in order to effect the purpose for which it is given. Mental health, alcohol and/or drug abuse, HIV and/or AIDS, sexually transmitted diseases and other similar conditions are confidentially protected by Federal State Law which prohibits disclosure without specific written authorization of the undersigned or as otherwise permitted by such regulations. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

USE ONLY IF TRANSFERRING OUT OF OUR PRACTICE (NOT FOR PATIENTS TRANSFERRING IN)
All files mailed or picked up are given on a CD in PDF format.

I would like the full records to be: ☐ picked up ($10 per child) ☐ mailed (+$5 per family)

or

☐ Courtesy copy ($0) – Last physical, shot record, growth chart and problem list ONLY

and

☐ patient balance ($_____)

Parent/Legal Guardian: _____ Relationship to Patient(s): _____

Signature: _____ Date: _____

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Pediatrics

Office Policies/Financial Policies Agreement

These are all of our financial and office policies. Please read carefully and retain this copy for your records.

As the patient's guarantor, you understand and agree to the following:

You authorize care and treatment by RDV Sportsplex Pediatrics (aka Pro Star Pediatrics, PA) and the release of all information to insurance and third party carriers and direct them to remit payments directly to us.

The guarantor or authorized person accompanying the child is required to pay at the time of services rendered. This includes any divorce or custody cases, regardless of who the decree or custody documents indicate makes payment. Payment may include any copays and/or coinsurances, non-insured patient services, and past due balances (over 30 days). If a copay is not paid at the time of service, a $5.00 fee will be assessed to the account.

All checks returned for insufficient funds, closed accounts, or any other reason will be subject to a $25.00 service charge. The amount of the check and the service charge must be paid in full within five business days by cash, credit card or certified funds. Thereafter, checks will no longer be accepted for services rendered.

We request a current insurance card and verify eligibility for every visit. However, you are responsible for knowing your insurance coverage and benefits, including well visits and immunizations. As a courtesy, claims are billed to your insurance carrier and they are allowed 60 days to make payment. All balances not paid by the insurance carrier after 60 days from the date of service become your responsibility, and it is also your responsibility to follow up with them. We will be happy to reimburse you for any payments made by you after your insurance company has paid in full.

If you have any changes to your insurance information and fail to notify us, RDV Sportsplex Pediatrics will not be responsible for timely filing denials if we did not receive the correct insurance information prior to or at the time of services rendered.

If you have a newborn, we will give you up to two weeks from the date of birth to provide proof of coverage. If you are unable to do so after two weeks time, you will be responsible for any previously accrued balances and will have to pay out of pocket until proof of coverage is provided. Proof of coverage includes a letter from the insurance company, a hard copy of an insurance card with your child's name on it, or a temporary card with your child's name on it printed from the insurance company's website. We will no longer accept a parent's insurance card as proof of coverage.

If we are unable to verify your insurance at the time of your appointment, you can either pay out of pocket for the visit or reschedule to another day.

Self-pay patients who have previously been established with the practice will receive a 25% discount off of the exam if there are no outstanding balances and payment is made in full at the time of service.

If your account is referred to collections, you will be responsible for all attorney's fees and collection expenses. A monthly late fee of up to 10% of the total balance will be charged to past due accounts over 90 days.

At each well checkup, you will receive a copy of your child's immunization record and physical form, and any additional form you bring with you (such as sports physical forms, WIC forms, school medication administration forms, FMLA forms, etc.) free of charge. If you request these forms or any other forms at any other time, they will be ready in 3 business days free of charge. In order to accommodate patients that need forms by the following business day, there is a $25.00 convenience fee for rush requests. **Under no circumstances will the doctors be interrupted from seeing patients during business hours to sign any forms.**

CONTINUED ON PAGE 2…

CONTINUED FROM PAGE 1…

If you choose to deviate from the recommended vaccine schedule and split vaccines into different visits, there will be an additional charge for the nurse visit. Insurance companies only allow well visits at certain intervals and do not cover the administration of these vaccines at a separate appointment. You will be responsible for this charge and it will be due at the time services are rendered.

We ask that you arrive 15 minutes prior to your appointment time. This is to ensure adequate time to check in and attend to any billing or insurance issues that may arise before your appointment time; otherwise, you may lose your slot and have to reschedule to the next available appointment time or another day.

If you are more than 10 minutes late for your appointment and it is a sick visit, you will be rescheduled to the next available appointment time; if there are no appointment slots left for the day, you will have to wait to be seen between patients. If you are more than 15 minutes late for your appointment and it is a well visit, you will need to reschedule to another day. Calling ahead when you are going to be late is greatly appreciated, as we can let you know in advance if you will need to reschedule.

A notice of 24 hours for cancelled appointments is appreciated. A $25.00 charge will be assessed to the account if there are more than two missed appointments without notification. Your family will be subject to dismissal if there are an excessive amount of no shows.

Requests for entire medical records will incur a $10.00 charge if picked up or a $15.00 charge if mailed. All records will be supplied on a CD in PDF format. You may request a courtesy copy at no charge which will only include the last physical, shot record, growth chart and problem list. All requests for medical records can take up to 10 business days.

Medication refill requests require up to 3 business days to complete. If your child is not up to date on his physicals, an appointment may be required before a refill is permitted.

If you have a medical question that cannot wait until normal office hours, there will be a $15 charge for speaking to a nurse through the Telecare answering service. This will not be billed to your insurance company, and will be due at the next time services are rendered or your next statement, whichever comes first. We do not receive any revenue by charging our patients for this service; this is a charge incurred directly from the Telecare program.

Per insurance regulations, an annual preventive exam is not the same as an office visit and does not include a discussion of new medical problems or evaluation of any chronic medical conditions. In the event that it is necessary to perform both services at the same visit, you may be charged an office visit as well as the preventive exam. Your insurance company may charge you a copay, co-insurance or deductible, depending on your plan.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Guarantor Name: _____ Relationship: _____

Guarantor Signature: _____ Date: _____

Patient History for _____

Please fill out to the best of your ability. If you are unable to or unsure of an answer, please ask the doctor.

Birth History:		
Type of delivery	Vaginal	C-Section
Premature birth	Y	N
Gestational Age	_____weeks	
Birth Weight	_____lbs_____oz	
Discharge Weight	_____lbs_____oz	
Single Birth	Y	N
One of Multiple Births	Y	N
Maternal Complications	Y	N
Perinatal Complications	Y	N
CPR	Y	N
Respiratory Conditons	Y	N
Neonatal Jaundice	Y	N
Congenital Abnormalities	Y	N
Exposed to Group B Strep	Y	N
1 Minute Apgar		
5 Minute Apgar		
Elective Circumcision	Y	N
Hep B Vaccine	Y	N

Past Medical History:		
Allergic Rhinitis	Y	N
Anemia	Y	N
Asthma	Y	N
Blood Disorders	Y	N
Chronic Illness	Y	N
Congenital Heart Disease	Y	N
Diabetes Mellitus	Y	N
Eye Disorders	Y	N
Gastrointestinal Disorders	Y	N
Hearing Loss	Y	N
Heart Disease	Y	N
Migraine	Y	N
Otitis Media	Y	N
Pneumonia	Y	N
Psychiatric Disorders	Y	N
Recurrent URIs	Y	N
Seizure Disorder	Y	N
Urinary Tract Infection	Y	N
Previous Hospitalizations	Y	N

Surgical History:		
Prior Surgery	Y	N
Appendectomy	Y	N
Hernia Repair	Y	N
Tonsillectomy	Y	N
Tympanostomy	Y	N

History of Childhood Disease:		
Chickenpox	Y	N
Meases (Rubeola)	Y	N
Mumps	Y	N
Rubella (German Measles)	Y	N

Lives With:		
Mother	Y	N
Father	Y	N
Step-Mother	Y	N
Step-Father	Y	N
# Sisters		
# Brothers		
Relatives (Not Parents)	Y	N
Legal Guardian	Y	N

Environment:		
Cigarette Smoke at Home	Y	N
Guns in Home	Y	N
Pets or Other Animals	Y	N
# Dogs		
# Cats		
Sick contacts	Y	N

Education:		
Name of School		
Daycare	Y	N
Public	Y	N
Private	Y	N
Home	Y	N
Grade		

Sports: (List all)

Date of Last PE:

(PLEASE SEE OTHER SIDE)

Family History:	MOM	DAD	MGM	MGF	PGM	PGF	BRO	SIS	OTHER
Alcoholism									
Asthma									
Birth Defects									
Blood Disorders									
Cancer									
Crohn's Colitis									
Diabetes									
Drug Use									
Epilepsy									
Heart Disease									
Hyperlipidemia									
Hypertension									
Juvenile RA									
Kidney Disease									
Mental Illness									
Mental Retardation									
Migraine									
Stroke									
Systemic Lupus									
Tuberculosis									
Other									

Family History Unknown: Child Adopted	Y

Parent signature:

By signing, you are confirming that all information is true to the best of your knowledge.

(PLEASE SEE OTHER SIDE)

RDV SPORTSPLEX

Pediatrics

Notice of Privacy Practices Acknowledgement Form

RDV Sportsplex Pediatrics (aka Pro Star Pediatrics, PA) Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or by visiting our website at www.rdvpediatrics.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Beginning December 1, 2013, RDV Sportsplex Pediatrics will be sharing our office space with Women's & Maternity Care Specialists. Their staff will not have access to our electronic or physical medical records system. We ensure that your protected health information will remain private and will not be shared with Women's & Maternity Care Specialists unless specifically authorized by you.

My signature below indicates that I have been given the opportunity to review a current copy of RDV Sportsplex Pediatrics "Notice of Privacy Practices," and have received notice of shared office space by Women's & Maternity Care Specialists.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Guarantor Name: _____ Relationship: _____

Guarantor Signature: _____ Date: _____