HUNT CLUB PEDIATRICS
407-786-4080

Patient Registration

Fill out the form below completely.

Today's Date _____

Patient Name _____

Date of Birth _____

Gender [ ] Male or [ ] Female

Address _____

City, State, Zip Code: _____

Contact Information:

Mother's Name: _____

Mother's Cell: _____

Mother's Email: _____

Mother's Occupation: _____

Mother's D.O.B: _____

Mother's SSN: _____

Father's Name: _____

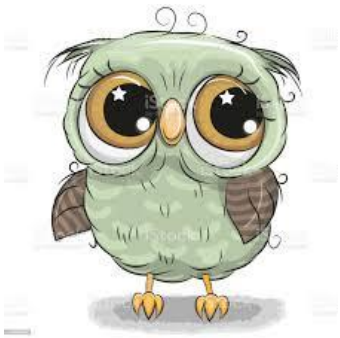
Father's Cell: _____

Father's Email: _____

Father's Occupation: _____

Father's D.O.B: _____

Father's SSN: _____



Pharmacy:

Name: _____

Street/City: _____

Phone: _____

Fax: _____

Insurance Information:

Primary Insurance:

Policy Holder Name: _____
Relationship to Patient: _____
SSN #: _____
Date of Birth: _____
Patient's ID #: _____
Patient's Group #: _____
Effective Date: _____
Today's Date: _____

Secondary Insurance:

Policy Holder Name: _____
Relationship to Patient: _____
SSN #: _____
Date of Birth: _____
Patient's ID #: _____
Patient's Group #: _____
Effective Date: _____
Today's Date: _____

Please list all children who currently are, or will be, patients at Hunt Club Pediatric Associates

Name: (last, first, MI)	Sex (M/F)	Date of Birth:	Same Ins?
_____	_____	_____	Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N

Patient History:

Patient Name: _____ **Date of Birth:** _____

Completed By: _____ **Relationship:** _____

Prior Pediatrician:

Last Dental Visit:

Last Eye Exam:

PREGNANCY & BIRTH

Mother's age at pregnancy?
Any illness during pregnancy? Y / N
Medications during pregnancy? Y / N
Smoking, alcohol, drugs during pregnancy? Y / N
Was baby early, late, or on time? Type of delivery:
Vaginal / C-Section Birth weight:
Problems/Complications with baby at birth?
- Breathing: Y / N
- Jaundice: Y / N
- Other?

Any problems soon after birth? Nursery or home? What kind?

FAMILY MEDICAL HISTORY: List all **blood** relatives of your child who have:

(F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle,

Asthma	Birth Defects
Allergies (Seasonal)	Sudden Infant Death Early
Allergies to Food	Deafness
Diabetes	Anemia/Blood Disorder
Epilepsy/Seizures	Mental Retardation
Heart Disease	Cancer
High Blood Pressure	Cystic Fibrosis
High Cholesterol	Arthritis
Tuberculosis	Muscular Dystrophy
HIV/AIDS	Drug Addition
Migraines/Headaches	Alcoholism

CHILD'S PAST MEDICAL HISTORY

Allergic Reactions to (if so, what kind)?
- Medicine: Y / N
- Food: Y / N
- Animals: Y / N
- Insect Bites: Y / N

Medications taken on regular basis? (excluding vitamins)

Immunizations up-to-date? Y / N
- Do you have a record? Y / N

Hospitalizations? When? Where? Why?

Serious Injuries? When? Where?

Whooping Cough: Y / N	Chicken Pox: Y / N
Rheumatic Fever: Y / N.	Asthma: Y / N
Recurrent Infections?	Eczema: Y / N
- Ear Y / N	Seizures: Y / N
- Throat Y / N	Anemia: Y / N
Bleeding Tendency: Y / N	Hepatitis: Y / N
Problems with hearing: Y / N	Mumps: Y / N
Problems with vision: Y / N	

Other significant history:

DEVELOPMENT & BEHAVIOR

Age at which child:
- Sat alone
- Walked
- Used sentences
- Toilet Trained

Is Development normal for his/her age? Y / N
- How are grades in school?
- Problems in school? Y / N

Behavior problems? Y / N

FEEDING & NUTRITION

Colic or feeding problems during first 3 months? Y / N

Breast fed? Y / N	- Number of months:
Formula fed? Y / N	- Current brand:
Vitamins? Y / N	Do the vitamins have Fluoride? Y / N
Special diet? Y / N	

FAMILY PROFILE

Parents are:
- Married? Y / N
- Separated? Y / N
- Divorced? Y / N

Father's current age:
- Highest school grade

Mother's current age:
- Highest school grade:

(List all brothers & sisters & their ages):

Responsible Party (Guarantor)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Hunt Club Pediatric Associates. This individual may not necessarily be the insurance card holder. Responsible Party must read and sign below.

Name: _____ Relationship to Patient:_____

Address: _____

Email Address: _____ Occupation:_____

Social Security Number: _____ Cell / Home #: _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of service. Furthermore, I agree to pay any collection costs and legal fees incurred by this office with respect to these charges.

SIGNATURE: _____ **DATE:** _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to HUNT CLUB PEDIATRICS for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

NAME: _____

SIGNATURE: _____ **DATE:** _____

Child Advocacy

As advocates for our young patients, Hunt Club Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

NAME: _____

SIGNATURE: _____ **DATE:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

Authorization to Release Information

I hereby authorize Hunt Club Pediatrics to release any medical or incidental information that may be necessary for either medical care, school forms, or in processing applications for financial benefit.

1. FULL DETAILS OF HIPAA POLICY ON DISPLAY IN OUR WAITING ROOM.
2. Signature below is acknowledgement that you have received this HIPAA Notice of Privacy Practices
3. A photocopy of these assignments shall be valid as the original

Patient/Child's Name: _____ **D.O.B:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ **Today's Date:** _____

Authorized Individuals

It is the law, and the policy that you must authorize which family members and other individuals who may make appointments and accompany your child(ren) to their appointments. Therefore, the following individuals (other than the parents) are authorized to act in your place with respect to any and all medical matters. Please note that we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

1. Name: _____ DOB: _____

Relationship to patient: _____ Phone #: _____

2. Name: _____ DOB: _____

Relationship to patient: _____ Phone #: _____

3. Name: _____ DOB: _____

Relationship to patient: _____ Phone #: _____

4. Name: _____ DOB: _____

Relationship to patient:_____ Phone #: _____

5. Name: _____ DOB: _____

Relationship to patient: _____ Phone #: _____

Hunt Club Pediatrics, LLC

NOTICE TO ALL PARENTS

NO SHOW POLICY

Effective January 1 2019 THERE WILL BE A **$50.00 FEE** IF THERE IS A "NO SHOW" OR CANCELLATION ON SAME DAY APPOINTMENTS.

ALL FUTURE APPOINTMENTS REQUIRE A 24-HOUR CANCELLATION NOTICE PRIOR TO THE APPOINTMENT OR A $50.00 FEE WILL APPLY.

TELE – CARE CALL POLICY

EFFECTIVE JANUARY 1 2019

ALL CALLS AFTER NORMAL BUSINESS HOURS REQUESTING MEDICAL ADVICE WILL BE REFERRED TO THE ARNOLD PALMER'S TELE-CARE NURSE PROGRAM.
THERE IS A $20.00 FEE PER CALL.

Patient Name: _____

Signature: _____ **Date:** _____

Financial Policy

Thank you for choosing Hunt Club Pediatrics as your health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. Please understand that payment of your bill is considered part of your care.

Due to the frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you are unable to provide proof of insurance or are on a plan in which we do not participate, or have no insurance coverage, payment is required at the time of your visit.

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your superbill at each visit so you will be able to file your claims with your insurance company. If we are a participating provider, we will file a claim for services rendered, although all co-pays and co-insurance amounts are due at the time of service.

If you are scheduled for a WCC (Well Child Check-up) and other health concerns are brought up that would typically require a separate visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly. Additionally, if it is determined that we need to treat a medical condition or must order additional tests or labs at the WCC (Well Child Check-up), your bill will reflect all services rendered. You may consider the appointment as one visit, but your insurance company may not. In that case, you could be billed for co-pay, Co-insurance or the service could be applied towards your yearly deductible.

Should there be a dispute with your insurance company, we will attempt to resolve it for you. During this time, a statement will be mailed to you each month that your account shows a balance due for all insurances other than HMO's. If your insurance has not paid within 90 days the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company. Even though you have health insurance, you as the guarantor are responsible for payment of all services provided to you by Hunt Club Pediatrics. Therefore, it is your responsibility to notify Hunt Club Pediatrics immediately of any insurance changes, to ensure the correct insurance carrier is billed for services rendered. If there is a change in your insurance company, please ensure we are listed as the PCP, if a PCP is required to receive payment.

Newborns

It is important that you add your newborn to your insurance policy within the first 30 days of life to prevent any lapse in coverage. Please contact your employer (human resources department) or insurance carrier to start the process and ensure all the proper paperwork has been submitted.

Vaccine for Children (VFC) Program

Children who are insured but do not have vaccine coverage, enrolled in Medicaid, or are either American Indian or Native Alaskan qualify for the Vaccines for Children Program. The vaccines are provided free of charge but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC Program, you must let the staff know. We cannot implement this program retroactively.

Divorce, Separation, and Custody Agreements

Hunt Club Pediatrics will not be party to custodial, separation or financial disputes relating to individuals with regards to minor children to whom services are provided. The individual who requests the medical services and sign the financial agreement is responsible for any balance due. All co-pays, co-insurance, and deductibles, if applicable, will be collected at the time services are rendered. We will not call the other parent for consent. Both parents have rights to the minor medical records unless there is a court order that mandates only one parent should have the records.

_____ Initials

Financial Responsibility

_____ **Initials** **I have received a copy of Hunt Club Pediatrics Financial Policy statement. I understand coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at Hunt Club Pediatrics. I am responsible for any health Insurance co-payments, Deductibles and remaining balance not covered by my insurance company. I understand that Hunt Club Pediatrics is not responsible for knowing what services my plan covers and does not cover.**

Insurance Responsibility

_____ **Initials** **I irrevocably assign and transfer to Hunt Club Pediatrics Associates, LLC, all insurance benefits covered to Hunt Club Pediatrics Associates, LLC services for payment of services rendered. I understand it is my Responsibility for providing a current copy of my insurance card and notifying Hunt Club Pediatrics of Any changes/addition to patient's insurance coverage.**

Patient Name: _____ **Signature:** _____ **Date:** _____

HOW DID YOU HEAR ABOUT US?

1. FRIEND / WORD OF MOUTH: _____
2. INTERNET SEARCH: _____
3. OBGYN / HEALTHCARE PROVIDER: _____
4. COMMUNITY EVENT / FESTIVAL: _____
5. SOCIAL MEDIA: _____
6. OTHER: _____

Patient's Name:_____ Date of Birth: _____

Today's Date: _____