Date: _____/_____/_____

Office Location: _____

NEW PATIENT REGISTRATION

How did you hear about Angel Kids Pediatrics? Please check all that apply!

- ⬭ Google
- ⬭ Television
- ⬭ Radio
- ⬭ Electronic Sign or Billboard
- ⬭ www.myangelkids.com
- ⬭ New Baby Seminar
- ⬭ Insurance Company
- ⬭ Facebook
- ⬭ Twitter
- ⬭ Brochure
- ⬭ Jax 4 Kids
- ⬭ Jax Moms Blog
- ⬭ Fun 4 First Coast Kids
- ⬭ Drive-by location
- ⬭ Internet Ad.
- ⬭ Direct Mail
- ⬭ Hospital/OB-GYN Office/ Dr. Referral *(please specify)*:_____
- ⬭ Referred by Friend or Family Member *(please specify)*:_____
- ⬭ Community Event *(please specify)*:_____
- ⬭ Other *(please specify)*:_____

PATIENT INFORMATION:

Last Name:_____ First Name:_____ M.I._____

Date of Birth: _____ Gender: ⬭ Male ⬭ Female Primary Language: _____

Ethnicity: ⬭ Hispanic ⬭ Non-Hispanic ⬭ Unknown Race: ⬭ Asian ⬭ Black ⬭ Hawaiian ⬭ Caucasian ⬭ American Indian ⬭ Two or More

Home Address: _____ City: _____ State:_____ Zip:_____

Primary Phone: __(_____)_____ ⬭ Home ⬭ Cell ⬭ Work ⬭ Other

Secondary Phone: __(_____)_____ ⬭ Home ⬭ Cell ⬭ Work ⬭ Other

HOW WOULD YOU LIKE TO BE REACHED REGARDING THE FOLLOWING MATTERS? *(Please mark **ONE** circle for each)*

Medical Issues: ⬭ Mailing Address ⬭ Home Phone ⬭ Work Phone ⬭ Cell Phone ⬭ Home E-Mail ⬭ Work E-Mail

Appointment Reminders: ⬭ Mailing Address ⬭ Home Phone ⬭ Text-to-Cell ⬭ Cell Phone ⬭ Home E-Mail ⬭ Work E-Mail

Recall Notices: ⬭ Mailing Address ⬭ Home Phone ⬭ Text-to-Cell ⬭ Cell Phone ⬭ Home E-Mail ⬭ Home Address

Billing Statements: ⬭ Mailing Address ⬭ Home E-Mail ⬭ Work E-Mail

General Practice Notices: ⬭ Mailing Address ⬭ Home Phone ⬭ Text-to-Cell ⬭ Cell Phone ⬭ Home E-Mail ⬭ Home Address

Patient Portal Notifications: ⬭ Text-to-Cell ⬭ Home E-Mail ⬭ Work E-Mail

May we leave a message? ⬭ Yes ⬭ No

CONTACT INFORMATION:

Contact 1:

Name: _____ Relation to Patient: ⬭ Mother ⬭ Father ⬭ Other: _____

Lives with Patient? ⬭ Yes ⬭ No DOB:_____/_____/_____ Social Security #: _____-_____-_____

Cell Phone: ____(_____)_____ Work Phone: ____(_____)_____

Employer: _____ Occupation: _____

Home E-Mail: _____

Contact 2:

Name: _____ Relation to Patient: ⬭ Mother ⬭ Father ⬭ Other: _____

Lives with Patient? ⬭ Yes ⬭ No DOB:_____/_____/_____ Social Security #: _____-_____-_____

Cell Phone: ____(_____)_____ Work Phone: ____(_____)_____

Employer: _____ Occupation: _____

Home E-Mail: _____

EMERGENCY CONTACTS:

Contact 1:

Name of friend/relative (not living at same address): _____ Relationship:_____

Home Phone: ___(_____)_____ Cell Phone: ___(_____)_____ Work Phone: ___(_____)_____

Contact 2:

Name of friend/relative (not living at same address): _____ Relationship:_____

Home Phone: ___(_____)_____ Cell Phone: ___(_____)_____ Work Phone: ___(_____)_____

INSURANCE INFORMATION:

Primary Policy

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Gender: ⬭ M ⬭ F

Insurance Carrier: _____ I.D. #:_____ Group #:_____

Secondary Policy

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Gender: ⬭ M ⬭ F

Insurance Carrier: _____ I.D. #:_____ Group #:_____

NEWBORN INSURANCE COVERAGE: *If your child is not a newborn, please skip this section.*

If you have not already, please notify your insurance company of the arrival of your newborn as soon as possible. Most insurance plans, including Medicaid, require immediate notification. Failure to do so could result in non-payment of filed claims. By signing below, I understand that I will be responsible for full payment of services should my insurance company deny payment.

Patient Name: _____ Date of Birth: _____/_____/_____

Parent/ Guardian Name: _____ Parent Guarding Signature: _____ Date:____/_____/_____

Witness: _____ Date: _____/_____/_____

BILLING:

Who should receive the billing statements? ⬭ Mother ⬭ Father ⬭ Other: _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I certify that the above information is true and correct. I authorize my insurance benefits be paid directly to the physician/practice. I understand that I am financially responsible for any balance that my insurance does not cover. I also authorize Angel Kids Pediatrics or my insurance company to release any information to process my claims. I understand that there is a $25 service charge for all returned checks.

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

Print Name: _____ Relationship to Patient: _____

ANGEL KIDS PEDIATRICS
We care for your angels

www.myangelkids.com
904-224-5437

13241 Bartram Blvd. #209
Jacksonville, FL. 32258

13770 Beach Blvd. #6
Jacksonville, FL. 32224

8225 Normandy Blvd.
Jacksonville, FL. 32221

6801 Beach Blvd
Jacksonville, FL 32216

774 State Road 13
St. Johns, FL 32259

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Failure to fill out this form so past medical records can be obtained may result in your child being discharged from our practice

Patient Name: _____ Date of Birth: _____/_____/_____

Information requested from:

Person/Facility:_____ Phone: ____(_____)_____

Address: _____ Fax: ____(_____)_____

**** Please only fax a maximum of 25 pages. If more than 25 pages, please mail to our office. Thank you! ****

Information may be disclosed to:

Person/ Facility: Medical Records Department/ Angel Kids Pediatrics **Phone: (904) 242-4220**

Address: _____ **Fax: _____**

For the purpose of:

◯ Continuity of Care ◯ Personal Use ◯ Other: _____

Information to be disclosed (via fax or mail):

◯ General Medical Records ◯ Medical History ◯ Physical Results ◯ Progress Notes

◯ Diagnostic Test Results ◯ Immunization Records ◯ Consultation Notes ◯ Other:_____

Please initial the statement below:

_____ These records may include information relating to: Sexually transmitted Diseases, HIV/AIDS, Tuberculosis, drug or alcohol abuse, pregnancy, mental health, child abuse, early intervention, and/ or WIC eligibility.

The authorization will expire on _____. I understand that if I fail to specify an expiration date, this authorization signature will expire (6) months from the date on which it was signed.

Parent/Guardian Signature:_____ Todays Date: _____

Print Name: _____ Relationship to Patient:_____

Witness:_____ Date: _____

*** As a courtesy, please no discs. Thank you! ***

HEALTHCARE STATUS AUTHORIZATION

I, _____ (Parent or legal guardian), hereby give authorization to Angel Kids Pediatrics for the release of information concerning the status of my child's care, including laboratory and imaging results to provide medical services and treatment to:

Patients Name: _____ Date of Birth: _____/_____/_____

While they are accompanied by the following individual(s) in my absence:

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

May all contacts have access to patient's records electronically? ⬭ Yes ⬭ No

If parents are divorced or separated, please fill out the section below:

Who has custody of the child? ⬭ Mother ⬭ Father ⬭ Other: _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ⬭ Yes ⬭ No

If yes, please explain and provide a copy of the legal paperwork that supports this restriction:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patients Name: _____ Patients DOB: _____/_____/_____ Gender: ⬭ M ⬭ F Is Child Adopted? ⬭ No ⬭ Yes

PATIENT'S PAST MEDICAL HISTORY

Condition	YES	NO	Comments
Comments			
Serious Injuries or Accidents			
Hospitalizations or ER Visits			
Surgeries			
Problems with Ears or Hearing			
Asthma / Bronchitis / Bronchiolitis / or Pneumonia (circle which applies)			
Indoor Allergens / Outdoor Allergens (circle which applies)			
ADD/ ADHD			
Heart Problems or Heart Murmur			
Anemia or Bleeding Problem			
Blood Transfusion			
Frequent Abdominal Pain			
Constipation Requiring Doctors Visits			
Bladder or Kidney Infection			
Bed Wetting (After 5 Years of Age)			
If Female patient, Have Menstrual Periods Started?			
If Female patient, Any Problems with Period? (cramping, discharge, irregular cycle)			
Chronic or Recurrent Skin Problems? (Acne, Eczema, Etc.)			
Frequent Headaches			
Convulsions or Other Neurologic Problems			
Thyroid or Endocrine Problems			
Other Significant Problems			
Cancers			
Receiving Medical Care from a Specialist			
Taking Any Daily Medications, Vitamins, or Herbal Supplements			
Delayed or Missing Immunizations			
Recurrent Medical Problems (Ear Infections, Strep Throat, UTIs)			

PATIENT'S SOCIAL HISTORY

Social History	Comments
Behavioral or Mental Health Problems	
History of Child Abuse	
Use of tobacco, drugs, alcohol	
Animals/Pets in Household	

Patients Name: _____ Patients DOB: _____/_____/_____ **HEALTH HISTORY CONTINUED**

FAMILY MEDICAL HISTORY

Condition	YES	NO	Family Member	Comments
Comments				
Deafness				
Nasal Allergies				
Asthma				
Tuberculosis				
Heart Disease Prior to Age 50				
High Blood Pressure Prior to Age 50				
High Cholesterol				
Anemia				
Bleeding Disorders				
Liver Disease				
Kidney Disease				
Diabetes (Prior to Age 50)				
Bed-wetting (After 10 Years of Age)				
Epilepsy or Convulsions				
Alcohol Abuse				
Drug Abuse				
Mental Illness				
Mental Retardation				
Immune Problems, HIV, or AIDS				
Additional Pertinent Concerns				

PATIENT'S BIRTH HISTORY

Birth History	Comments
Baby's Gestational Age	_____weeks
Birth Weight	_____lbs. _____oz.
Birth Hospital	
Doctor who delivered child	
Vaginal or C-section?	
Breastfeeding, Formula Feeding, or Both?	

Please answer the following	YES	NO	Comments
Was Hepatitis B vaccine given in hospital?			
Was Hearing Screen passed in hospital?			
Did the child have jaundice?			

OTHER OCCUPANTS LIVING WITH CHILD:

Name: _____ Age:_____ Relationship:_____

Name: _____ Age:_____ Relationship:_____

Name: _____ Age:_____ Relationship:_____

Name: _____ Age:_____ Relationship:_____

ANGEL KIDS PEDIATRICS
We care for your angels

CANCELLATION/NO SHOW POLICY

Your time is important to us and while we strive to provide quality care to all of our patients and families, we must also adhere to our practice polices. Please understand that your scheduled appointment time has been reserved especially for you. Late cancellations or missed appointments negatively impact our schedule.

In order to improve our care, we have implemented a new Cancellation/No Show policy that will take effect January 1, 2018. We appreciate your cooperation and patience as we try to adhere to these guidelines.

It is required that **new patients** arrive ONE HOUR prior to your child's scheduled appointment time for insurance and paperwork purposes. For any subsequent appointments, we ask that you arrive 15 minutes prior to your scheduled appointment time. As a courtesy to our providers, staff, and other patients, we ask that you call at least 24 hours in advance of your scheduled appointment time for cancellations. If unable to, please notify us as soon as possible. **If you arrive late for your appointment and we do not have availability, your appointment will need to be rescheduled.**

If you do not call to cancel your child's appointment, a "no show" will be documented in the child's chart. After THREE “No Shows” within 12 months you will be discharged from the practice and asked to find another pediatric practice for your child and their siblings.

EMERGENCY ROOM POLICY

If your child has 2 or more unnecessary emergency room visits (i.e. runny nose, constipation, etc.) during our regular business hours (including the hours of all five locations), you will be discharged from the practice and asked to find another pediatrician for your child and their siblings.

Please initial next to each statement.

_____After the first "no show", you will be given a courtesy call to inform you of your missed appointment.

_____After the second "no show", there will be a $50 no show fee. Your insurance will not cover this fee.

_____After the third "no show", will result in a discharge of the patient from Angel Kids Pediatrics.

_____After the first “unnecessary ER visit”, you will be given a courtesy call to inform you of your unnecessary ER use and asked to schedule a follow-up appointment.

_____After the second “unnecessary ER visit”, will result in a discharge of the patient from Angel Kids Pediatrics

I certify that I have read, understood, and agree to the terms presented above.

Patient Name:_____
Parent Name: _____
Parent Signature:_____
Date:_____

ANGEL KIDS PEDIATRICS PRIVACY NOTICE ACKNOWLEDGEMENT AND FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review a copy of the Angel Kids Pediatrics Privacy Notice. I understand that I am responsible to read this Notice and notify Angel Kids Pediatrics, in writing, of any request for restrictions in the use or disclosure of my child's individually identifiable health information. I understand the notice included electronic access to my child's medical history. Angel Kids Pediatrics has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.myangelkids.com. Angel Kids Pediatrics will provide me with a copy of its most recent Notice upon my request.

Patient name: _____ Date of Birth: _____/_____/_____

Parent, Guardian or Legal Representative Signature:

_____

Person(s) authorized to have access to child's records:
Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services (including laboratory testing and radiology) and procedures rendered at Angel Kids Pediatrics. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services.

Angel Kids Pediatrics may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Angel Kids Pediatrics in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Angel Kids Pediatrics. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

The billing department and/or office mangers handle financial matters, not the doctors. Please direct your questions accordingly.

Settlements/financial responsibilities, such as divorce, must be resolved between parents. We do not get involved with these issues.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is my responsibility to provide Angel Kids Pediatrics with a copy of my child's **current insurance card.** If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Angel Kids Pediatrics immediately upon any change in my insurance.**

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and course of treatment, the administration of all anesthetics, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my child's diagnosis and/or treatment.

ADDITIONAL INFORMATION

Angel Kids Pediatrics accepts payments in: Cash, Check, Debit and Credit Cards.

I understand additional charges ($25.00) are applied to my account for any returned checks used to pay on my account. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Angel Kids Pediatrics.

FORM FEE

For special forms to be completed, you will be charged $25.00 per form. Physical and shot record forms requested after the well-exam visit will incur a charge of $10.00 per set. This fee must be paid in full prior to receiving the completed forms. Angel Kids Pediatrics will not hold the liability of faxing or mailing any forms. Please give us 48-72 hours notice when requesting forms so that we have adequate time to prepare them.

IN-NETWORK INSURANCES

AETNA PPO, HMO, (COVENTRY-PPO/Meritan Health ONLY-DR. AFFAN ONLY), AVMED, ASSURANT, BCBS (BLUECARE, BLUE OPTION, FLORIDA BLUE, TRADITIONAL PLANS), CAMBRIDGE PPO (INTERGRATED HEALTHPLAN), CIGNA PPO (GREATWEST/PHCS), GOLDEN RULE, HUMANA, MMSI, TRICARE (PRIME/STANDARD/RETIRED), UMR, UNITED HEALTHCARE PPO ONLY, SUNSHINE (MEDICAID/HEALTHYKIDS-STARS-STARSPLUS),MOLINA HEALTHCARE MEDICAID, ALLSTATE (AUTO ACCIDENTS ONLY- NEED CASE#), DAIRYLAND (AUTO ACCIDENTS ONLY-NEED CASE#), GEICO (AUTO ACCIDENTS ONLY-NEED CASE #), DIRECT GENERAL (AUTO ACCIDENTS ONLY NEED CASE #), SMARTHEALTH (LOCAL BCBS-DR. AFFAN ONLY PPO), PROGRESSIVE (AUTO ACCIDENT ONLY NEED CASE#), GEHA PPO, GREAT WEST PPO, HEALTHPARTNERS PPO (DR. AFFAN ONLY), MAYO PPO (ONCE CLAIM IS FILED PT'S PCP WILL FALL UNDER TAXID), MOAA, ONENET PPO (DR. AFFAN ONLY), OXFORD HEALTH (DR. AFFAN ONLY), RSL SPECIALTY, CORESOURCE PPO (DR. AFFAN ONLY), MVP (DR. AFFAN-ONLY), PHCH PPO, MULTIPLAN PPO, STATE FARM (AUTO ACCIDENT ONLY CASE# NEEDED), UHS SERVICES (DR.AFFAN ONLY), HEALTHEASE KIDS (WELLCARE/STAYWELL AGES 3-17 ONLY), HUMANA PPO

OUT OF NETWORK PLANS GATORCARE (BCBS-SHAND/UFHEALTH), UNITED HEALTHCARE HMO/COMPASS/COMMUNITY MEDICAID/HEALTHYKIDS, AETNA (HEALTHSCOPE)

*__ALL INSURANCES WE ACCEPT ARE SUBJECT TO CHANGE WITHOUT NOTICE.__

ASSIGNEMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patients, directly to Angel Kids Pediatrics. I hereby authorize Angel Kids Pediatrics to release medical information necessary to obtain payment. I understand that I am financially responsibly for all changes not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS AGREENMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDIITIONS.

Patient's Printed Name: _____ Patient's Date of Birth: _____/_____/_____

Parent, Guardian or Legal Representative Signature: _____ Date Signed:

_____/_____/_____