VERO BEACH PEDIATRICS

Email Form To: careteam@verobeachpediatrics.com

NEW PATIENT REGISTRATION

Primary Parent/Guardian Information

Parent/Guardian Name: _____ DOB _____Sex: ___

Relationship to patient _____ Lives with patients below ____ SSN_____

Primary address _____

City _____State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

Secondary Parent/Guardian Information (optional)

Parent/Guardian Name: _____ DOB _____Sex: ___

Relationship to patient _____ Lives with patients below ____ SSN_____

Primary address _____

City _____State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

VERO BEACH PEDIATRICS

Child 1

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 2

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 3

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 4

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Primary Insurance

Subscriber's Name: _____ DOB _____ Sex: ___

Subscriber ID#: _____ Patient relationship to subscriber _____

Insurance carrier _____ Group #: _____ Group name: _____

Authorized persons other than parent/guardian

Persons other than parent/guardian who are authorized to accompany child to appointment include:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Note: These persons are required to bring photo ID on the day of the appointment

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of Vero Beach Pediatrics to request and obtain my child's prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescriptions directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Vero Beach Pediatrics to enroll my child in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of Vero Beach Pediatrics to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to VERO BEACH PEDIATRICS the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and Optimal Care Pediatrics to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

Consent to Treat Form

1. I _____ (patient name) give permission for **[VERO BEACH PEDIATRICS]** to give me medical treatment.

2. I allow **[VERO BEACH PEDIATRICS]** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **[VERO BEACH PEDIATRICS]** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print name

CONSENT FORM FOR TREATMENT OF MINOR CHILD

The State of Florida has enacted a new law that imposes additional obligations on health care providers when obtaining consent to treat a minor child. This form seeks to comply with our obligations under this new law, including obtaining a written consent to prescribe, where medically indicated, medicinal drugs needed by the minor child identified below. The new law also states that written consent must be obtained from a parent who has legal custody of the minor child or is the legal guardian of the minor child.

By signing below, I represent that I am either a parent with legal custody or the legal guardian of the minor child named below.

I give Vero Beach Pediatrics physicians, other medical professionals, and employees, consent to provide, solicit and arrange for health care services, and prescribe medicinal drugs when necessary, to the minor child named below.

THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED.

DATE: _____ TIME: _____ Signature: _____

Print Name: _____

Relationship: _____

Print Name of Minor Child: _____ Date of Birth: _____

If Interpretation is Used:

_____ Check: ☐ Phone ☐ Video

Qualified Staff / Interpreter Signature

_____

Print Qualified Staff / Interpreter Name ID Number Language Interpreted Date

PATIENT LABEL

OR

Patient / Minor Name _____

DOB _____

Patient ID _____

This consent form allows Vero Beach Pediatrics to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Vero Beach Pediatrics has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at _____.

_____ I hereby authorize that Vero Beach Pediatrics may leave messages on my voicemail to confirm Initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. ___ cell phone ___ home phone ___work phone

_____ I hereby authorize that Vero Beach Pediatrics may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Vero Beach Pediatrics may disclose my personal health information to the person who I have listed as my emergency contact.

_____ I hereby authorize that Vero Beach Pediatrics may disclose my personal health information to the Initial following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Vero Beach Pediatrics may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Vero Beach Pediatrics may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while Vero Beach Pediatrics is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Vero Beach Pediatrics may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ **Date**_____

Signature of Parent (if minor) / Authorized Representative_____ **Date**_____