Children's Health of Ocala
1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

PATIENT REGISTRATION

1st Child_____D.O.B_____ ☐M ☐F
First MI Last

2nd Child_____D.O.B_____ ☐M ☐F
First MI Last

Address _____City_____ State_____Zip_____

Email Address for Patient Portal_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____
First MI Last

Relationship to Patient_____ Phone _____

GURANTOR INFORMATION

Mother/Guardian _____ D.O.B_____
First MI Last

SSN_____ Home Phone _____Cell Phone_____

Address _____City_____ State_____Zip_____

Name of Employer_____ Work Phone _____

Father/Guardian_____-_____ D.O.B_____
First MI Last

SSN_____ Home Phone _____Cell Phone_____

Address _____City_____ State_____Zip_____

Name of Employer_____ Work Phone _____

Authorization and Release

I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____
Signature of Responsible Party/Guarantor Date

Children's Health of Ocala
1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

Children's Health of Ocala is committed to providing you with the best possible care and will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees, financial policy or your responsibility.

Commercial Insurance

If you are covered by a commercial insurance carrier that we accept we will file a claim to your carrier. You will be expected to pay any co-pay, Co-Insurance and or any deductibles at the time of service.

If you are a member of any other insurance carrier that we do not accept, you are expected to pay in full at the time of service and we will provide you with the necessary forms to file a claim with your insurance carrier for reimbursement.

Medicaid

We accept Medicaid assignments. Children's Health of Ocala does adhere to the Florida Medicaid Agreement and title 42 code of the federal regulation 447.20 and civil rights act of 1964.

Self Pay

Full payment is due at the time of service. We accept cash, credit cards with the exception of American express and checks.

Agreement

I agree that should the amount for insurance benefit be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due (excluding disallowed amounts per a managed care contract) for services rendered if the expense is not covered under the policy. I understand that Children's Health will not become involved in disputes between me and my insurance company. Regarding deductibles, co-payments, covered charges and or usual and customary charges other than to supply factual information as necessary.

The undersigned will pay all cost and expenses including a reasonable attorney fee incurred or paid by Children's Health in the collection of this obligation by suit or otherwise the entire amount is due and payable upon billing.

This agreement shall remain in effect until revoked by me in writing; I also permit Children's Health to use a photocopy of these assignments to be used in place of the original on file at Children's Health.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

_____ _____

Signature of Responsible Party/Guarantor **Date**

Consent for Treatment

I hereby consent to the medical treatment at Children's Health by its Doctor, Nurse Practitioner and Staff.

_____ _____

Signature of Responsible Party/Guarantor **Date**

Children's Health of Ocala

1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

PEDIATRIC HEALTH HISTORY

Patient Name_____D.O.B_____
First MI Last

Ethnicity (Please Choose One)

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer

Race (Please Choose One)

☐ American Indian /Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian Native or Pacific Islander ☐ white ☐ Decline to Answer

ALLEGIES / REACTIONS	**FAMILY HISTORY**				
		Patient	**Parents**	**Grandparents**	**Siblings**
	Diabetes				
	Lung Disease				
	Cancer				
	Heart Disease				
PERINATAL HISTORY	**Hypertension**				
	Allergies				
Prenatal Care:	**Bleeding Disorder**				
Birth weight lbs oz length	**Kidney Disease**				
APAGAS	**Birth Defects**				
Vaginal Delivery Yes / No Caesarean Yes / No	**Mental Illness**				
Pre Term Yes / No **No. of weeks**	**Smoking**				
Full Term Yes / No **Deformities** Yes / No	**Asthma**				
Jaundice Yes / No	**Substance Abuse**				
Breast Yes / No **Formula** Yes / No	**Pets**				

HOSPITALIZATIONS OR SURGERY

DATE	**REASON**

_____ _____

Signature of Responsible Party **Date**

Children's Health of Ocala
1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

PATIENT CONTACT INFORMATION

I wish to be contacted in the following manner (Please check all that apply)

Home Phone:_____

☐ Ok to leave message with detailed information

☐ Leave message with call back number only

Work Phone:_____

☐ Ok to leave message with detailed information

☐ Leave message with call back number only

Cell Phone:_____

☐ Ok to leave message with detailed information

☐ Leave message with call back number only

Written Communication

☐ Ok to mail to my home address:_____

☐ Ok to mail to my work/office address:_____

☐ Ok to fax to this number:_____

I understand it is my responsibility to change this information should circumstances change. I will notify Children's Health of Ocala, in writing of any changes to the above.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Guarantors Signature **Date Signed**

Children's Health of Ocala
1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Children's
Patient's Name

Health Of Ocala's Notice of Privacy Practices.

_____ _____

Signature of Parent/Guardian If patient is minor **Date**

Children's Health of Ocala
1301 SE 25th Loop Suite 101
Ocala, Fl. 34471

Patient Name:_____ D.O.B:_____

CONSENT FOR TREATMENT OF A MINOR

This is to authorize and consent to any necessary or routine medical or surgical treatment including examination, injection, immunization, and/or diagnostic procedures, including x-ray and laboratory analysis. I understand that only myself, and those listed below will have the authority to authorize treatment.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

Any person bringing the patient in for treatment not listed above must have a dated and signed letter of consent from myself, or treatment could be refused or delayed. I understand that in unusual circumstances, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated that such consent for treatment of minor is canceled. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Children's Health of any changes to this information in the form a signed and dated letter.

_____ _____/_____/_____
Print Name **Date**

_____
Signature