CELEBRATION FAMILY PHYSICIANS

1530 Celebration Blvd Ste 103, Celebration, FL 34747
407-566-8898
celebrationfamily123@gmail.com
Mon 7-5 / Tues 7-5 / Wed 7-7 / Thurs 8-5 / Fri 7-12

New Patient Registration Form – Child

Welcome to Celebration Family Physicians!

We look forward to working together with you towards your child's good health.Should you have any questions, please do not hesitate to reach out to us.

Child's Information

First Name ______________________ Middle Initial _______ Last Name ___________________________

DOB __________________________ Social Security No ___________________________ Sex ☐ M ☐ F

Primary Address ____

City _______________________________________ State __________________ Zip __________________

Emergency Contacts

Name _______________________________ Relationship ________________ Phone __________________

Name _______________________________ Relationship ________________ Phone __________________

Parent / Legal Guardian Information

First Name ______________________ Middle Initial _______ Last Name ___________________________

DOB ____________________________________ Sex ☐ M ☐ F

Social Security No _________________________ Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Address ____

City _______________________________________ State __________________ Zip __________________

Home Phone __________________ Work Phone ___________________ Cell Phone ___________________

E-mail ____ Authorize Use of E-mail? ☐ Y ☐ N

Employment Status ☐ Employed ☐ Not Employed ☐ Retired ☐ Student

Employer ____ Occupation ____________________________

Primary Insurance

Insurance Name ____________________________ Policy Holders Name ______________________________

Relationship to Insured ________________ Social Security No _____________________ DOB _____________

Insurance ID No ____________________________________ Group No ________________________________

Secondary Insurance

Insurance Name ____________________________ Policy Holders Name ______________________________

Relationship to Insured ________________ Social Security No _____________________ DOB _____________

Insurance ID No ____________________________________ Group No ________________________________

Referral Source

Referring Physician ____ Specialty _________________________

☐ Friend or Family ____ ☐ Google ☐ Facebook ☐ Other

Pharmacy

Pharmacy name ______________________________ Phone ________________ Fax _________________

Pharmacy Address ____

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AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN PARENT OR LEGAL GUARDIAN IS UNABLE TO BRING PATIENT

I, ____, the parent or legal guardian of
Print Name

____, a minor,
Child's Name

do hereby authorize the following individuals:

1.____ Relationship to Minor ___________________________
Print Name

2.____ Relationship to Minor ___________________________
Print Name

3.____ Relationship to Minor ___________________________
Print Name

as my agent(s) to consent to any examination, anesthesia, medical evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician or advanced practitioner at Celebration Family Physicians.

This authorization includes first aid, emergency care and hospital admission if such is deemed necessary by the physician or advanced practitioner at Celebration Family Physicians. It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnostic tests, office treatment(s) including immunizations, anesthetic administration or surgical treatment(s) which a physician or other provider, in the exercise of his/her best judgment, may deem advisable. I accept responsibility for physician charges and laboratory fees. This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

I give permission for the provider at Celebration Family Physicians to share any relevant health information with the person who is accompanying my child.

This authorization shall remain effective from _______/_______/____________ to _______/_______/____________, unless sooner revoked in writing delivered to said agent(s).

Name ____Phone Number ________________________
(Print Name of Parent or Legal Guardian)

Signature ____ Date _______________________
(Signature of Parent or Legal Guardian)

CONSENTS - GENERAL

GENERAL CONSENT FOR TREATMENT

I, the patient or patient’s legal represantitive, agree to allow Celebration Family Physicians and its Providers to provide all health care services to me or to the individual I am representing that are routine or otherwise deemed necessary.

I understand I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it.

I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed.

I agree that no guarantees have been given to me or the individual I am representing as to the outcome of any treatment.

I authorize my provider and Celebration Family Physicians to photograph me or the individual I am representing for medically related documentation or identification purposes.

Printed Name	Signature	Date

CONSENT TO PERFORM PELVIC EXAM

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider’s gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I, the patient or patient’s legal represantitive, authorize Celebration Family Physicians and any health care practitioners associated with the practice to perform a pelvic examination, including vaginal sonography, as described above. By my signature below I acknowledge that I have read and understand the contents of this form.

Printed Name	Signature	Date

PATIENT TO AUTHORIZE FOR E-PRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I, the patient or patient’s legal represantitive, hereby authorize the physician and/or staff of Celebration Family Physicians to enroll me in the ePrescribe Program.

Printed Name	Signature	Date

PATIENT AUTHORIZATION FOR PHARMACY BENEFITS MANAGER

I, the patient or patient’s legal represantitive, authorize the physician and/or staff of Celebration Family Physicians to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Printed Name	Signature	Date

PATIENT AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER

I, the patient or patient’s legal represantitive, authorize the providers and/or staff of Celebration Family Physicians 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 the insurance company to pay directly to Celebration Family Physicians the amount due for medical or surgical services. I understand that I, the patient or patient’s legal represantitive, am financially responsible for any services deemed non-covered by my insurance company.

Printed Name	Signature	Date

FINANCIAL POLICY

Payment is required for all services at the time they are rendered including deductables, co-payments and any outstanding balances. I, the patient or patient's legal represantitive, understand that I am financially responsible for all services rendered and for the following reasons:

- I do not have the proper referral at the time of service.
- My referral is invalid/expired.
- I have given incorrect/invalid insurance information.
- Expenses are not covered by my insurance company.
- I have not met my deductible.
- The services rendered are deemed medically unnecessary by my insurance company. *(This applies to present and future visits).*

I, the patient or patient's legal represantitive, agree to assign insurance benefits to Celebration Family Physicians whenever necessary. Celebration Family Physicians will bill participating insurance companies. If Celebration Family Physicians has not received payment from my insurance company within 45 days of the date of service, I may be expected to pay the balance in full. I am responsible for ensuring that all charges are paid whether by myself or by my insurance carrier.

If my account must be turned over to collections, a $25.00 collection fee will be added to my account. I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Cancellations are required 24 hours prior to the appointment. If I am more than 15 minutes late after my scheduled appointment, this is considered a late arrival and my appointment will be rescheduled. **Celebration Family Physicians reserves the right to charge $25.00 for missed or late-canceled appointments.**

Per insurance regulations, an annual wellness exam is not a visit to discuss chronic condition(s) or new problem(s). I understand that instead of scheduling a separate office visit to address these condition(s) or new problem(s), I have the option of addressing them at the time of my annual wellness exam. Two claims will be submitted to my insurance: one for the annual wellness and one for an office visit addressing my chronic condition(s) or new problem(s). If I have a co-pay or co-insurance, I will be responsible for that amount as with my normal office visit.

Should I require special accommodations for my appointment, I must notify Celebration Family Physicians of the needed accommodation one week prior to the appointment. If I do not provide at least 24 hour notice prior to cancelling my appointment or do not show to the scheduled appointment, all charges incurred by Celebration Family Physicians is my responsibility.

By signing below, I understand and accept the Celebration Family Physicians Financial Policy as stated above.

__________________________	__________________________	____________
Printed Name of Patient or Patient's Legal Representative	Signature of Patient or Patient's Legal Representative	Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPPA). You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting the same at the front desk.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to request that we restrict, in writing, how PHI about you is used or disclosed for treatment, payment or healthcare operations.

By my signature below, I, the patient or patient's legal represantitive, acknowledge that I had the opportunity to review Celebration Family Physician's Notice of Privacy Practices.

__________________________	__________________________	____________
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CONSENTS TO SHARE INFORMATION

REMINDERS AND NOTIFICATIONS

Please choose which contact method(s) you prefer for APPOINTMENT REMINDERS (you may select more than one):

☐ Email
☐ Phone
☐ Text Messages (message and data rates may apply)
☐ Patient Portal (if activated)

Please choose which contact method(s) you prefer for TEST RESULTS NOTIFICATIONS (you may select more than one):

☐ Email
☐ Phone
☐ Text Messages (message and data rates may apply)
☐ Patient Portal (if activated)

E-MAIL CONSENT

I choose to communicate via e-mail on matters related to my health and/or my medical treatment.

I understand that any Confidential Health Information that I send to the practice using may not be secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted, I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

☐ I agree with the above ☐ I do not agree with the above

PHONE CONSENT

I authorize Celebration Family Physicians to:

Leave a detailed message on voice mail/machine/cell	☐ YES	☐ NO
Leave a detailed message with individual answering the phone	☐ YES	☐ NO

CONSENT TO DISCUSS MEDICAL INFORMATION

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individual(s) you authorize the providers and office staff of Celebration Family Physicians to discuss care with.

1.____________________________ Relationship __________________
Print Name

2.____________________________ Relationship __________________
Print Name

3.____________________________ Relationship __________________
Print Name

____________________ ____________________ ________
Printed Name of Patient or Patient's Legal Representative **Signature of Patient or Patient's Legal Representative** **Date**

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PREVENTIVE vs PROBLEM FOCUSED VISITS

We all need good preventive care! Early detection and prevention are key to maintaining good health and often saves money. Preventive care includes exercise, eating healthy, and getting regular wellness exams with your doctor.

What are preventive services?

Typically, the following services are considered preventive services:

- Review of your health history and family health history
- Physical exam (must be one year from previous exam)
- Vaccinations/Immunizations
- Men and Women's Health Screenings (i.e. mammogram, pap smear)
- Screening exams (i.e. blood pressure, cholesterol screening, diabetes screening, STD screening)
- Education about wellness, diet, exercise, and prevention
- ***Other routine screening labs/services may be ordered by your physician and, as every insurance company differs in coverage, it is the patient's responsibility to make sure these are covered prior to being completed.***

What if I have a medical problem to discuss?

Per insurance regulations, an annual preventive exam is not the same thing as a normal office visit. An annual preventive exam does not include a discussion of a new medical problem or detailed evaluation of chronic medical conditions. Due to those regulations and our desire to run on time, we may ask you to schedule a separate visit to address these concerns. This will allow your physician time to adequately address your medical problems.

Instead of scheduling a separate office visit, you may have the option of addressing these chronic conditions or new problems at the same time as your annual wellness exam. Two claims will be submitted to your insurance: one for the annual wellness and one for an office visit addressing the chronic condition(s) or new problem(s). If you have a co-pay or co-insurance, you will be responsible for that amount as with a normal office visit.

By signing below, you acknowledge that you have read and understand the policies stated above.

____________________	____________________	__________
Printed Name of Patient or Patient’s Legal Representative	Signature of Patient or Patient’s Legal Representative	Date