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)

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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 (Only female adult and pediatric patients)

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

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CONSENTS - GENERAL CONT'D

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
_____	_____	_____

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.

Printed Name of Patient or Patient's Legal Representative	Signature of Patient or Patient's Legal Representative	Date
_____	_____	_____

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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.

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

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AUTHORIZATION TO RECEIVE/ACCESS AND USE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Phone number _____ Social Security No. _____

I, _____, **REQUEST AND AUTHORIZE:**
(name)

Name of Facility/Organization/Person _____

Address _____

Phone Number _____ Fax Number _____

TO RELEASE THE HEALTH INFORMATION OF THE PATIENT NAMED ABOVE TO:

Celebration Family Physicians
1530 Celebration Boulevard Suite 103 / Celebration, FL 34747
Fax Number 1-877-553-1366 / Phone Number 407-566-8898

PLEASE FAX (preferred) OR MAIL THE HEALTH INFORMATION INDICATED BELOW: (check all that apply)

- ☐ Entire medical record
- ☐ Results of specific service(s) test(s) and/or procedure(s):
  - ☐ Laboratory results
  - ☐ radiology reports
  - ☐ immunizations
  - ☐ medications
- ☐ Other _____
- ☐ Discharge summaries
- ☐ Procedure/operative notes
- ☐ Specific date(s) of service (s):

_____

☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s)/entity listed above. I must give permission before disclosure of these results.

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s)/entity listed above.

PURPOSE OF RELEASE

- ☐ Changing Providers
- ☐ Moving
- ☐ Personal File
- ☐ Coordination of Care with Specialist or Agency
- ☐ Life Insurance
- ☐ Other

_____ _____
Printed Name of Patient or Legal Guardian Relationship of Patient

_____ _____
Signature of Patient or Legal Guardian Date

This authorization expires 1 year from the date it is signed.

INFORMED CONSENT TO TELEHEALTH SERVICES

I understand and agree that I have reviewed, understand and accept the risks and benefits of telehealth services as described below and wish to receive such services. If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

1. By using the Celebration Family Physicians telehealth portal, I agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Celebration Family Physicians provider and I will be able to see and speak with each other from remote locations.
2. I understand and agree that:
    - I will not be in the same location or room as my medical provider.
    - My Celebration Family Physicians provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
    - Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Celebration Family Physicians provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
    - Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Celebration Family Physicians responsible for lost information due to technological failures.
    - I further understand that my Celebration Family Physicians Provider's advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Celebration Family Physicians provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
    - I may discuss these risks and benefits with my Celebration Family Physicians provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to present or future treatment by Celebration Family Physicians.
    - I understand that the level of care provided by my Celebration Family Physicians provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to visit the office of Celebration Family Physicians, hospital emergency department or other appropriate health care provider.
    - I have the right to receive face-to-face medical services at any time by traveling to a Celebration Family Physicians medical center that is convenient to me.
    - In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.
3. I consent to, understand and agree that:
    - I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives.
    - Celebration Family Physicians will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
    - Before prescribing any controlled substance to me, Celebration Family Physicians may review information from the Prescription Drug Monitoring Program in my state of residence regarding my prior receipt of controlled substances.
    - My Celebration Family Physicians provider will not prescribe opioids to me during a telehealth visit.
    - I have the right to review and receive copies of my medical records, including all information obtained during a telehealth interaction, subject to Celebration Family Physicians' standard policies regarding request and receipt of medical records and applicable law.
    - The laws of the state in which I am located will apply to my receipt of telehealth services.

_____	_____	_____
Printed Name	Signature	Date

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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:

- **$5.00 for missed or late-cancelled nurse visits**
- **$25.00 for missed or late-canceled appointments**
- **$50.00 for missed or late-cancelled procedures**

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